Division of Health Care Financing and Policy
Nevada Medicaid Managed Care

State Fiscal Year 2018–2019 Internal Quality Assurance Program Compliance Review

for

LIBERTY Dental Plan of Nevada, Inc.

November 2019

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

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

The purpose of the state fiscal year (SFY) 2018–2019 Internal Quality Assurance Program (IQAP) Compliance Review was to assess the DBA's compliance with the compliance review standards found in 42 Code of Federal Regulations (CFR) §438 Subparts A–F and the State contract requirements found in the DHCFP Contract 3425. The SFY 2018–2019 IQAP Compliance Review focused on the requirements for member services and experiences found in Subparts A, C, D, and F. The review period was January 1, 2018, through June 30, 2018. This report details **LIBERTY Dental Plan of Nevada, Inc.**'s (**LIBERTY**'s) compliance with the following:

- **IQAP Standards:** State and federal managed care requirements, which were categorized into five contract standards.
- **Checklists:** Contractual requirements related to the member handbook as well as member rights and responsibilities.
- **File Reviews:** Contractual requirements related to processing grievances, appeals, and service denials.

LIBERTY had a composite score of 94.1 percent for all elements evaluated in the SFY 2018–2019 IQAP Compliance Review. With the exceptions noted in this report, **LIBERTY** demonstrated average compliance with the federal and State requirements contained in its managed care contract. Table 1-1 summarizes the overall ratings for **LIBERTY**'s IQAP standards, checklists, and file reviews for the SFY 2018–2019 IQAP Compliance Review.

Table 1-1—SFY 2018–2019 IQAP Compliance Review Results for LIBERTY

Overall Ratings for LIBERTY	
IQAP Standards Score	For the IQAP standards, **LIBERTY** received a total score of **87.3%**.
Checklist Score	For the checklist review, **LIBERTY** received a total score of **100%**.
File Review Score	For the file review, **LIBERTY** received a total score of **97.1 %**.
Composite Score	**LIBERTY** received an overall rating of **94.1 %** for all elements reviewed in the SFY 2018–2019 IQAP Compliance Review.

While the compliance review scores highlight areas of compliance with **LIBERTY**'s contract provisions, two areas indicate significant opportunities for improvement for **LIBERTY**. The first

opportunity for improvement involves **LIBERTY**'s inability to follow instructions related to the submission of documents for the desk review. **LIBERTY** staff members were instructed not to change certain areas of the desk review tool and instead provide the specific names of documents submitted as evidence to support compliance with each element. **LIBERTY** staff members had marked some elements in the desk review tool as Not Applicable (N/A), which were in fact applicable to the review. **LIBERTY** did not submit all supporting documentation to HSAG by the requested due date. Instead, **LIBERTY**'s desk review tool included dates as to when the information would be submitted; however, not all documentation was received by the date provided by **LIBERTY**. For some elements, HSAG requested specific documents that were provided during the Readiness Review in 2017 but were not provided as part of **LIBERTY**'s desk submission for the SFY 2018–2019 compliance review. In some instances, **LIBERTY** staff members were not familiar with the documents.

The second opportunity for improvement is related to an area of concern found in the 2017 Readiness Review that **LIBERTY** had not corrected. It was noted during the file reviews that the dental record request letter to the provider included instructions that providers could email the dental records and other protected health information (PHI) to **LIBERTY**. It was unclear if encrypted and secure email would be used. During **LIBERTY**'s Readiness Review completed in 2017, this issue was also noted. **LIBERTY** submitted a corrective action plan (CAP), which included revisions to the dental request letter template instructing the provider that email encryption must be used if the dental provider chose to send dental records via email. The revised language contained in the CAP also invited providers to establish a secure email account with **LIBERTY**, if needed. During the SFY 2018–2019 compliance review, HSAG found that **LIBERTY** had not implemented the CAP approved by the DHCFP. While **LIBERTY**'s email system may be secure and its emails encrypted, these conditions may not be true for a dental provider. An increased risk for a breach of PHI when transmitting dental records from unsecured emails remains a serious concern. Further discussion with the DHCFP should occur to determine next steps in addressing this matter.

2. Background

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

Mandatory Activity

The BBA, Public Law 105-33, requires that states contract with an EQRO to conduct an annual evaluation of their managed care entities (MCEs), including DBAs, to determine each MCE's compliance with federal and the State's managed care standards. The U.S. DHHS, Centers for Medicare & Medicaid Services (CMS) regulates requirements and procedures for the EQR. The DHCFP contracted with HSAG to conduct EQR services for the Nevada Medicaid and Nevada Check Up managed care program.

According to the 42 CFR §438.358, which describes the activities related to EQRs, a state or its EQRO must conduct a review within a three-year period to determine a Medicaid MCE's compliance with federal standards and standards established by the State for access to care, structure and operations, and quality measurement and improvement. These standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR §438. To meet this requirement, the DHCFP contracted with HSAG to initiate a new three-year cycle of MCE reviews starting in SFY 2017–2018, to complete a comprehensive review of compliance with State and federal standards within the three-year period. The full review schedule is detailed in Table 2-1. For **LIBERTY**, year 1 review standards (i.e., Provider Network Management, Standard 1 through Standard 5) were reviewed as part of the **LIBERTY** Readiness Review, which was completed in November 2017.

Table 2-1—Nevada IQAP Compliance Review Cycle for LIBERTY

Standard	Year 1 SFY 2017–2018	Year 2 SFY 2018–2019	Year 3 SFY 2019–2020
Provider Network Management			
1. Credentialing and Recredentialing	✓		
2. Availability and Accessibility of Services	✓		
3. Subcontracts and Delegation	✓		
4. Provider Dispute and Complaint Resolution	✓		
5. Provider Information	✓		

Standard	Year 1 SFY 2017–2018	Year 2 SFY 2018–2019	Year 3 SFY 2019–2020
Member Services and Experiences			
6. Member Rights and Responsibilities		✓	
7. Member Information		✓	
8. Continuity and Coordination of Care		✓	
9. Grievances and Appeals		✓	
10. Coverage and Authorization of Services		✓	
Managed Care Operations			
11. Internal Quality Assurance Program			✓
12. Cultural Competency Program			✓
13. Confidentiality and Recordkeeping			✓
14. Enrollment and Disenrollment			✓
15. Program Integrity			✓

Purpose of the Review

The purpose of the SFY 2018–2019 IQAP Compliance Review was to determine **LIBERTY**'s compliance with federal and the State's managed care standards related to member services and experiences. In addition, HSAG conducted a review of individual files for the areas of grievances, appeals, and service denials to evaluate **LIBERTY**'s implementation of the standards. Checklist reviews validated that the DBA apprised recipients of their rights and responsibilities and that the member handbook met established contract and CFR requirements. The review period was January 1, 2018, through June 30, 2018.

3. Methodology

Compliance Review Process

The IQAP standards were derived from the requirements as set forth in the *Department of Human Services, Division of Health Care Financing and Policy Request for Proposal No. 3425 for Dental Benefits Administrator*, and all attachments and amendments in effect during the review period of January 1, 2018, through June 30, 2018. HSAG followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012[3-1] to create the process, tools, and interview questions used for the SFY 2018–2019 IQAP Compliance Review.

Methods for Data Collection

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and requirements outlined in the contract between the DHCFP and **LIBERTY**. HSAG conducted pre-on-site, on-site, and post-on-site review activities.

Pre-on-site review activities included:

- Developing the compliance review tools.
- Preparing and forwarding to **LIBERTY** a customized questionnaire, instructions for completing the questionnaire, and instructions for submitting the requested documentation to HSAG for its desk review.
- Conducting a technical assistance session to assist **LIBERTY** in preparing for the compliance review.
- Scheduling the on-site review.
- Developing the agenda for the on-site review.
- Providing the detailed agenda and the data collection (compliance review) tool to **LIBERTY** to facilitate preparation for HSAG's review.
- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents and other information obtained from the DHCFP, and of documents that **LIBERTY** submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of **LIBERTY**'s operations, identify areas needing clarification, and begin compiling information before the on-site review.
- Generating a list of 10 sample cases plus an oversample of five cases for each file review.
- Completing the desk review of grievance, appeal, and service denial files.

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1.pdf. Accessed on: Oct 22, 2019.

On-site review activities included:

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

HSAG documented its findings in the data collection (compliance review) tool shown in Appendix A, which serves as a comprehensive record of HSAG's findings, performance scores assigned to each requirement, and actions required to bring **LIBERTY**'s performance into compliance for those requirements that HSAG assessed as less than fully compliant. The results for the IQAP standards are noted in Table 3-1 of this report. The results of the checklists and file reviews are summarized in Table 3-2 and Table 3-3, respectively, in the pages that follow.

Post-on-site review activities: HSAG reviewers aggregated findings to produce this comprehensive compliance review report. In addition, HSAG created a CAP template, shown in Appendix B, which contains the findings and recommendations for each element scored *Partially Met* or *Not Met*. When submitting its CAP to the DHCFP, **LIBERTY** must use this template to propose its plan to bring all elements scored *Partially Met* or *Not Met* into compliance with the applicable standard(s). **LIBERTY** must submit its CAP to the DHCFP **within 14 days of receiving this report.**

Description of Data Obtained

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

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

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

IQAP Standards, Checklists, and Files Reviewed

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

Table 3-1—IQAP Standards

IQAP Standard #	IQAP Standard Name	Number of Elements
VI	Member Rights and Responsibilities	11
VII	Member Information	11
VIII	Continuity and Coordination of Care	4
IX	Grievances and Appeals	33
X	Coverage and Authorization of Services	24
	Total Number of IQAP Elements	**83**

Table 3-2—Checklists

Associated IQAP Standard #	Checklist Name	Number of Elements
VI	Member Rights and Responsibilities	14
VII	Member Handbook	27
	Total Number of Checklist Elements	**41**

Table 3-3—File Reviews

Associated IQAP Standard #	File Review Name	Number of Elements
IX	Grievances	4
IX	Appeals	8
X	Service Denials	3
	Total Number of Elements Reviewed in Each File	**15**

Data Aggregation and Analysis

IQAP Standards

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which **LIBERTY**'s performance complied with the requirements. A designation of *NA* was used when a requirement was

not applicable to **LIBERTY** during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. The protocol describes the scoring as follows:

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

From the scores that HSAG reviewers assigned for each requirement, HSAG calculated a total percentage-of-compliance score for each IQAP standard and an overall percentage-of-compliance score across the IQAP standards. HSAG calculated the total score for each standard by adding the weighted score for each requirement in the standard receiving a score of *Met* (value: 1 point), *Partially Met* (value: 0.50 point), or *Not Met* (0 points), then dividing the summed weighted scores by the total number of applicable requirements for that standard.

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

Checklists

For the checklists reviewed, HSAG reviewers scored each applicable element within the checklist as either *Yes*, the element was contained within the associated document; or *No*, the element was not contained within the document. Elements not applicable to **LIBERTY** were scored *Not Applicable* and were not included in the denominator of the total score. To obtain a percentage score, HSAG added the total number of elements that received *Yes* scores, then divided by the total number of applicable elements.

File Reviews

HSAG conducted file reviews of **LIBERTY**'s records of grievances, appeals, and service denials to verify that **LIBERTY**'s documented policy had been put into practice in its policy. For grievances, appeals, and service denials, HSAG selected 10 files of each type of record from the full universe of records provided by **LIBERTY**. The file reviews were not intended to be a statistically significant representation of all of **LIBERTY**'s files. Rather, the file review highlighted instances of practices described in policy not being followed by **LIBERTY** staff. Based on the results of the file reviews, **LIBERTY** 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.

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

Aggregating the Scores

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

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

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

Evaluation Ratings for LIBERTY Dental Plan of Nevada, Inc.

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

IQAP Standards

Table 4-1 presents **LIBERTY**'s scores for the IQAP standards. Details regarding **LIBERTY**'s compliance with the five IQAP standards, including the score that **LIBERTY** received for each element within each standard, are found in Appendix A, SFY 2018–2019 IQAP Compliance Review Tool for **LIBERTY**.

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

IQAP Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				M	*PM*	*NM*	*NA*	
VI	Member Rights and Responsibilities	11	11	11	0	0	0	100%
VII	Member Information	11	11	11	0	0	0	100%
VIII	Continuity and Coordination of Care	4	4	2	2	0	0	75.0%
IX	Grievances and Appeals	33	33	20	13	0	0	80.3%
X	Coverage and Authorization of Services	24	24	18	6	0	0	87.5%
Total Compliance Score		**83**	**83**	**62**	**21**	**0**	**0**	**87.3%**

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

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

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

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

A review of the IQAP standards shows how well **LIBERTY** has interpreted the required elements of the managed care contract and developed the necessary policies, procedures, and plans to carry out the required functions of the DBA. Of the 83 applicable elements, **LIBERTY** received *Met* scores for 62 elements, *Partially Met* scores for 21 elements, and no elements received a *Not Met* score. The findings suggest that **LIBERTY** should further develop the necessary policies, procedures, and plans to operationalize the required elements of its contract to demonstrate compliance with the contract. Further, interviews with **LIBERTY** staff showed that staff members were knowledgeable about most

of the requirements of the contract and the policies and procedures that **LIBERTY** employed to meet contractual requirements.

The areas with the greatest opportunity for improvement for IQAP standards were related to Standard VIII—*Continuity and Coordination of Care*, Standard IX—*Grievances and Appeals*, and Standard X—*Coverage and Authorization of Services*, which received scores of 75 percent, 80.3 percent, and 87.5 percent, respectively.

Prior to the on-site review, **LIBERTY** did not submit all supporting documentation to HSAG by the requested due date. **LIBERTY**'s desk review tool included dates as to when the information would be submitted; however, not all documentation was received by the date provided by **LIBERTY**. **LIBERTY** also did not request an extension from HSAG or the DHCFP. Further, **LIBERTY** staff members had marked some elements in the desk review tool as Not Applicable (N/A), which were in fact applicable to the review. Additional delays occurred after the on-site visit as **LIBERTY** was required to submit documentation by the end of the business day following the on-site review, as requested by HSAG. Not all documentation was received by the agreed-upon due date, and some information was sent to HSAG nearly two weeks after the on-site review.

Checklist Reviews

Table 4-2 presents the scores for the checklists. HSAG reviewed all requirements related to the member handbook and member's rights and responsibilities to verify compliance with State and federal requirements. HSAG scored the elements required via the checklists. The checklists review area was scored based on the total number of **LIBERTY**'s compliant elements divided by the total number of applicable elements.

Table 4-2—Checklist Score

Associated IQAP Standard #	Checklist	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
VI	Member Rights and Responsibilities	14	14	100%
VII	Member Information	27	27	100%
	Checklist Totals	**41**	**41**	**100%**

The results generated by the checklists serve as additional indicators of **LIBERTY**'s ability to develop the required outreach information and to ensure that the information contains all contractually required elements. Of the 41 elements reviewed for the checklists, **LIBERTY** received scores of *Met* for all elements. The findings suggest that **LIBERTY** had strong compliance in each of the areas evaluated by the checklists and that **LIBERTY** developed the necessary manuals, handbooks, and policies according to contract requirements.

File Reviews

For the file reviews, each file review area was scored based on the total number of **LIBERTY**'s compliant elements divided by the total number of applicable elements for each individual file reviewed. Table 4-3 presents **LIBERTY**'s scores for the file reviews.

Table 4-3—Summary of Scores for the File Reviews

Associated IQAP Standard #	Description of File Review	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
IX	Grievances	10	30	30	100%
IX	Appeals	10	44	42	95.5%
X	Service Denials	10	30	29	96.7%
	File Review Totals	**30**	**104**	**101**	**97.1%**

File reviews are important to the overall findings of the IQAP review because the results show how well **LIBERTY** operationalized and followed the policies it developed for the required elements of the contract. Of the 104 total elements reviewed for the file reviews, **LIBERTY** received scores of *Met* for 101 elements.

The area with the greatest opportunity for improvement for file reviews was related to appeals, which demonstrated compliance with 42 of 44 elements. Documentation that demonstrated **LIBERTY** made reasonable efforts to give oral notice of resolution to the member for an expedited appeal was not found in the appeal file. Further, one expedited appeal was not resolved within the required 72-hour time frame.

LIBERTY's grievance process outlined in policy was inconsistent with contractual and federal standards. Specifically, **LIBERTY**'s policy included the provisions for an expedited grievance and second-level appeal for a grievance decision. The grievance file review for **LIBERTY**, however, showed that policy inconsistencies did not adversely affect the manner in which grievances were processed by the DBA. All 30 elements reviewed in the grievance file reviews were compliant with the processing time frames and requirements.

LIBERTY demonstrated compliance with 29 of 30 applicable elements related to the service authorization denial file review. A standard authorization decision was not rendered, and notice provided to the member within the required 14-day time frame for one of the service authorization denial files reviewed.

The Your Rights Under Managed Dental Care document, which was attached to all notices of adverse benefit determination (NABDs) generated by **LIBERTY** and also to the notice of appeal resolution, contained incorrect information about the grievance process and listed incorrect time frames for members to request an appeal or State fair hearing.

Written notices to members did not always contain easily understood language or format as outlined in federal regulations. Additionally, three appeal files reviewed did not demonstrate that members were provided with grievance rights when **LIBERTY** made the decision to deny the member's expedited appeal request.

It was noted during the file reviews that the dental record request letter to the provider included instructions that providers could email the dental records to the DBA. It was unclear if encrypted and secure email would be used. During **LIBERTY**'s Readiness Review completed in 2017, this issue was also noted. **LIBERTY** submitted a corrective action plan (CAP) which included revisions to the dental request letter template instructing the provider that email encryption must be used if the dental provider chose to send dental records via email, but the CAP was not implemented. While **LIBERTY**'s email system may be secure and its emails encrypted, these conditions may not be true for a dental provider. An increased risk for a breach of PHI when transmitting dental records from unsecured emails remains a serious concern. Further discussion with the DHCFP should occur to determine next steps in addressing this matter.

Conclusions and Recommendations

Table 5-1 presents overall ratings for **LIBERTY** for IQAP standards, checklists, and file reviews, as well as the overall composite score.

Table 5-1—Overall Rating for LIBERTY

IQAP Standards Score	For the IQAP standards, **LIBERTY** received a total score of **87.3%**.
Checklist Score	For the checklist review, **LIBERTY** received a total score of **100%**.
File Review Score	For the file review, **LIBERTY** received a total score of **97.1%**.
Composite Score	**LIBERTY** received an overall rating of **94.1%** for all elements reviewed in the SFY 2018–2019 IQAP Compliance Review.

LIBERTY's overall results for the review of the IQAP standards in the SFY 2018–2019 IQAP Compliance Review was 87.3 percent. In addition, **LIBERTY** received a score of 97.1 percent for the file review, a score of 100 percent for the checklist review, and an overall composite score of 94.1 percent. The overall results demonstrated that **LIBERTY** had average adherence to State and federal standards required by its contract with the DHCFP. **LIBERTY** developed the necessary policies, procedures, and plans to carry out the required functions of the contract in most areas reviewed; the checklist results demonstrated that **LIBERTY** staff appropriately operationalized the elements described in **LIBERTY**'s policies, procedures, and plans; and file review results demonstrated that **LIBERTY** staff did not appropriately operationalize the elements described in **LIBERTY**'s policies, procedures, and plans.

Compliance With IQAP Standards

Of the five standard areas reviewed, **LIBERTY** achieved 100 percent compliance on two standards, demonstrating performance strengths and adherence to all requirements measured in these areas: Standard VI—*Member Rights and Responsibilities* and Standard VII—*Member Information*.

The areas with the greatest opportunity for improvement for IQAP standards were related to Standard VIII—*Continuity and Coordination of Care*, Standard IX—*Grievances and Appeals*, and Standard X—*Coverage and Authorization of Services*, which received scores of 75 percent, 80.3 percent, and 87.5 percent, respectively.

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

Compliance With Checklists

LIBERTY achieved 100 percent compliance for the Member Rights and Responsibilities checklist review, which demonstrates strong compliance with the requirements for informing members of their rights and responsibilities.

LIBERTY achieved 100 percent compliance for the Member Information checklist review, which demonstrates strong compliance with the requirements for information included in the member handbook.

Compliance With File Review

LIBERTY received 100 percent compliance for all required elements related to the grievance file review. All files reviewed demonstrated **LIBERTY**'s strong compliance with the standards detailed in the contract.

LIBERTY's grievance process outlined in policy was inconsistent with contractual and federal standards. Specifically, **LIBERTY**'s policy included the provisions for an expedited grievance and second-level appeal for a grievance decision. The grievance file review for **LIBERTY**, however, showed that inconsistencies in the policies did not adversely affect the manner in which grievances were processed by the DBA.

- HSAG recommends that **LIBERTY** ensure that:
  - Grievance policies and procedures include accurate information that is consistent with federal regulations and the contract with the DHCFP.
  - Members have access to the correct State Fair Hearing Request form.
  - When a dental provider emails dental records, that mechanisms are in place to assure protection and security of the member's PHI. Further, discussion with the DHCFP should occur to determine next steps in addressing this matter.
  - Mechanisms are in place to verify that remediations identified in CAPs are implemented.

LIBERTY received 95.5 percent compliance for all required elements related to the appeal file review. All files reviewed demonstrated **LIBERTY**'s partial compliance with the standards detailed in the contract. Documentation that demonstrated **LIBERTY** made reasonable efforts to give oral notice of resolution to the member for an expedited appeal was not found in the appeal file. Further, one expedited appeal was not resolved within the required 72-hour time frame.

- HSAG recommends that **LIBERTY** ensure that:
  - Policies describing the appeal processes include the correct terminology and that processes are consistent with federal regulations.
  - Appeal template letters and the Your Rights Under Dental Managed Care document include correct information and all the requirements identified in federal regulations.

  - Reasonable efforts are made to give oral notice of resolution to the member for expedited appeals.
  - All expedited appeals are resolved within the 72-hour time frame.
  - When an expedited appeal request is denied, the member or member's representative is provided with grievance rights.

LIBERTY received 96.7 percent compliance for all required elements related to the service denials file review. All files reviewed demonstrated **LIBERTY**'s strong compliance with most standards detailed in the contract.

- HSAG recommends that **LIBERTY** ensure that all service authorization requests are reviewed and a decision rendered within the required 14-day time frame.

Corrective Action Plan

Appendix B contains the CAP template that HSAG prepared for **LIBERTY** to use in preparing its CAP to be submitted to the DHCFP. The template lists each element for which HSAG assigned a score of *Partially Met* or *Not Met*, as well as the associated findings and recommendations made to bring the organization's performance into full compliance with the requirement. **LIBERTY** must use this template to submit its CAP to bring any elements scored *Partially Met* or *Not Met* into compliance with the applicable standard(s). **LIBERTY**'s CAP must be submitted to the DHCFP **no later than 14 calendar days after receipt of this report**.

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

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

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

Standard VI: Member Rights and Responsibilities			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
DHCFP Contract Section 3.5.4.1	1. Primary Dental Provider (PDP) or Primary Dental Care Site (PDCS) The DBA must implement procedures to ensure that each recipient has an ongoing source of primary care appropriate to their needs. Each enrolled recipient must be assigned to a Primary Dental Provider or Primary Dental Care Site, within five (5) business days of the effective date of enrollment. The DBA may auto-assign a PDP or PDCS that has traditionally served the Medicaid population to an enrolled recipient who does not make a selection at the time of enrollment.	**Documents Submitted:** 01. 2_Capitated_Provider-to-Member Assignments V2 **Description of Process:** Please see description of process in the above P&P.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Capitated Provider-to-Member Assignments policy and procedure stipulated that recipients may request a specific provider or office during the initial enrollment process. If the recipient did not select a provider, the system auto-assigns the recipient to a provider. The auto-assignment protocol followed the following steps: Identify if the recipient had a previous provider assignment in the system, identify if the recipient had other family members with an active assignment, and identify if the recipient could be assigned to the same office as a previous provider. If none of the above applied, the system used a combination of the recipient's spoken language and ZIP code to match the member with the closest provider who could accommodate the language requirements. If no provider was available within 15 miles that matched the recipient's language requirements, the system removed the language requirement, and the recipient was matched by ZIP code to the closest available provider. LIBERTY staff members stated that the member enrollment system contains an algorithm that automatically assigns a provider to a member at the time of enrollment, which is within five business days. The algorithm considers the geographical location of the member's residence, age, and continuity of care based on enrolled family members.		
	Recommendations: None.		

Standard VI: Member Rights and Responsibilities			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.3(1) *DHCFP Contract Section 3.5.4.4 (A)*	2. Changing PDP or PDCS An enrolled recipient may change a PDP or PDCS for any reason. The DBA shall notify enrolled recipients of procedures for changing PDPs or PDCS.	**Documents Submitted:** 02. QM PP – Member Rights and Responsibilities **Description of Process:** LIBERTY provides members instructions to change their dental provider in the Member Handbook and is available online.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Member Rights and Responsibilities policy and procedure noted that recipients may choose their primary care dentist (PCD) in the LIBERTY network within a reasonable distance from their place of residence from the provider directory list on enrollment, and recipients have the freedom to change their PCD on request for any reason and as frequently as needed. The Member Rights and Responsibilities section of the Nevada Medicaid Dental Program Member Handbook dated December 2018 (Handbook) also included this information. The Handbook furnished a link to the automated provider directory and advised recipients to call the Member Services Department to change their dental home.		
	Recommendations: None.		
42 CFR §438.10(f)(1) *DHCFP Contract Section 3.5.4.4 (B)*	3. Provider Terminations In cases where a PDP has been terminated, the DBA must notify enrolled recipients in writing and allow recipients to select another PDP or make a reassignment within fifteen (15) business days of the termination effective date and must provide for urgent care for enrolled recipients until re-assignment.	**Documents Submitted:** 03. NM PP - Member Transfer Notification - Provider Termination 03. NM PP - Member Transfer Notification - (Provider Termination) **Description of Process:** Please see description of process in the above P&P.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI: Member Rights and Responsibilities			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	Findings: The Member Transfer Notification – (Provider Termination) policy and procedure contained the statement that provider contracts included language requiring dentists to provide advance notification of termination from the plan to enable LIBERTY to notify members of their transfer to another PCD no later than 30 days prior to the effective date of the transfer. The policy also noted that the provider relations staff completed all data entry to affect the transfers of recipients to a new PCD no later than 30 days prior to the effective date of the transfers. In case of the immediate termination of a contracting general dentist due to potential imminent harm to a member, notification of the transfer should be given to members immediately and no later than 15 days of the termination date.		
	Recommendations: None.		
42 CFR §438.100(b)(2)(iii, iv) *42 CFR §438.102(a)(1)(i-iv)* *DHCFP Contract Section 3.6.5.13 (E)(1-4)*	4. Restricting Provider Communication to Members The DBA may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a recipient who is his or her patient: a. For the recipient's health status, dental care, or treatment options, including any alternative treatment that may be self-administered. b. For any information the recipient needs in order to decide among all relevant treatment options. c. For the risks, benefits, and consequences of treatment or non-treatment. d. For the recipient's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.	**Documents Submitted:** 04. Nevada Medicaid Program Addendum 04. NV Provider Agreement 2016.07.26 **Description of Process:** LIBERTY does not prohibit, or otherwise restrict dental professionals from advising or advocating on behalf of their patients. The Nevada Provider Agreement as well as the Nevada Medicaid Program Addendum is distributed to all providers upon contracting with LIBERTY, includes this provision. Details of member rights are also communicated in the member handbook and provider reference guide.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI: Member Rights and Responsibilities			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	Findings: The Nevada Medicaid Provider Reference Guide (Provider Manual) included the requirements of this element in the Anti-discrimination Section on page 13.		
	Recommendations: None.		
DHCFP Contract Section 3.9.16.3	5. Communicating Rights and Responsibilities to Providers A copy of the DBA's policies on recipients' rights and responsibilities is provided to all participating providers upon initial credentialing and when significant changes are made.	**Documents Submitted:** 05. NM PP - Provider Orientation **Description of Process:** Member rights and responsibilities are included in the Provider Reference Guide, which is an extension of the provider contract and is disseminated to providers upon contracting. It is discussed/presented during the orientation / re-orientation process as well as during site visits. Whenever there are updates to the Provider Reference Guide, including member rights /responsibilities, it is communicated to the providers through a provider alert and/or provider newsletter and are always made available online.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Provider Manual included the requirements of this element in the Member Rights and Responsibilities Section on pages 22–24. The Provider Orientation policy and procedure confirmed that LIBERTY addressed recipients' rights and responsibilities in the provider orientation conducted within 30 days of activation in the provider network.		
	Recommendations: None.		

Standard VI: Member Rights and Responsibilities			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.10(g)(2)(ix) *42 CFR §438.100(b)(2)(i)* *DHCFP Contract Section 3.9.16.4*	6. Communicating Rights and Responsibilities to Recipients Upon enrollment, recipients are provided a written statement that includes information on their rights and responsibilities. *Cross-reference Recipient Rights and Responsibilities Checklist*	**Documents Submitted:** 06. NM PP - Provider Notifications 06. NM PP - Provider Orientation **Description of Process:** Members' rights and responsibilities are available on line and included in and communicated to members via the Member Handbook, that is disseminated to members upon enrollment.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Handbook contained the Member Rights and Responsibilities on pages 13–14. LIBERTY staff members confirmed that within three calendar days of enrollment, members were mailed a welcome packet, which includes the Handbook. LIBERTY staff members confirmed that during high-volume days, mailing the member welcome packets could take as long as five calendar days.		
	Recommendations: None.		
DHCFP Contract Section 3.9.16.6	7. Recipient Suggestions An opportunity must be provided for recipients to offer suggestions for changes in policies and procedures.	**Documents Submitted:** 07. 2019 Member Advisory Committee Charter **Description of Process:** Please see description of process in the above P&P.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Member Advisory Committee Charter listed the following members of the committee as having voting rights: dental director; committee chair; senior vice president; member; Board of Directors; vice president, quality management; and five public members. The charter required (at least) 51 percent of the voting members to be represented by the public served by the dental plan. Other LIBERTY staff members may be in attendance at the meetings to provide information to the committee to foster discussion and furnish subject matter expertise. The Member Advisory Committee meeting minutes from		

Standard VI: Member Rights and Responsibilities			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	July 17, 2018, and December 4, 2018, provided evidence that the member advisory committee met and obtained recipient input on LIBERTY reporting and policies.		
	Recommendations: None.		
DHCFP Contract Section 3.9.16.10	8. Treatment of Minors The DBA must have written policies regarding the treatment of minors.	**Documents Submitted:** 08. QM PP - Member Rights and Responsibilities **Description of Process:** Please see description of process in the above P&P.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Member Rights and Responsibilities policy and procedure included the following statement: Members under the age of 18 cannot receive or make decisions about their treatment without a parent or guardian's consent; however, this does not apply if emergency care is necessary. Emancipated minors may make their own decisions regarding dental care. The Treatment of Minors section of the Provider Manual contained the information on page 19.		
	Recommendations: None.		
DHCFP Contract Section 3.9.16.11 (A–B)	9. Assessment of Recipient Satisfaction The DBA must conduct periodic surveys of recipient satisfaction annually with its services, and the survey(s) must include content on perceived problems in the quality, availability, and accessibility of care. The survey(s) assess at least a sample of: a. All recipients; b. Recipient requests to change practitioners and/or facilities; and c. Disenrollment by recipients.	**Documents Submitted:** 09. Desktop PP MS 229 Member Satisfaction Survey Data for Outbound Outreach **Description of Process:** Please see description of process in the above P&P.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI: Member Rights and Responsibilities			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	Findings: The Member Satisfaction Survey Data for Outbound Outreach policy and procedure explained the process LIBERTY used to select members to receive survey calls from member services representatives. LIBERTY selected members who received a service two months prior to the current month. The Member Satisfaction Survey Results summary report provided to DHCFP on June 26, 2019, provided evidence of the results of LIBERTY's satisfaction survey activities. The report included information from the surveys conducted June 2018 through May 2019. The summary report included survey results for the following categories: appointment availability, wait time, appearance and cleanliness of office, language availability, staff professionalism, amount of time with provider, treatment explanation, treatment, if the member recommended the office to others, overall satisfaction, and overall health of teeth and gums.		
	Recommendations: None.		
Drag DHCFP Contract Section 3.9.16.11 (C–D)	10. Survey Results As a result of the survey(s), the DBA must: a. Identify and investigate sources of dissatisfaction; b. Outline action steps to follow up on the findings; c. Inform practitioners and providers of assessment results; and d. The DBA re-evaluates the effects of the above activities.	**Documents Submitted:** 10. Desktop PP MS 229 Member Satisfaction Survey Data for Outbound Outreach **Description of Process:** Please see description of process in the above P&P.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The LIBERTY policy, Member Satisfaction Survey, described the process and tool used to measure member satisfaction with LIBERTY. The policy described how LIBERTY staff members would identify and investigate sources of dissatisfaction and follow up on the findings. The policy also described how the survey results would be reported quarterly to the Quality Management and Improvement Committee and disseminated to providers. The Member Satisfaction Survey Results summary report provided to DHCFP on June 26, 2019, provided evidence of the results of LIBERTY's satisfaction survey activities. The report included information from the surveys conducted June 2018 through May 2019.		
	Recommendations: None.		

Standard VI: Member Rights and Responsibilities			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.100(d) *42 CFR §438.3(d)(3-4)* *DHCFP Contract Section 3.4.2*	11. Non-discrimination Based on Health Status The DBA will not, on the basis of health status or need for health services, discriminate against recipients eligible to enroll. The DBA will not deny the enrollment nor discriminate against any Medicaid or Nevada Check Up recipients eligible to enroll on the basis of race, color or national origin and will not use any policy or practice that has the effect of discrimination on the basis of race, color or national origin.	**Documents Submitted:** 11. QM PP - Anti-Discrimination Policy **Description of Process:** It is LIBERTY's policy that no member is discriminated against on any basis and although enrollment/eligibility is determined by DHCFP, LIBERTY commits to accept all members from DHCFP's data file as eligible based on coverage dates and parameters as specified with no regard to health status, race, color, or national origin.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Anti-discrimination Policy emphasized that LIBERTY trained staff and maintained procedures to ensure that members were not discriminated against in the delivery of healthcare services based on race, color, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, health status, or source of payment. The policy included the requirement for staff members to report alleged discrimination to LIBERTY's civil rights coordinator and outlined the reprimands and/or sanctions imposed for verified discriminatory practices. LIBERTY confirmed that the dental plan accepted all members included in the DHCFP enrollment file based on the coverage dates specified to ensure nondiscrimination of the Medicaid or Nevada Check Up recipients.		
	Recommendations: None.		

Results for Standard VI: Member Rights and Responsibilities							
Total Elements	Met	=	11	X	1.00	=	11.00
	Partially Met	=	0	X	.50	=	0.00
	Not Met	=	0	X	.00	=	0.00
	Not Applicable	=	0	X	.00	=	0.00
	Total Applicable	=	11	**Total Rate**		=	11.00
Total Rate ÷ Total Applicable = Total Score							**100%**

Standard VII: Member Information			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.10(g)(2)(xiv) *DHCFP Contract Section 3.5.1.1*	1. Written Information about Access to Services The DBA must have written information about its services and access to services including Recipient Services phone number available to recipients and potential recipients. The written information must also be available in the prevalent non-English languages, as determined by the State, in its particular geographic service area.	**Documents Submitted:** 01. 2019 Cultural and Linguistics Program_CLEAN 01. QM PP - Provider Education Training **Description of Process:** It is LIBERTY's policy that all member facing materials are sent with both the Non-Discrimination Notice (NDN) and Notice of Language Assistance (NOLA) language however, the member handbook is the primary source of written information to our members on available services and how they can access them.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Translation of Written Member Informing Materials policy and procedure indicated that LIBERTY made vital member-informing materials available to all members and potential members in each threshold language on request. The LIBERTY Dental Plan Cultural and Linguistic Competency Program document dated December 2018 delineated the services available to ensure culturally and linguistically appropriate services for recipients. The plan indicated that Language Assistance Notices were available to recipients in at least the top 15 prevalent languages spoken in Nevada. LIBERTY employed bilingual member services representatives who were available during normal business hours to provide verbal and written interpretation for services to include explanation of benefits, scheduling appointments, transportation, and grievances and appeals. LIBERTY also ensured availability of teletypewriter (TTY) lines 24 hours a day, 365 days a year for hearing impaired recipients, and large print documents for visually impaired recipients. Available on request and at no charge to the recipient, LIBERTY translated any written recipient information. The Provider Education and Training policy and procedure noted that LIBERTY informed providers about translation services during initial orientation and in the Provider Manual. The Provider Manual noted that 24-hour access to interpreter services must be available to all recipients at no charge, and face-to-face interpreters must be available if requested. The Handbook included the statement that LIBERTY provided translation services in the recipient's preferred language at no cost to the recipient.		
	Recommendations: None.		

Standard VII: Member Information			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.10(d)(2,4) *DHCFP Contract Section 3.5.1.1*	2. Oral Interpretation Services The DBA must make free, oral interpretation services available to each recipient and potential recipient. This applies to all non-English languages, not just those that the State identifies as prevalent.	**Documents Submitted:** 02. CU PP - Cultural and Linguistic Competency Program Compliance **Description of Process:** LIBERTY provides language assistance services to members at no cost. Members are notified of the availability of services in the Member Handbook.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Translation of Written Member Informing Materials policy and procedure included the provision that LIBERTY made vital member-informing materials available to all members and potential members in each threshold language on request. The LIBERTY Dental Plan Cultural and Linguistic Competency Program document dated December 2018 delineated the services available to ensure culturally and linguistically appropriate services for recipients. LIBERTY employed bilingual member services representatives who were available during normal business hours to provide verbal interpretation for services to include explanation of benefits, scheduling appointments, assistance with transportation, and filing grievances and appeals. Available on request and at no charge to the recipient, LIBERTY provided oral translation of member materials. The Provider Education and Training policy and procedure noted that LIBERTY informed providers about translation services during initial orientation and in the Provider Manual. The Provider Manual noted that 24-hour access to interpreter services must be available to all recipients at no charge, and face-to-face interpreters must be available if requested. The Handbook included the statement that LIBERTY provided interpretation and translation services in the recipient's preferred language at no cost to the recipient. Pages 8, 9, and 10 provided the notice of language assistance, also referred to as a Babel sheet, which detailed the manner in which an enrollee would obtain language assistance in 16 different languages. LIBERTY staff members stated the most common non-English language requested is Spanish, but they do receive rare requests for Vietnamese translation.		
	Recommendations: None.		

Standard VII: Member Information			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.10(d)(5)(i) *DHCFP Contract Section 3.5.1.2*	3. Notifying Recipients about Interpretation Services The DBA is required to notify all recipients and potential recipients that oral interpretation is available for any language and written information is available in prevalent languages. The DBA must notify all enrollees and potential enrollees how to access this information.	**Documents Submitted:** 03. CU PP - Cultural and Linguistic Competency Program Compliance **Description of Process:** Members are informed of the availability of free interpretation services at all points of access. Information on accessing language assistance services is included on the Non-Discrimination Notice and Notice of Language Assistance and in the Member Handbook. The NDN and NOLA are sent with all member materials and posted on LIBERTY's website. Provider offices are provided the Notice of Language Assistance to post in offices.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Translation of Written Member Informing Materials policy and procedure indicated that LIBERTY made vital member-informing materials available to all members and potential members in each threshold language on request. Pages 8–10 of the Handbook contained information in English and 15 other languages to inform recipients about their right to receive language assistance at no cost, and the information included the telephone number to the Member Services Department. The Interpreter/Translation Services section of the Handbook also included information about accessing language services. LIBERTY prominently displayed the telephone number for the Member Services Department and provided information concerning access to TTY/telecommunications device for the deaf (TDD) in the Handbook.		
	Recommendations: None.		

Standard VII: Member Information			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.10(d)(2,4) *42 CFR §438.10(e)(1,2)* *DHCFP Contract Section 3.14.7.2*	4. Potential Enrollees If requested by potential enrollees, the DBA must provide accurate oral and written information that he/she needs to make an informed decision regarding whether to enroll with the DBA.	**Documents Submitted:** 04. CU PP - Translation of Written Informing Member Materials **Description of Process:** Please see description of process in the above P&P.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Translation of Written Member Informing Materials policy and procedure indicated that LIBERTY made vital member-informing materials available to all members and potential members in each threshold language on request. Pages 8–10 of the Handbook contained information in English and 15 other languages to inform recipients about their right to receive language assistance at no cost, and the information included the telephone number to the Member Services Department. The Interpreter/Translation Services section of the Handbook also included information about accessing language services. LIBERTY prominently displayed the telephone number for the Member Services Department and provided information concerning access to TTY/TDD in the Handbook.		
	Recommendations: None.		
42 CFR §438.10(d)(5)(i-ii) *42 CFR §438.10(d)(6)(i-iv)* *DHCFP Contract Section 3.5.1.3*	5. Appropriate Format for Communications The DBA's written material must use an easily understandable format and language. The DBA must also develop appropriate alternative methods for communicating with visually and hearing-impaired recipients and accommodating physically disabled recipients in accordance with the requirements of the Americans with Disabilities Act of 1990. All recipients and potential recipients are informed that the information is available in alternative formats and how to access those formats. The DBA is responsible for effectively informing Title XIX Medicaid recipients	**Documents Submitted:** 05. CU PP - Language Assistance Services for Members with Disabilities **Description of Process:** LIBERTY ensures culturally competent care for members by making language assistance services available to members at no cost. LIBERTY Non-Discrimination Notice and Notice of Language Assistance taglines are sent out with all vital member materials.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII: Member Information			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, regardless of any thresholds.		
	Findings: The Steps to Follow for the Nevada Medicaid and Nevada Check Up Health & Wellness Member Newsletter process document included the requirement that the newsletter be published semiannually in summer and winter. The document also required the recipient information to be written at an eighth-grade level that is readable and easily understood. The Translation of Written Member Informing Materials policy and procedure indicated that LIBERTY fulfilled member requests for materials in alternate formats to include accessible PDF and Braille. LIBERTY employed bilingual member services representatives who were available during normal business hours to provide verbal and written interpretation for services to include explanation of benefits, scheduling appointments, assisting with transportation, and filing grievances and appeals. LIBERTY also ensured availability of TTY lines 24 hours a day, 365 days a year for hearing impaired recipients, and large print documents (i.e., 18-point font) for visually impaired recipients. Available on request and at no charge to the recipient, LIBERTY translates any written recipient information. The Handbook included the statement that LIBERTY provided translation services in the recipient's preferred language at no cost to the recipient.		
	Recommendations: None.		
42 CFR §438.10(d)(3) *DHCFP Contract Section 3.5.2.1 and 3.5.2.2*	6. Member Handbook Written information is available to members via the member handbook. *Cross-reference Member Handbook Checklist*	**Documents Submitted:** 06. NV_Medicaid_Handbook_20181116_v2_[ENG_01.28.2019] 06. NV_Medicaid_Handbook_20181116_v2_[SPA_02.12.2019] **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII: Member Information			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
		Please see description of process in the above P&P.	
	Findings: The Member Handbook Checklist detailed the information required in that document.		
	Recommendations: None.		
DHCFP Contract Section 3.5.2.1	7. Updating Handbook Annually The DBA must maintain documentation that the handbook is updated at least once per year, and the annual updates must be submitted to DHCFP for approval before publication and/or distribution.	**Documents Submitted:** 07. Steps for NV Medicaid Member Handbook **Description of Process:** Please see description of process in the above P&P.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Steps for Nevada Medicaid Member Handbook process document included the requirement that LIBERTY maintain documentation indicating that the Handbook is updated at least once per year. Staff members confirmed that the Handbook was updated annually. The process for the last revision began in September 2018, and the Handbook was final in January 2019.		
	Recommendations: None.		
DHCFP Contract Section 3.6.7	8. Provider Directory The DBA: a. Publishes its provider directory which includes all providers including Federally Qualified Health Centers (FQHCs), and any subcontractors' provider directory via an Internet website upon contract implementation and will update the website on a monthly basis for all geographic service areas.	**Documents Submitted:** 08. NV Medicaid Directory Sample Report Export from LIBERTY Website **Description of Process:** LIBERTY publishes and maintains the provider directory in real time on our website.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII: Member Information			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	b. Provides DHCFP with the most current provider directory upon contract award for each geographic service area. c. Confirms, upon request by DHCFP, the network adequacy and accessibility of its provider network and any subcontractor's provider network.		
	Findings: The Handbook included a link to the provider directory on page 20. During the on-site review, auditors accessed the online provider directory and confirmed that FQHCs were included. LIBERTY staff members confirmed that LIBERTY's information system pulled directly from the information logged for contracts and populated the provider directory. LIBERTY provider services staff members stated that once information is changed or updated in the system, LIBERTY updates the provider directory. Staff members also described the process for conducting secret shopper survey calls to provider offices to ensure that appointment times were within acceptable limits. LIBERTY staff members also observed office wait times and investigated complaints received from members.		
	Recommendations: None.		
DHCFP Contract Section 3.5.2.3 *DHCFP Contract Section 3.6.8* *DHCFP Contract Section 3.9.16.8 (A)*	9. Recipient Newsletter The DBA, subject to the prior review and approval of DHCFP, must publish a newsletter for enrolled recipients at least twice per year and must be written at an eighth (8th) grade level of understanding reflecting cultural competence and linguistic abilities.	**Documents Submitted:** 09. Steps for NV Medicaid Member Newsletter **Description of Process:** Please see description of process in the above P&P.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Steps to Follow for the Nevada Medicaid and Nevada Check Up Health & Wellness Member Newsletter process document included the requirement that the newsletter be published semiannually in summer and winter. The document also required the recipient information to be written at an eighth-grade level that is readable and easily understood. The Translation of Written Member Informing Materials policy and procedure noted that an eighth-grade reading level was		

Standard VII: Member Information			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	the standard reading level for Nevada. LIBERTY staff members confirmed that DHCFP approved newsletters prior to the release of the newsletter.		
	Recommendations: None.		
DHCFP Contract Section 3.5.2.3	10. Notice of Significant Change The DBA must give each recipient written notice of any significant change, as defined by the State, pertaining to the Member Handbook. The DBA shall issue updates to the Member Handbook, 30 days before the intended effective date, as described in 42 CFR §438.100(f)(4), when there are material changes that affect access to services and information about the DBA program. The DBA will provide notification when a change directly affects the ongoing care of the recipients. The DBA shall also provide such notices in its semi-annual recipient newsletters and shall maintain documentation verifying handbook updates.	**Documents Submitted:** N/A **Description of Process:** LIBERTY will communicate significant changes to recipients in writing. Any required changes to the Member Handbook will be made 30 days prior to the effective date of such changes. LIBERTY will notify DHCFP of any material change that requires approval. Notifications of changes will be made available semi-annually via newsletters and will also be made available via the web or by contacting Member Services. LIBERTY will maintain records of all Member Handbook changes.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Steps to Follow for the Nevada Medicaid and Nevada Check Up Health & Wellness Member Newsletter process document reiterated the contract requirement for this element. The Translation of Written Member Informing Materials policy and procedure also confirmed that an eighth-grade reading level was the standard reading level for Nevada. LIBERTY staff member stated that changes to the member handbook would first be routed to the quality management department, which would propose revisions to the document. The changes would then be routed to the cultural and linguistic committee for a readability check and then routed to the DHCFP for final approval prior to printing and issuing the revised handbook.		
	Recommendations: None.		

Standard VII: Member Information			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.10(d)(3) *42 CFR §438.10(d)(6)* *DHCFP Contract Section 3.9.16.8 (B)*	11. Prevalent Languages for Written Information Written information is available in the prevalent languages of the population groups served.	**Documents Submitted:** 11. CU PP - Cultural and Linguistic Competency Program Compliance **Description of Process:** LIBERTY ensures vital written information are available in DHCFP threshold, "prevalent" languages. LIBERTY's Non-Discrimination Notice and Notice of Language Assistance taglines are sent out with all vital member materials informing members of the availability to request translations in their primary language.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Translation of Written Member Informing Materials policy and procedure indicated that LIBERTY made vital member-informing materials available to all members and potential members in each threshold language on request. The LIBERTY Dental Plan Cultural and Linguistic Competency Program document dated December 2018 delineated the services available to ensure culturally and linguistically appropriate services for recipients and indicated that Language Assistance Notices were available to recipients in the top 15 prevalent languages spoken in Nevada. LIBERTY employed bilingual member services representatives who were available during normal business hours to provide verbal and written interpretation for services to include explanation of benefits, scheduling appointments, transportation, and grievances and appeals. Available on request and at no charge to the recipient, LIBERTY translated any written recipient information. The Handbook included the statement that LIBERTY provided translation services in the recipient's preferred language at no cost to the recipient.		
	Recommendations: None.		

Results for Standard VII: Member Information							
Total Elements	Met	=	11	X	1.00	=	11.00
	Partially Met	=	0	X	.50	=	0.00
	Not Met	=	0	X	.00	=	0.00
	Not Applicable	=	0	X	.00	=	0.00
	Total Applicable	=	11	**Total Rate**		=	11.00
Total Rate ÷ Total Applicable = Total Score							**100%**

Standard VIII: Continuity and Coordination of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.208(b)(2-4) *45 CFR Parts 160 and 164* *42 CFR §438.208(b)(1)* *42 CFR §438.224* *DHCFP Contract Section 3.3.6.10 (A-B)*	1. Coordination with Other vendors and Other Services Pursuant to 42 CFR §438.208(b) (2), (3), and (4) the DBA is required to implement procedures to coordinate services it may provide to the recipient with the services the recipient may receive from any other DBA. a. Upon request or notification of need, the DBA is required to communicate with other vendors serving the recipient the results of its identification and assessment of any special health care needs to ensure that services are not duplicated, and to ensure continuity of care. The DBA's procedures must ensure that, in the process of coordinating care, each recipient's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164 [(the Health Insurance Portability and Accountability Act (HIPAA)]. b. The DBA case managers are responsible for coordinating services with other appropriate Nevada Medicaid and non-Medicaid programs. c. In addition, the DBA is responsible for ensuring continuity of services for recipients with special needs. These recipients may include but are not limited to: 3.3.1.11	**Documents Submitted:** **Description of Process:**	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VIII: Continuity and Coordination of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	d. juveniles temporarily detained by a state or county agency; Seriously Emotionally Disturbed children, adults with Severe Mental Illness and individuals with substance abuse disorders; Children with Special Health Care Needs; homeless recipients; recipients with chronic conditions; women with pregnancies, and referring orthodontic recipients to their appropriate Dental Home for periodic examinations and cleanings.		
	Findings: The policy, QM PP – Coordination of Dental Services, described LIBERTY's policy to coordinate dental healthcare services to meet an individual's specific needs to ensure timely coordination of services between the member, the plan, providers, as well as medical service providers. The policy also defined "special needs members" as those with physical and/or mental disabilities in need of dental care from providers who have special experience working with this population. The policy also described the methods to coordinate with pediatric specialists, sub-specialists, ancillary therapists, community resources, primary care dentists, and providers of specialized equipment and supplies for persons with special health care needs (SHCN). The policy, Continuity of Care System, described the process for outreaching to noncontracted providers to join LIBERTY's network. LIBERTY staff members described the use of the Guardian network to support special needs of recipients when an in-network provider was not available. Neither policy described the care coordination and continuity of services for homeless or pregnant recipients.		
	Recommendations: The DBA is responsible for ensuring continuity of services for recipients with special needs. These recipients may include homeless and pregnant recipients.		
42 CFR §438.208(a-b) *DHCFP Contract Section 3.9.20*	2. Continuity of Care System The DBA has a basic system in place which promotes continuity of care. a. The DBA must take a comprehensive and collaborative approach to coordinate care for	**Documents Submitted:** To Be Provided by DBA on 8/14/2019, EOD. **Description of Process:** To Be Provided by DBA on 8/14/2019, EOD.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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	the eligible population and conditions as specified by DHCFP through an effective care coordination program, partnerships with primary care general dentists or pediatric dentists and specialists, other service providers and recipient participation, recipient/family outreach and education, and the ability to holistically address member's health care needs. b. Care coordination must include not only the specific diagnosis, but also the complexities of multiple co-morbid conditions.		
	Findings: The Desktop Standard Operating Procedures—Customer Care Unit outlined the Customer Care Unit's (CCU's) responsibility to receive and resolve requests for assistance with member issues such as benefits, claims, and eligibility. The desktop procedure indicated that customer care analysts (CCAs) may work with dental consultants, internal departments, and health plans as appropriate to resolve member issues. The policy, QM PP – Coordination of Dental Services, described LIBERTY's policy to coordinate dental healthcare services to meet an individual's specific needs to ensure timely coordination of services between the member, the plan, providers, as well as medical service providers. The policy also defined "special needs members" as those with physical and/or mental disabilities in need of dental care from providers who have special experience working with this population. The policy also described the methods to coordinate with pediatric specialists, sub-specialists, ancillary therapists, community resources, primary care dentists, and providers of specialized equipment and supplies for persons with SHCN. The policy also described the procedure for care coordinators to coordinate services for persons with complex cases where the dental condition is compromised by a medical condition and the care needs to be coordinated between medical and dental providers and specialty providers.		
	Recommendations: None.		

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DHCFP Contract Section 3.9.20.1	3. Information Technology (IT) System for CM The DBA's IT system contains the following components: a. The DBA's information technology system for its care coordination program must maximize the opportunity for communication between the DBA, PDP, the patient, other service providers and care coordinators. b. The DBA must have an integrated database that allows DBA staff that may be contacted by a recipient to have immediate access to and review of the most recent information within the DBA's information systems relevant to the case. c. The integrated database may include the following: administrative data, call center communications, service authorizations, and case notes. For example, DBA recipient services staff must have access to a recipient's case notes and recent utilization if contacted by that recipient. d. The information technology system must also have the capability to share relevant information (i.e. utilization reports, etc.) with the recipient, the PDP, and other service providers.	**Documents Submitted:** To Be Provided by DBA on 8/14/2019, EOD. **Description of Process:** To Be Provided by DBA on 8/14/2019, EOD.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: During the on-site review, LIBERTY staff members demonstrated the information system capabilities of the Health Solutions Plus (HSP) platform. The HSP demonstration provided evidence that care coordinators had access to all records stored in the system, all history of the member, as well as the claims and prior authorizations that existed for each		

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	member. The system demonstration also provided evidence that users had access to case notes as well as the capability to retrieve and share information with recipients or dental providers as needed.		
	Recommendations: None.		
DHCFP Contract Section 3.9.8.3 (D)	4. Identification of Race and Ethnicity The DBA works collaboratively with DHCFP to determine recipient race and ethnicity. The DBA organizes interventions specifically designed to reduce or eliminate disparities in health care.	**Documents Submitted:** 04. CU PP - Membership Demographic Profile **Description of Process:** Please see description in the above P&P.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The policy, 04. CU PP – Membership Demographic Profile, described the process LIBERTY used to collect and analyze enrollee population demographic data to ensure the linguistic and cultural needs of enrollees are met and to reduce health disparities and achieve health equity. The meeting minutes from the Quarter 4 2018 Cultural and Linguistic Competency Committee meeting provided evidence that the committee reviewed member race and ethnicity reporting information as part of the meeting. Most of the information reported focused on the linguistic needs of the population served and the linguistic services provided by the dental provider. The reports, however, did not contain information about disparities that may exist in the services provided or accessed by the population. For example, the reports did not show how LIBERTY examined disparities through analysis of performance measures or PIP data to determine if certain ethnicities or races have disproportionate utilization of services and if so, what LIBERTY will do to reduce and eliminate those disparities.		
	Recommendations: LIBERTY must define the ways in which it uses data to identify healthcare disparities and organize interventions specifically designed to reduce or eliminate disparities in healthcare.		

Results for Standard VIII: Continuity and Coordination of Care							
Total Elements	Met	=	2	X	1.00	=	2.00
	Partially Met	=	2	X	.50	=	1.00
	Not Met	=	0	X	.00	=	0.00
	Not Applicable	=	0	X	.00	=	0.00
	Total Applicable	=	4	**Total Rate**		=	3.00
Total Rate ÷ Total Applicable		=		**Total Score**			**75%**

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

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	This is not the correct State Fair Hearing Request form. The Nevada Medicaid Dental Program Member Handbook and the Nevada Medicaid Provider Resource Guide included information on the member's right to a SFH, how to obtain such a hearing, and the rules for representation. LIBERTY staff members confirmed that the Your Rights Under Dental Managed Care document is provided to members with the NABD letter when a decision is made to deny, reduce, terminate, or suspend a service. The appeal file reviews demonstrated that the Your Rights Under Dental Managed Care documents were sent to members with the NABD; however, the files reviewed contained three different versions of the Your Rights Under Dental Managed Care document, where all but one version had incorrect time frames for filing appeals and requesting a SFH. During the on-site interview session, LIBERTY staff members stated they were aware of the incorrect time frame to request a SFH listed in the Your Rights Under Dental Managed Care document and had recently received approval from the DHCFP for the revised Your Rights Under Dental Managed Care document and request for a SFH.		
	Recommendations: The DBA must ensure that the notice provided to members about SFH requests contains accurate, complete information that is consistent with federal regulations and provide members with the correct SFH request form.		
42 CFR §438 Subpart F *DHCFP Contract Section 3.9.16.5*	2. Grievance System linked to IQAP The DBA must have a system(s) linked to the IQAP for addressing recipients' grievances and providing recipient appeals.	**Documents Submitted:** 01. 2018 QMI Program Description **Description of Process:** LIBERTY's Grievance and Appeals Process woven throughout our Quality Management and Improvement (QMI) Program. Grievance and Appeals data is reported and analyzed by various committees to identify opportunities for improvement. Peer Review, Public Policy, the ultimately the Quality Management and Improvement Committee, all receive quarterly GA reports, which are reported to LIBERTY's Board of Directors.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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	Findings: The 2018 Quality Management and Improvement Program Description listed the goals of the IQAP program, which included monitoring program effectiveness and compliance with regulatory and accreditation guidelines through member and provider grievances and appeals.		
	Recommendations: None.		
42 CFR §438.402(a) *DHCFP Contract Section 3.9.16.5 (A–F)*	3. Recipient Grievance and Appeals Procedures This grievance and appeals system must include: a. Procedures for registering and responding to grievances and appeals within thirty (30) calendar days. DBAs establish and monitor standards for timeliness; b. Documentation of the substance of grievances, appeals, and actions taken; c. Procedures ensuring a resolution of the grievance and providing the recipient access to the State Fair Hearing process for appeals; d. Aggregation and analysis of grievance and appeal data and use of the data for quality improvement; e. Compliance with DHCFP due process and fair hearing policies and procedures specific to NV Medicaid and NV Check Up recipients; and f. Compliance with 42 CFR §438 Subpart F Grievance and Appeals.	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process – Medicaid 02. GA PP - Grievance and Appeals Process - Medicaid - APPENDIX 2 03. Member Grievance and Appeal Form – NEVADA 04. Grievance and Appeals Process Flowchart 05. NV_Medicaid_Handbook 06. NV Medicaid Provider Reference Guide **Description of Process:** LIBERTY resolves all Medicaid member grievances and appeals within 30 calendar days of receipt, and expedited grievances and appeals are resolved within 72 hours from time of receipt. The Assistant Manager, QM, oversees the receipt and processing of all member grievances and appeals to ensure that each case is resolved	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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		in a timely manner. Additionally, weekly grievance and appeals reports are reviewed by the Supervisor of Grievance and Appeals to ensure timeliness. Information on can be located on: GA PP – Grievance and Appeals Process – Medicaid -Appendix 2 Page 33 Nevada Medicaid Member Handbook Page 60 Nevada Medicaid Provider Reference Guide	
	Findings: While the GA PP—Grievance and Appeals Process (Medicaid) policy provided evidence of LIBERTY's procedures for processing grievances and appeals, the language in the policy was inconsistent with federal regulations. The processes for handling member grievances and appeals used the terms "grievance" and "appeal" interchangeably, even though a grievance and appeal are distinctly different. Further, the policy described the process for "a second-level grievance involving an appeal of LIBERTY's initial grievance determination." However, it was not clear through LIBERTY's written documentation how LIBERTY was using the second level grievance process. This policy also described LIBERTY's process for logging all grievances and appeals in Uniflow, the DBA's single source database, including documenting the details of the grievance or appeal and ensuring grievances and appeals are resolved according to State and federal requirements. The GA PP–Grievance and Appeals Process (Medicaid) policy also identified how grievances and appeals were aggregated and analyzed in support of continuous quality improvement. The Nevada Medicaid Member Handbook included an incorrect link to the State Fair Hearing Request form on the DHCFP website. It was noted during the file reviews that the dental record request letter to the provider included instructions that providers could email the dental records to the DBA. It was unclear if encrypted and secure email would be used. While LIBERTY's email system may be secure and its emails encrypted, these conditions may not be true for a dental provider. Since dental records contain protected health information (PHI), caution should be used when transmitting PHI to ensure that the DBA is not in violation of any federal or State laws regarding the protection and security of PHI. During LIBERTY's Readiness		

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	Review completed in 2017, this issue was also noted. LIBERTY submitted a corrective action plan (CAP) which included revisions to the dental request letter template instructing the provider that email encryption must be used if the dental provider chose to send dental records via email. During the on-site interview session, LIBERTY staff members were unable to explain why the original dental record request letter was still in use and the revised request letter was not implemented after the 2018 CAP was approved. An increased risk for a breach of PHI when transmitting dental records from unsecured emails remains an issue. Post-on-site review response provided by LIBERTY on September 26, 2019, specified that effective September 26, 2019, the Grievance and Appeal Nevada Medicaid records request template with the revised and 2018 CAP approved language was implemented for automation within LIBERTY's management information system (MIS) workflow and provided a sample of the template letter. Additionally, LIBERTY identified that Nevada grievance and appeal cases will be reviewed to determine if records were received by email. Providers are to be contacted to verify that dental record submissions were secure no later than October 11, 2019.		
	Recommendations: The DBA must ensure that grievance and appeal policies and procedures include accurate information that is consistent with federal regulations and the contract with the DHCFP; that members have access to the correct State Fair Hearing Request form; and when a dental provider emails dental records, that mechanisms are in place to assure protection and security of the member's PHI. Further, it is recommended that LIBERTY develop mechanisms to ensure that remediations identified in CAPs are implemented.		

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42 CFR Subpart F *42 CFR §438.402* *42 CFR §438.414* *DHCFP Contract Section 3.12.1*	4. System to Resolve Grievances and Appeals The DBA shall establish: a. A system for recipients, which includes a grievance process, an appeal process, and access to the State Fair Hearing system. b. A similar system to resolve disputes with providers.	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process – Medicaid 02. GA PP - Member Grievance and Appeal Form - NEVADA - APPENDIX 1 03. GA PP - Grievance and Appeals Process - Medicaid - APPENDIX 2 04. GA PP - Provider Complaint and Dispute Resolution Process - Medicare and Medicaid 05. GA PP - Provider Complaint and Dispute Resolution Process - Medicare and Medicaid - APPENDIX 1 **Description of Process:** LIBERTY's Grievance and Appeals Process ensures timely receipt, acknowledgement and resolution of all member grievances, appeals and State Fair Hearing requests. LIBERTY's established Grievance and Appeals Process ensures timely receipt, acknowledgement and resolution of provider grievances, appeals and State Hearing requests.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy outlined the DBA's procedures for processing grievances and appeals and providing access to the SFH system. The policy also outlined the process to resolve disputes with providers. The policy, however, did not use the correct terminology when referencing grievances or standard or expedited appeals. Specifically, the policy referenced expedited grievances and a second-level grievance involving an		

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Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	appeal of the plan's initial grievance determination, neither of which are consistent with federal regulations. Please refer to Element 1 of this standard for additional findings and recommendations.		
	Recommendations: LIBERTY must ensure that policies describing the grievance and appeal processes include the correct terminology and that processes are consistent with federal regulations.		
42 CFR §438.414 *42 CFR §438.10(g)(xi)* *DHCFP Contract Section 3.12.1.3*	5. Informing Enrollees and Providers about the Grievance System The DBA must provide information about the recipient and provider grievance system to recipients at the time of enrollment and to providers and subcontractors at the time they enter into a contract.	**Documents Submitted:** 01. NV_Medicaid_Handbook 02. NV Medicaid Provider Reference Guide 03. Notice of Action Your Rights **Description of Process:** LIBERTY has an established Grievance and Appeals Process that both members and providers can access through multiple venues, including the Member Handbook, the Provider Reference Guide and on the Plan's website. Information is also included with every notification of an adverse determination. Page 33 of the Member Handbook Page 60 of the Nevada Medicaid Provider Reference Guide	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: LIBERTY staff members stated during the on-site interview session that members receive a member handbook at the time of enrollment into the DBA. The NV-Medicaid-Handbook contained information about the member grievance system; however, the member handbook incorrectly informed members that if LIBERTY's decision for a grievance is unsatisfactory to the member, a SFH can be requested. According to federal regulations, a SFH can only be requested for		

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	appeal decisions. The NV-Medicaid Provider Reference Guide provided evidence that the DBA included information about the recipient and provider grievance system in the Provider Manual.		
	Recommendations: The DBA must ensure that the information included in the member handbook is accurate, complete, and consistent with federal regulations.		
DHCFP Contract Section 3.12.1.4	6. Quarterly Reports of Grievances and Appeals The DBA submits to DHCFP monthly and quarterly reports that document the grievance and appeal activities listed on the templates located in the Forms and Reporting Guide.	**Documents Submitted:** 01. NV Medicaid GA Reporting 07.01.18_12.31.18 **Description of Process:** LIBERTY provides grievance and appeals reports, on the templates provided, to the DHCFP on a monthly and quarterly basis	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: LIBERTY's staff members confirmed that monthly and quarterly grievance and appeal reports are sent to DHCFP as required. Examples of the grievance and appeal reports were provided and demonstrated compliance with this element.		
	Recommendations: None.		
42 CFR §438.402(a) *DHCFP Contract Section 3.12.2.1*	7. Grievances and Appeals Process Approval The DBA's recipient grievance and appeal system must be in writing and submitted to DHCFP for review and approval at the time the DBA's Policies and Procedures are submitted, and at any time thereafter when the DBA's recipient grievances and appeals policies and procedures have been revised or updated (not including grammatical or readability revisions or updates). The DBA may not implement	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process - Medicaid **Description of Process:** LIBERTY submits the above-named policy to DHCFP for review and approval. LIBERTY will not implement any changes to the grievance and appeals process without obtaining formal approval from the DHCFP.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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	any policies and procedures concerning its recipient grievance and appeal system without first obtaining the written approval of the DHCFP.	Information located: Page 3 GA PP – Grievance and Appeals Process – Medicaid	
	Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy provided evidence of the DBA's written procedures for processing grievances and appeals and providing access to the SFH system. While this element is scored as *Met*, please reference the findings and recommendations in elements 1, 3, and 4 of this standard.		
	Recommendations: None.		
42 CFR §438.56(d)(5)(i) *42 CFR §438.400(a)(3)* *DHCFP Contract Section 3.12.2.5*	8. Filing a Grievance or Appeal on Behalf of the Recipient The following people may file a grievance or appeal on behalf of the recipient: a. A recipient or a recipient's representative (including a provider on behalf of a recipient) may file a grievance or submit an appeal directly with the DHCFP. However, such grievances and appeals are referred to the DBA for resolution. b. In the event a provider files an appeal on the recipient's behalf, with the exception of an expedited appeal, the provider must first obtain the recipient's written permission.	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process – Medicaid 02. GA PP - Provider Complaint and Dispute Resolution Process - Medicare and Medicaid **Description of Process:** LIBERTY accepts grievances and appeals from members, providers acting on behalf of a member or other designees of the member both in writing or orally. Information located: Page 3 GA PP – Grievance and Appeals Process – Medicaid Page 7 GA PP – Grievance and Appeals Process – Medicaid	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
		Pages 2 - 3 GA PP – Provider Complaint and Dispute Resolution Process – Medicare and Medicaid	
	Findings: The policy, GA PP–Grievance and Appeals Process (Medicaid), included the requirements of this element regarding who may file a grievance or appeal on behalf of the recipient.		
	Recommendations: None.		
42 CFR §438.402(c)(2) *DHCFP Contract Section 3.12.2.6*	9. Process for Filing an Appeal Grievances are not eligible for referral to the State Fair Hearing process, but in the case of appeals: a. The recipient must first exhaust the DBA's appeal process, but if not satisfied with the outcome, may request a State Fair Hearing from the DHCFP. b. The DBA is required to provide access to and information about the State Fair Hearing process in the event a recipient's appeal is not resolved in favor of the recipient.	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process – Medicaid 02. NV_Medicaid_Handbook 03. NV Medicaid Provider Reference Guide 04. Notice of Action Your Rights **Description of Process:** Members are notified of their right to a State Fair Hearing in the Member Handbook and in the Your Rights Documents. Information located: Page 7 GA PP – Grievance and Appeals Process – Medicaid Page 11 GA PP – Grievance and Appeals Process – Medicaid Page 17 GA PP – Grievance and Appeals Process – Medicaid Page 34 NV Medicaid Member Handbook	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
		Page 36 NV Medicaid Member Handbook Page 64 NV Medicaid Provider Reference Guide Page 2 Notice of Action Your Rights	
	Findings: The policy, GA PP–Grievance and Appeals Process (Medicaid), included the provision that grievances were not eligible for the SFH process. The policy also described the process for appeals that must be exhausted prior to requesting a SFH as well as the process for requesting a SFH. While this element is scored as *Met*, please reference the findings and recommendations in Element 3 of this standard.		
	Recommendations: None.		
42 CFR §438.402(c)(3)(i-ii) *DHCFP Contract Section 3.12.2.7*	10. Grievances and Appeals Accepted Orally or in Writing A recipient, or a provider acting on behalf of the recipient, may file an appeal or grievance either orally or in writing. a. Unless the recipient has requested an expedited resolution, an oral appeal must be followed by a written, signed appeal. b. If a grievance or appeal is filed orally, the DBA is required to document the contact for tracking purposes and to establish the earliest date of receipt. c. There is no requirement to track routine telephone inquiries.	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process – Medicaid 02. GA PP - Member Grievance and Appeal Form - NEVADA - APPENDIX 1 03. NV_Medicaid_Handbook 04. NV Medicaid Provider Reference Guide **Description of Process:** LIBERTY accepts grievance and appeals in writing, orally or in person from enrollees or authorized representatives acting on behalf of enrollees. LIBERTY notifies enrollees that oral appeals must be followed-up with a written signed appeal. LIBERTY does not dismiss the enrollee appeal based solely on the fact the	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
		written appeal was not received following the oral submission for an appeal. Information located: Pages 3-4 GA PP – Grievance and Appeals Process – Medicaid Pages 7-8 GA PP – Grievance and Appeals Process – Medicaid Pages 33-35 NV Medicaid Member Handbook Page 61 NV Medicaid Provider Reference Guide	
	Findings: The policy, GA PP–Grievance and Appeals Process (Medicaid), detailed the processes for accepting grievances and appeals either orally or in writing. The policy described the process for documenting oral receipt of grievances and appeals to establish the earliest date of receipt for tracking purposes. For appeals filed by a provider on behalf of a recipient, the policy provided that the appeal may be followed by a written, signed appeal from the recipient. The Your Rights Under Dental Managed Care document that is included with the NABD and acknowledgement letters included the statement that for oral appeals, the member must complete and sign the appeal form and return it within 15 calendar days. If the member did not return the form, LIBERTY would not process the appeal. This practice is not consistent with the intent of the federal regulations that an oral appeal should be processed as a standard appeal even if the member does not follow the oral appeal with a written, signed appeal. Although the Your Rights Under Dental Managed Care document indicated that an oral appeal would not be processed unless a written, signed appeal was received, the appeal file reviews demonstrated that oral appeals were processed as standard appeals even when a written, signed appeal was not submitted by the member. The information included in policy and the Your Rights Under Dental Managed Care document were not consistent. During the on-site interview session, LIBERTY staff members acknowledged that the grievance and appeal template letters and Your Rights Under Dental Managed Care documents contained incorrect information and time frames. The staff members further stated that grievance and appeal template letters and the Your Rights Under Dental Managed Care document were revised and approved by the DHCFP on September 10, 2019, just prior to LIBERTY's compliance review. According to LIBERTY staff members, the revised grievance and appeal template letters and Your Rights Under Dental Managed Care document		

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Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	were in the process of being updated in LIBERTY's grievance and appeal electronic data system with implementation scheduled for the end of September 2019.		
	Recommendations: The DBA must ensure that grievance and appeal template letters and the Your Rights Under Dental Managed Care document include all the requirements identified in federal regulations. Additionally, the DBA must ensure that information in policy and member information materials is consistent and meets federal regulations.		
DHCFP Contract Section 3.12.1.1, 3.12.2.8	11. Routine Telephone Inquiries vs. Grievances For tracking purposes, an oral appeal or grievance is differentiated from a routine telephone inquiry by the content of the inquiry. A grievance is an expression of dissatisfaction about any matter other than one of the actions listed in element 12 below. Possible issues for grievances include, but are not limited to, access to care, quality of services, interpersonal relationships between DBA staff and enrollees, and failure to respect an enrollee's rights.	**Documents Submitted:** 01. MSR PP - Member Service Inquiries 02. GA PP - Grievance and Appeals Process - Medicaid **Description of Process:** LIBERTY's Member Services Department is fully trained to differentiate between routine enrollee telephone inquiries and an enrollee grievance. Information located: Pages 1-2 MS PP – Member Service Inquiries Pages 1, 3-4 GA PP – Grievance and Appeals Process – Medicaid	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The GA PP–Grievance and Appeals Process—Medicaid policy provided the definition of "grievance" and the difference between a routine telephone inquiry and a grievance. The policy, MSR PP–Member Services Phone Inquiries, also included the definition of "grievance," provided differentiation between a "grievance" and an "inquiry," and included the provision that if an inquiry could not be resolved within 24 hours, it would be referred as a formal grievance. Staff members confirmed their process for processing telephone inquiries versus grievances.		
	Recommendations: None.		

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Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
DHCFP Contract Section 3.12.1.2(A-E)	12. Appeals An appeal is a specific request for review of one of the following actions: a. The denial or limited authorization of a requested service; b. The reduction, suspension, or termination of a previously authorized service; c. The denial, in whole or in part, of payment for a service; d. The failure to provide services in a timely manner, or e. The failure of a DBA to process grievances, appeals or expedited appeals within the required timeframes for resolution and notification.	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process – Medicaid 02. GA PP - Grievance and Appeals Process - Medicaid - APPENDIX 2 **Description of Process:** LIBERTY defines an appeal as a request by an enrollee, provider acting on behalf of an enrollee with consent, or other authorized designee, to review an Adverse Benefit Determinations issued by the Plan. LIBERTY defines and Adverse Benefit Determination as any of the following in accordance with DHCFP Contract Section 3.12.1.2(A-E). Information located: Pages 1-2 GA PP – Grievance and Appeals Process – Medicaid	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The GA PP–Grievance and Appeals Process–Medicaid policy provided the definition of an "appeal," which was consistent with the requirements of this element.		
	Recommendations: None.		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.210(d)(1)(i-ii) *42 CFR §438.404(c)(4)(i-ii)* *42 CFR §438.408(c)(1)(i-ii)* *DHCFP Contract Section 3.12.3.1*	13. Standard Authorization Decisions The DBA must provide standard authorization decisions as expeditiously as the recipient's health requires and within the State's established timelines that may not exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days if the recipient or provider requests the extension; or, the DBA justifies (to the DHCFP upon request) a need for additional information and how the extension is in the recipient's interests. The DBA must provide written notice of the reason for the extension and inform the recipient of their right to file a grievance.	**Documents Submitted:** 01. UM PP - Coverage and Authorization of Services **Description of Process:** LIBERTY ensures that all standard authorization decisions are completed within federal and state regulated turnaround times. Information located: Page 3 UM PP - Coverage and Authorization of Services	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The UM PP–Coverage and Authorization of Services policy included information about standard authorization decisions, which was consistent with the requirements of this element.		
	Recommendations: None.		
42 CFR §438.210(d)(2)(i-ii) *42 CFR §438.404(c)(4)(i)* *42 CFR §438.408(b)(3)* *42 CFR §438.408(c)(1)(i-ii)* *DHCFP Contract Section 3.12.3.2*	14. Expedited Authorization Decisions For cases in which a provider indicates or the DBA determines that following the standard timeframe could seriously jeopardize the recipient's life or health or ability to attain, maintain, or regain maximum function, the DBA must make an expedited authorization decision and provide a Notice of Action as expeditiously as the recipient's health condition warrants and no later than seventy-two (72) hours after receipt of the request for service.	**Documents Submitted:** 01. UM PP - Coverage and Authorization of Services **Description of Process:** LIBERTY ensures that all expedited requests for authorization decisions are completed as expeditiously as the enrollee's health condition	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	The DBA may extend the (72) hours' time period by up to fourteen (14) calendar days if the recipient requests an extension or if the DBA justifies (to the DHCFP upon request) a need for additional information and how the extension is in the recipient's interest. The DBA must provide written notice of the reason for the extension and inform the recipient of their right to file a grievance.	requires but not later than 72 hours from time of receipt. Information located: Page 3 UM PP - Coverage and Authorization of Services	
	Findings: The UM PP–Coverage and Authorization of Services policy included information about expedited authorization decisions, which was consistent with the requirements of this element.		
	Recommendations: None.		
42 CFR §438.210(c) *42 CFR §438.404(a)* *DHCFP Contract Section 3.12.4.1*	15. Written Notice of Action and Provider Notification The DBA must provide a written Notice of Action to the recipient when the DBA takes action or makes an adverse determination affecting the recipient. If a provider has made a request on a recipient's behalf and the DBA makes an adverse determination, the provider must be notified but this notification need not be in writing.	**Documents Submitted:** 01. UM PP - Coverage and Authorization of Services 02. NV-Medicaid EOB Template 03. NV-Medicaid UM Template **Description of Process:** LIBERTY ensures that enrollees receive written Notice of Action on the DHCFP approved templates. Information located: Page 4 UM PP - Coverage and Authorization of Services	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	Findings: The UM PP–Coverage and Authorization of Services policy included information concerning the provision of a written notice of action (NABD) to the member and the provider anytime LIBERTY makes the decision to (1) deny a service authorization request; or (2) authorize a service in an amount, duration, or scope that is less than what was requested due to lack of dental necessity. During the on-site interview session, staff members confirmed LIBERTY's process for provision of a written NABD and provider notification.		
	Recommendations: None.		
42 CFR §438.10(c-d) *42 CFR §438.404(a)* *DHCFP Contract Section 3.12.4.2 (A-C)*	16. Language and Format of Written Notice of Action The notice must meet all of the following requirements: a. Be available in the State-established prevalent non-English languages; b. Be available in alternative formats for persons with special needs (visually impaired recipients, or recipients with limited reading proficiency); and c. Use easily understood language and format requirements of 42 CFR §438.404(c); 42 CFR §438.10(c) and (d).	**Documents Submitted:** 01. UM PP - Coverage and Authorization of Services 02. NV-Medicaid EOB Template 03. NV-Medicaid UM Template **Description of Process:** LIBERTY ensures that all written Notice of Actions are issued within the cultural and linguistic needs of the NV Medicaid population. Information located: Page 3 UM PP - Coverage and Authorization of Services	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The UM PP–Coverage and Authorization of Services policy included information about the requirements of the notice, which were consistent with the requirements of this element. The file reviews revealed that five NABD letters contained language that was not easily understood and had typographical errors, grammatical errors, or an incorrect spelling of the member's name.		

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Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	Recommendations: The DBA must ensure that a notice contains easily understood language and format requirements as outlined in 42 CFR §438.404(c) and 42 CFR §438.10(c) and (d).		
42 CFR §438.404(b)(1-6) *42 CFR §438.404(c)(1)* *42 CFR §438.408(e)(1)* *42 CFR §438.408(e)(2)(i-iii)* *42 CFR §438.420(a)(i-ii)* *42 CFR §438.420(b)* *DHCFP Contract Section 3.12.4.3(A-J), 3.12.4.4*	17. Requirements of a Written Notice of Action A written Notice of Action to the recipient must meet the following requirements and must explain: a. The action the DBA or its subcontractor has taken or intends to take; b. The reasons for the action; c. The recipient's or the provider's right to file an appeal; d. The recipient's right to request a State Fair Hearing after the recipient has exhausted the DBA's internal appeal procedures; e. The procedures for exercising the recipient's rights to appeal; f. The circumstances under which expedited resolution is available and how to request it; g. The recipient's rights to have benefits continue if the appeal is filed on or before the latter of the following: within ten (10) calendar days of the DBA mailing the Notice of Action or the intended effective date or the proposed action pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee	**Documents Submitted:** 01. UM PP - Coverage and Authorization of Services 02. NV-Medicaid EOB Template 03. NV-Medicaid UM Template **Description of Process:** LIBERTY ensures that all written Notice of Actions include the federal and state regulatory language. Please reference attached exhibits Information located: Pages 3-5 UM PP - Coverage and Authorization of Services	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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

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Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	revised grievance and appeal template letters and Your Rights Under Dental Managed Care document were in the process of being updated in LIBERTY's grievance and appeal electronic data system, with implementation scheduled for the end of September 2019.		
	Recommendations: The DBA must ensure that written notice of action and supplemental information included with the written notice contain the correct time frames for filing an appeal or SFH identified in federal regulations.		
42 CFR §438.404(c)(1-3) *DHCFP Contract Section 3.12.4.5–3.12.4.7*	18. Timing of the Notice of Action The DBA gives notice by the date of the action for the following circumstances: a. In the death of the recipient; b. A signed written recipient statement requesting termination or giving information requiring termination or reduction of services (where the recipient understands that this must be the result of supplying that information); c. The recipient's admission to an institution where he is ineligible for Medicaid services; d. The recipient's address is unknown and mail directed to him has no forwarding address; e. The recipient has been accepted for Medicaid services by another local jurisdiction; f. The DBA must give a notice of action on the date of action when the action is a denial of payment; and, g. the DBA must give notice on the date that the timeframes expire when service	**Documents Submitted:** 01. UM PP - Coverage and Authorization of Services **Description of Process:** LIBERTY ensures that written Notice of Action letters are issued to enrollees timely. Information located Pages 2-5 UM PP - Coverage and Authorization of Services	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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	authorization decisions are not reached within the timeframes for either standard or expedited service authorizations; and h. Untimely service authorizations constitute a denial and are thus adverse actions.		
	Findings: The UM PP–Coverage and Authorization of Services policy detailed the requirements of a NABD, which included items a through h of this element. The denial reviews confirmed that the NABD was provided in accordance with requirements of this element.		
	Recommendations: None.		
42 CFR §438.404(b)(3,6) *DHCFP Contract Section 3.12.4.8, 3.12.4.9*	19. Notice of Action Requirements For appeals not resolved wholly in favor of the recipient, the notice of action must include: a. The recipient's right to request a State Fair Hearing, and how to do so; b. The recipient's right to request to receive benefits while the hearing is pending, and how to make the request; c. That the recipient may be held liable for the cost of those benefits if the hearing decision upholds the DBA's action; and d. The recipient's right to receive written resolution notice, and reasonable efforts are made to provide oral resolution notice.	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process – Medicaid 02. Notice of Appeal Resolution - Uphold Template 03. Notice of Action Your Rights **Description of Process:** LIBERTY's appeals process ensures that all cases that are not fully resolved in favor the enrollee, receive a copy of the your "Your Rights" document that explains that enrollees right to request a State Fair Hearing, how to request the State Fair Hearing, the right to continuation of benefits during the State Fair Hearing and the potential liability if the State Fair Hearing is not ruled in his/her favor.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
		Information located: Page 11 GA PP – Grievance and Appeals Process – Medicaid	
	Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy included the provision that for adverse determinations of appeals, LIBERTY would include the document, Your Rights Under Dental Managed Care, along with the notice of resolution. The GA PP–Grievance and Appeals Process (Medicaid) policy included LIBERTY's process for issuing a notice of action, and the required information to be included as outlined in items a through d of this element, for appeals not resolved wholly in favor of the recipient. The document, Your Rights Under Dental Managed Care Under Dental Managed Care, contained information on the recipient's right to request a SFH and how to do so; the recipient's right to request to receive benefits while the hearing is pending, and how to make the request; that the recipient may be held liable for the cost of those benefits if the hearing decision upholds LIBERTY's action; information about the recipient's right to receive written resolution notice; and LIBERTY's reasonable efforts to provide oral resolution notice.		
	Recommendations: None.		
42 CFR §438.404(c)(5-6) *42 CFR §438.408(b)(1-2)* *42 CFR §438.408(d)(1)* *42 CFR §438.408(d)(2)(i)* *DHCFP Contract Section 3.12.5 – 3.12.5.3*	20. Handling of Grievances and Appeals The DBA is required to dispose of each grievance and resolve each appeal and to provide notice as expeditiously as the recipient's health condition requires within the State's established time frames specified as follows: a. Standard disposition of grievances: The DBA is allowed no more than ninety (90) calendar days from the date of receipt of the grievance. b. Standard resolution of appeals: The DBA is allowed no more than thirty (30) calendar days from the date of receipt of the appeal.	**Documents Submitted:** 01. GA PP – Grievance and Appeals Process – Medicaid 02. GA PP - Grievance and Appeals Process - Medicaid - APPENDIX 2 **Description of Process:** LIBERTY's established grievance and appeals process ensure proper resolution within all federal and contractual turnaround times for standard and expedited cases.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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	c. Expedited resolution of appeals: The DBA must resolve each expedited appeal and provide notice, as expeditiously as the recipient's health condition requires, not to exceed seventy-two (72) hours after the DBA received the expedited appeal request.	Information located: Page 6 GA PP – Grievance and Appeals Process – Medicaid Pages 10-11 GA PP – Grievance and Appeals Process – Medicaid Page 14-15 GA PP – Grievance and Appeals Process – Medicaid	
	Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy included the provision that although Nevada allows up to 90 days to resolve grievances, LIBERTY will resolve all grievances and appeals within 30 calendar days. For resolving expedited resolution of appeals, Appendix 2 of the policy included the provision that expedited appeals must be resolved within 72 hours of the receipt of the expedited appeal. The grievance file review confirmed that all 10 grievances were resolved within the required time frame. The appeal file review showed that two of the three expedited appeal files reviewed were resolved within the required 72 hours and that no notice of extension was sent for the one expedited appeal that was resolved outside the 72-hour time frame. All seven standard appeals reviewed were resolved within the 30-day time frame.		
	Recommendations: The DBA must ensure that expedited appeals are resolved within the required time frames and that notice to affected parties is provided if an extension of the resolution time frame is requested.		

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42 CFR §438.408(d)(2)(i) *42 CFR §438.410(a-b)* *42 CFR §438.410(c)(1-2)* *DHCFP Contract Section 3.12.5.3, 3.12.5.3(A-B)*	21. Expedited Review Process for Appeals The DBA is required to establish and maintain an expedited review process for appeals when the DBA determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the recipient's life or health or ability to attain, maintain, or regain maximum function. a. The DBA must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an appeal. b. If the DBA denies a request for an expedited resolution of an appeal, it must transfer the appeal to the standard timeframe of no longer than thirty (30) calendar days from the day the DBA receives the appeal (with a possible fourteen (14) calendar day extension) for resolution of appeal and give the recipient prompt oral notice of the denial and follow up within two (2) calendar days with a written notice. c. The DBA must inform the recipient of the limited time available to present evidence and allegations of fact or law, in person or in writing, in the case of the expedited resolution.	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process – Medicaid 02. GA PP - Grievance and Appeals Process - Medicaid - APPENDIX 2 **Description of Process:** LIBERTY's established grievances and appeals process accounts for circumstances in which a standard resolution could seriously jeopardize the enrollee's life or health requiring expedited resolution. Information located: Page 14-16 GA PP – Grievance and Appeals Process – Medicaid	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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	d. These time frames may be extended up to 14 calendar days if the recipient requests such an extension or the DBA demonstrates to the satisfaction of the DHCFP that there is a need for additional information and how the extension is in the recipient's interests. e. If the State grants the DBA's request for an extension, the DBA gives the recipient written notice of the reason for the delay.		
	Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy described LIBERTY's processing of expedited appeals which included all requirements of this element. While the policy identified that prompt oral notice be provided to a member when the DBA denies a request for an expedited appeal resolution, one of the 10 appeal files reviewed did not contain documentation that prompt oral notice of a decision to deny the member's request for an expedited appeal was provided to the member or member's representative.		
	Recommendations: The DBA must ensure that members receive prompt oral notice of the denial of a request for an expedited appeal resolution.		
42 CFR §438.10(g)(2)(xi) *42 CFR §438.406(a)* *42 CFR §438.406(b)(1-2(i-ii))* *DHCFP Contract Section 3.12.5.4(A-D)(1-3)*	22. Notification of Disposition of Grievances and Appeals In handling grievances and appeals, the DBA meets the following requirements: a. The DBA must provide recipients any reasonable assistance in completing forms and taking other procedural steps, including assisting the recipient and/or the recipient's representative to arrange for non-emergency transportation services to attend	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process – Medicaid 02. GA PP - Grievance and Appeals Process - Medicaid - APPENDIX 2 **Description of Process:** LIBERTY's Member Services Department is trained to not only appropriately respond to inquiries from members, but also offer the	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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	and be available to present evidence at the appeal hearing. This also includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability; b. Acknowledge receipt of each grievance and appeal; c. Ensure that the individuals who make decisions on grievances and appeals were not involved in any previous level of review or decision-making; and d. Ensure that the individuals who make decisions on grievances and appeals are health care professionals who have the appropriate clinical expertise, in treating the recipient's condition or disease if the grievance or appeal involves any of the following: i. An appeal of a denial that is based on medical necessity; ii. A grievance regarding the denial of an expedited resolution of an appeal; or iii. A grievance or appeal that involves clinical issues.	grievance and appeals process when found to be appropriate. This includes offering assistance completing the form, explaining the website grievance and appeals submission process and educating the member on language assistance and/or arranging non-emergency transportation, as needed. LIBERTY's established grievance and appeals process ensures written enrollee acknowledgement and disposition letters within all federal and state regulatory turnaround times. Information located: Pages 3-10 GA PP – Grievance and Appeals Process – Medicaid	
	Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy addressed LIBERTY's plan for processing and resolving grievances and appeals for requirements a through d of this element. The policy contained the provisions that individuals who made decisions on grievances and appeals were healthcare professionals who had the appropriate clinical expertise if the grievance or appeal involved an appeal of a denial that is based on medical necessity, a grievance regarding the denial of an expedited resolution of an appeal, or a grievance or appeal that involves clinical issues. Three of		

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	the 10 appeal files reviewed did not demonstrate that members were provided with grievance rights when LIBERTY made the decision to deny the member's expedited appeal request. The GA PP–Grievance and Appeals Process (Medicaid) policy identified that LIBERTY would acknowledge receipt of grievances and appeals within five calendar days of receipt. The review of grievance and appeal files confirmed that all acknowledgement letters were provided to the member or member's representative within five calendar days of receipt of the grievance or appeal. All 10 appeal files reviewed contained evidence that individuals who made decisions on the grievance or appeal were not involved in any previous level of review or decision making. All 10 appeal and 10 grievance files reviewed contained documentation which verified that licensed dentists rendered the appeal or grievance decision.		
	Recommendations: The DBA must ensure that when an expedited appeal request is denied by LIBERTY, the member or member's representative is provided with grievance rights.		
42 CFR §438.406(b)(1-3) *42 CFR §438.406(b)(4-6)* *DHCFP Contract Section 3.12.5.5(A-D)*	23. Process for Appeals The process for appeals also requires: a. That oral inquiries seeking to appeal an action are treated as appeals (in order to establish the earliest possible filing date for the appeal) and must be confirmed in writing unless the recipient requests expedited resolution; b. That the recipient is provided a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing, and that the recipient is informed by the DBA of the limited time available for this in the case of expedited resolution; c. That the recipient and his/her representative are provided the opportunity, before and during the appeals process, to examine the	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process – Medicaid 02. Grievance and Appeals Process Flowchart **Description of Process:** LIBERTY's appeals process is described throughout LIBERTY's policy titled "Grievance and Appeals Process-Medicaid. Please reference the attached exhibit. Information located:	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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	recipient's case file, including medical records, and any other document and records considered during the appeals process; and d. Include, as parties to the appeal, the recipient and his/her representative or the legal representative of a deceased recipient's estate.	Pages 7-8 GA PP – Grievance and Appeals Process – Medicaid Page 12 GA PP – Grievance and Appeals Process – Medicaid Page 14 GA PP – Grievance and Appeals Process – Medicaid	
	Findings: The policy, GA PP–Grievance and Appeals Process (Medicaid), detailed the processes for accepting appeals either orally or in writing. The policy described the process for documenting oral receipt of appeals to establish the earliest date of receipt for tracking purposes. For appeals filed by a provider on behalf of a recipient, the policy provided that the appeal may be followed by a written, signed appeal from the recipient. The Your Rights Under Dental Managed Care document that is included with the NABD and acknowledgement letters included the statement that for oral appeals, the member must complete and sign the appeal form and return it within 15 calendar days. If the member did not return the form, LIBERTY would not process the appeal. This practice is not consistent with the intent of the federal regulations that an oral appeal should be processed as a standard appeal even if the member does not follow the oral appeal with a written, signed appeal. Although the Your Rights Under Dental Managed Care document indicated that an oral appeal would not be processed unless a written, signed appeal was received, the appeal file reviews demonstrated that oral appeals were processed as standard appeals even when a written, signed appeal was not submitted by the member. The information included in policy and the Your Rights Under Dental Managed Care document were not consistent.		
	Recommendations: The DBA must ensure that information included in policy and member information materials is consistent and meets the federal regulations.		
42 CFR §438.404(a-b) *42 CFR §438.408(e)(1)* *DHCFP Contract Section 3.12.5.6*	24. Notification of Disposition of Grievances and Appeals The DBA must notify the recipient of the disposition of the grievance and appeal in written format. The written notice must include the results	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process - Medicaid **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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	of the resolution process and the date it was completed.	Notice of Determinations and Notice of Appeal Resolutions provide all members with a clear and concise response, and include the date the initial complaint was received, the date of the resolution, the name and contact information of the representative involved in the resolution of the case and appeal language for member that are not in agreement with the Plan's decision. Information located: Pages 6-7 GA PP – Grievance and Appeals Process – Medicaid Pages 10-11 GA PP – Grievance and Appeals Process – Medicaid	
	Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy and Grievance and Appeals Process Flowchart specified that LIBERTY notified recipients of the disposition of grievances and appeals in written format, which included the results of the resolution process and the date it was completed. The grievance and appeal file reviews confirmed that members received written notification of the disposition of their grievance or appeal that included the results of the resolution process and date it was completed.		
	Recommendations: None.		
42 CFR §438.408(e)(2)(iii) *DHCFP Contract Section 3.12.5.6 (A-C)*	25. Notice for Written Appeals not Resolved in Favor of the Recipient For appeals that are not wholly resolved in favor of the recipient, the notice includes:	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process – Medicaid 02. Notice of Action Your Rights	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	a. The right of the recipient to request a State Fair Hearing from the DHCFP and how to do so; b. The right to request to receive benefits while the hearing is pending and how to make this request; and, c. That the recipient may be held liable for the cost of those benefits if the State Fair Hearing's Officer upholds the DBA's action.	**Description of Process:** The Your Rights Document provides enrollees with instructions on how to file an State Fair Hearing and that they may have to pay for the cost of any continued benefits if the final decision is not in their favor. Information located: Page 11 GA PP – Grievance and Appeals Process – Medicaid Page 17 GA PP – Grievance and Appeals Process – Medicaid	
	Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy included the provision that LIBERTY would notify the member of the right to request a SFH for appeals that are not wholly resolved in favor of the member. The document, Your Rights Under Dental Managed Care, contained information about the members' right to request a SFH and how to obtain one; the right to request the continuation of benefits and how to do so; and that the member could be held liable for the costs of treatment if the final decision is not in the member's favor. All appeal files reviewed contained written resolution notices and the Your Rights Under Dental Managed Care document; however, the notice for written appeals that are not wholly resolved in the member's favor did not include the member's right to request a SFH but provided the member with appeal rights.		
	Recommendations: The DBA must ensure that the notice for written appeals that are not wholly resolved in the member's favor include the member's right to request a SFH from the DHCFP and how to do so.		
42 CFR §438.408 (d)(2)(ii) *DHCFP Contract Section 3.12.5.7*	26. Written Notice of Expedited Appeal Resolutions For expedited appeal resolution requests, the DBA makes a good faith effort to provide an oral notice	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process - Medicaid	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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	of the disposition in addition to the required written notice.	**Description of Process:** LIBERTY's expedited appeals process ensures that members receive oral notification if their request for an expedited appeal resolution has been approved or denied. Information located: Page 7-8 GA PP – Grievance and Appeals Process – Medicaid Page 14 GA PP – Grievance and Appeals Process – Medicaid	
	Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy included the provision that LIBERTY would contact the member by telephone within 24 hours of the decision for expedited appeals in addition to providing the written notice of resolution. Documentation that LIBERTY made reasonable efforts to provide oral notice of resolution for an expedited appeal was demonstrated in two of the three expedited appeals reviewed.		
	Recommendations: The DBA must ensure that reasonable efforts to provide oral notice of resolution for an expedited appeal are documented in the appeal file.		
42 CFR §438.416(a) *DHCFP Contract Section 3.12.5.8*	27. Written Records of Grievances and Appeals The DBA maintains records of grievances and appeals, which the DHCFP reviews as part of the Division's quality strategy.	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process - Medicaid **Description of Process:** LIBERTY's established grievance and appeals process ensure the retention of all grievance and appeals records.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
		Information located: Page 16 GA PP – Grievance and Appeals Process – Medicaid	
	Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy identified that LIBERTY maintains a complete and accurate record of grievances and appeals. The policy further identified that all grievance and appeal records were available on request by the State or the Centers for Medicare & Medicaid Services (CMS).		
	Recommendations: None.		
DHCFP Contract Section 3.12.5.9	28. Review of Enrollee Complaints and Appeals The DBA shall devote a portion of its regularly scheduled Quality Management/Quality Improvement committee meetings to the review of recipient complaints and appeals that have been received.	**Documents Submitted:** 01. QM PP - Quality Management and Improvement Program and Committee 02. QM Committee Structure **Description of Process:** LIBERTY's QMI Committee meets quarterly to address quality management needs, including grievances and appeals.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Quality Management and Improvement (QMI) Committee meeting minutes provided evidence that member complaints and appeals received are reviewed quarterly.		
	Recommendations: None.		
42 CFR §438.408(f)(3) *DHCFP Contract Section 3.12.6.1*	29. State Fair Hearing Process The State Fair Hearing process is described in Chapter 3100 of the Medicaid Services Manual (MSM). A recipient, recipient's representative or the representative of a deceased recipient's estate has the right to request a State Fair Hearing from	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process – Medicaid 02. NV_Medicaid_Handbook 03. NV Medicaid Provider Reference Guide	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	the DHCFP when they have exhausted the DBA's appeal system without receiving a wholly favorable resolution decision.	04. Notice of Action Your Rights **Description of Process:** LIBERTY ensures members are notified of their right to a State Fair Hearing after they have exhausted the Plan's appeal system. Any representative acting on behalf of a member, including a representative of a deceased member's estate, may file a request for a State Fair Hearing, in writing, with the enrollees signed authorization. Information located: Page 16-17 GA PP – Grievance and Appeals Process – Medicaid Page 36 NV Medicaid Member Handbook Page 64 NV Medicaid Provider Reference Guide	
	Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy included the provision that the member, a provider, the member's representative, or the representative of a deceased recipient's estate may request a SFH for appeals that are not wholly resolved in favor of the member.		
	Recommendations: None.		
42 CFR §438.402(c)(1)(i) *42 CFR §438.408(f)(1)(i)* *42 CFR §438.408(f)(2)* *DHCFP Contract Section 3.12.6.1, 3.12.6.3*	30. Processing Requests for State Fair Hearings The request for a State Fair Hearing must be submitted in writing within one hundred-twenty (120) calendar days from the date of the DBA's notice of resolution. The DBA will participate in the	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process – Medicaid 02. NV_Medicaid_Handbook	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	State Fair Hearing process, at the DBA's expense, in each circumstance in which a recipient for whom the DBA has made an adverse determination requests a State Fair Hearing. The DBA is bound by the decision of the Fair Hearing Officer.	03. NV Medicaid Provider Reference Guide 04. Notice of Action Your Rights **Description of Process:** LIBERTY ensures that enrollees and providers are notified of the State Fair Hearing process. The Plan abides by the State Fair Hearing decision. Information located: Pages 17-18 GA PP – Grievance and Appeals Process – Medicaid Page 37 NV Medicaid Member Handbook Page 64 NV Medicaid Provider Reference Guide	
	Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy included the provisions regarding SFHs for appeals that are not wholly resolved in favor of the member. Appendix 2, State Timeliness Requirements of the policy listed the timelines associated with a SFH, which included the provision that requests for a SFH had to be submitted in writing within 120 calendar days from the date of LIBERTY's notice of resolution. While this element received a score of *Met*, please refer to the findings and recommendations listed in Element 1 of this standard.		
	Recommendations: None.		
42 CFR §438.420(a) *42 CFR §438.420(b)(1-5)* *DHCFP Contract Section 3.12.2.3 and 3.12.7.1 (A-E)*	31. Continuation of Benefits The DBA must continue the recipient's benefits while the DBA's internal appeals process is pending	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process – Medicaid 02. NV_Medicaid_Handbook	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	and while the State Fair Hearing is pending if all the following conditions exist: a. The appeal is submitted to the DBA on or before the later of the following: within ten (10) days of the DBA mailing the Notice of Action; or, the intended effective date of the DBA's proposed action; b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; c. The services were ordered by an authorized provider; d. The original periods covered by the original authorization have not expired; and e. The recipient requests an extension of benefits.	03. NV Medicaid Provider Reference Guide 04. Notice of Action Your Rights **Description of Process:** LIBERTY ensures that enrollees are provided with their right for continuation of benefits through the appeal and State Fair Hearing process. Information located: Page 13 GA PP – Grievance and Appeals Process – Medicaid Page 35 NV Medicaid Member Handbook Page 62-63 NV Medicaid Provider Reference Guide	
	Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy included the provisions regarding the continuation of benefits while an appeal or SFH is pending. The policy included all the provisions noted in items a through e of this element.		
	Recommendations: None.		
42 CFR §431.230(b) *42 CFR §438.420(c)(1-3)* *42 CFR §438.420(d)* *DHCFP Contract Section 3.12.2.4, 3.12.7.2, and 3.12.7.3*	32. Continuation of Benefits while Appeal is Pending If, at the recipient's request, the DBA continues the recipient's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process – Medicaid 02. NV_Medicaid_Handbook 03. NV Medicaid Provider Reference Guide	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	a. The recipient withdraws the appeal; b. Ten (10) days pass after the DBA mails the notice of action, providing the resolution of the appeal against the recipient, unless the recipient, within the 10-day timeframe has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached; c. A State Fair Hearing Officer issues a hearing decision adverse to the recipient; and, d. The time period of service limits of a previously authorized service has been met. e. If the final resolution of the appeal is adverse to the recipient, the DBA may recover the cost of the services furnished to the recipient while the appeal was pending, to the extent that they were furnished solely because of the requirements of this section and in accordance with policy set forth in 42 CFR §431.230(b).	04. Notice of Action Your Rights **Description of Process:** LIBERTY will ensure continued benefits unless the criteria set-forth is met. We retain the right to recover that cost of the services furnished to a member while the appeal is in process, for services that are provided during the appeal process. Information located: Page 13 GA PP – Grievance and Appeals Process – Medicaid Page 35 NV Medicaid Member Handbook Page 62-63 NV Medicaid Provider Reference Guide	
	Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy included provisions regarding the continuation of benefits while an appeal is pending. The policy included the provisions noted in items a through d of this element.		
	Recommendations: None.		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.420(d) *42 CFR §438.424(a-b)* *DHCFP Contract Section 3.12.7.4*	33. Reversing an Action to Deny, Limit, or Delay Services If the DBA or Fair Hearing Officer reverses an action to deny, limit, or delay services that were not furnished while the appeal was pending, the DBA must authorize or provide the disputed services promptly and as expeditiously as the recipient's health condition requires. If the DBA or State Fair Hearing Officer reverses a decision to deny authorization of services, and the recipient received the disputed services while the appeal was pending, the DBA must pay for those services.	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process - Medicaid **Description of Process:** LIBERTY will ensure continued benefits until a final decision is made on the members appeal or State Fair Hearing, at which time LIBERTY will promptly execute any decision to reverse a previous adverse benefit determination. Information located: Page 17 GA PP – Grievance and Appeals Process – Medicaid	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Grievance and Appeals Process (Medicaid) policy included the provisions regarding SFHs and appeals. The policy included the provisions that if LIBERTY or a SFH officer reverses an action to deny, limit, or delay services that were not furnished while the appeal was pending, LIBERTY authorizes or provides the disputed services promptly and as expeditiously as the recipient's health condition requires. Further, the policy included the provision that if LIBERTY or a SFH officer reversed a decision to deny authorization of services, and the recipient received the disputed services while the appeal was pending, LIBERTY must pay for those services.		
	Recommendations: None.		

Results for Standard IX: Grievances and Appeals							
Total Elements	Met	=	20	X	1.00	=	20.00
	Partially Met	=	13	X	.50	=	6.50
	Not Met	=	0	X	.00	=	0.00
	Not Applicable	=	0	X	.00	=	0.00
	Total Applicable	=	33	**Total Rate**		=	26.50
Total Rate ÷ Total Applicable		=	**Total Score**				**80.3%**

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §440.230 *42 CFR §438.210(a)(2)* *42 CFR §438.210(a)(3)(i-ii)* *42 CFR §438.210(a)(4)(i)* *42 CFR §438.210(a)(5)(i)* *DHCFP Contract Section 3.3.1.1–3.3.1.2*	1. DBA Managed Care Benefit Package The DBA must furnish services in the same amount, duration and scope as services furnished to recipients under FFS Medicaid as set forth in 42 CFR §440.230, which states that the DBA: a. Must ensure the services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished; b. May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the recipient; c. May place appropriate limits on a service on the basis of criteria applied under the Title XIX and Title XXI State plans, such as medical necessity, or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose; d. Must specify what constitutes "medically necessary services" in a manner that is no more restrictive than that used in the State Medicaid and Children's Health Insurance Program (CHIP) programs as indicated in State statutes and regulations, the Title XIX and Title XXI State Plans, and other State policy and procedures, including the MSM.	**Documents Submitted:** UM PP - Coverage and Authorization of Services QM PP - Coverage of EPSDT Services QM PP - Coverage of EPSDT Services - APPENDIX B – NV MEDICAID NV Medicaid Adult Benefit Schedule 6.4.19 NV Medicaid Child Benefit Schedule 5.26.19 **Description of Process:** The benefit schedule describes all services covered for this program, as well as any limitations, exclusions and prior-authorization requirements. The benefit schedule is currently under review with DHCFP but will include coverage in the same amount, duration and scope as services furnished to recipients under FFS Medicaid as set forth in 42 CFR §440.230; see attached draft schedule.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	Findings: The UM PP–Coverage and Authorization of Services policy included information that pertained to the coverage of dental services based on appropriateness of care, and in a manner that is sufficient in duration and scope reasonably expected to achieve the purpose for which the services are furnished. This policy specified that services were provided in a nondiscriminatory manner and that services were not arbitrarily denied or reduced in amount, duration, or scope solely because of diagnosis, type of illness, or condition. Additionally, the UM PP–Coverage and Authorization of Services policy defined the term "dentally/medically necessary" and described LIBERTY's authorization of services protocols as being based on standardized criteria guidelines and program-specific requirements. The policy QM PP–Coverage of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services and EPSDT Services Appendix B outlined the services for Nevada Medicaid enrollees under the age of 21, and LIBERTY's Medicaid Adult and Child benefit schedules listed all covered services, including limitations and prior authorization requirements.		
	Recommendations: None.		
42 CFR §438.210(a)(5)(ii)(A-C) *DHCFP Contract Section 3.3.1.2*	2. Covered Services The DBA addresses the extent to which it is responsible for covering services related to the following: a. The prevention, diagnosis, and treatment of oral health impairments; b. The ability to achieve age-appropriate growth and development; and c. The ability to attain, maintain, or regain functional capacity.	**Documents Submitted:** UM PP - Coverage and Authorization of Services QM PP - Coverage of EPSDT Services QM PP - Coverage of EPSDT Services - APPENDIX B – NV MEDICAID NV Medicaid Adult Benefit Schedule 6.4.19 NV Medicaid Child Benefit Schedule 5.26.19 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
		Please see description of process in the above P&P.	
	Findings: The UM PP–Coverage and Authorization of Services policy stipulated LIBERTY's responsibility to cover medically necessary dental services including services and supplies that prevent the onset of an illness, condition, or disability; are services necessary to achieve age-appropriate growth and development; and are necessary to attain, maintain, or regain functional capacity. The QM PP– Coverage of EPSDT Services policy identified LIBERTY's responsibility to cover all medically necessary dental items and services for members under the age of 21 to correct or ameliorate defects, physical illnesses, and conditions or prevent a condition from worsening, or prevent the development of additional health problems.		
	Recommendations: None.		
42 CFR §438.210(b)(1) *DHCFP Contract Section 3.3.1.3 (A)*	3. Written Policies and Procedures The DBA must, for itself and its subcontractors, have in place and follow, written policies and procedures for the processing of requests for initial and continuing authorizations of services.	**Documents Submitted:** UM PP - Coverage and Authorization of Services **Description of Process:** Please see description of process in the above P&P.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The UM PP–Coverage and Authorization of Services policy provided evidence that LIBERTY had a written procedure for the initial and continuing authorization of services that were based on standardized guidelines and program-specific requirements. During the interview session, LIBERTY staff members articulated the process from receipt of an authorization request to the time the decision was rendered by a licensed dental provider. Staff members further stated that if a service authorization request lacks a sufficient amount of clinical documentation to support the requested services, then LIBERTY staff members would follow up with the provider to obtain additional clinical documentation within the required time frames to render a decision.		
	Recommendations: None.		

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.206(b)(4) *DHCFP Contract Section 3.3.5*	4. Out-of-Network Services If the DBA's provider network is unable to provide medically necessary services covered under the plan to a particular recipient, the DBA must adequately and timely cover these services out-of-network for the recipient for as long as the DBA is unable to provide them.	**Documents Submitted:** UM PP - Coverage and Authorization of Services NM PP - Access and Availability Guidelines **Description of Process:** Please see description of process in the above P&P.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The UM PP–Access and Availability Guidelines policy addressed protocols to provide services from an out-of-network provider when access to in-network services are limited. While the policy did not identify that out-of-network services would be continued for as long as LIBERTY was unable to provide reasonable access to a contracted provider, staff members stated during the on-site interview that LIBERTY would provide services until such services are no longer necessary or the out-of-network provider becomes an in-network provider.		
	Recommendations: The DBA must ensure that if the DBA's provider network is unable to provide medically necessary services covered under the plan to a particular member, the DBA must adequately and in a timely manner cover these services out-of-network for the recipient for as long as the DBA is unable to provide them.		
42 CFR §438.210(b)(2)(i-ii) *DHCFP Contract Section 3.3.1.3 (B)*	5. Consistent Application of Review Criteria The DBA must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and consult with the requesting and/or servicing provider, when necessary.	**Documents Submitted:** UM PP - Clinical Criteria for UM Decisions **Description of Process:** Please see description of process in the above P&P.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The UM PP–Clinical Criteria for UM Decisions policy identified that consistent application of review criteria for authorizations was monitored at least annually through the Inter-Rater Reliability (IRR) process. Additionally, the policy identified that the DBA's dental director consults with the requesting and/or servicing provider, when necessary. LIBERTY staff members confirmed the mechanisms described in policy.		
	Recommendations: None.		

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
DHCFP Contract Section 3.3.1.3 (C)	6. Monitoring Prior Authorization Requests The DBA shall monitor prior authorization requests. DHCFP, at its sole discretion, may require removal of the prior authorization requirement based on reported approval percentage rates, to align prior authorization procedures across delivery entities, and if determined necessary for the proper administration of the Medicaid program.	**Documents Submitted:** UM PP - UM Tracking and Trending **Description of Process:** Please see description of process in the above P&P.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The UM PP–UM Tracking and Trending policy described the process for monitoring and tracking of prior authorization requests, including authorization review decisions.		
	Recommendations: None.		
DHCFP Contract Section 3.5.5.1	7. Personnel Completing the Children with Special Health Care Needs (CSHCN) Assessment The assessment of CSHCN is completed by appropriately qualified health care professionals.	**Documents Submitted:** QM PP - Coordination of Dental Services **Description of Process:** Please see description of process in the above P&P.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The QM PP–Coordination of Dental Services policy identified that LIBERTY will implement and maintain services for children with special health care needs (CSHCN) including a comprehensive oral assessment. While the policy included language about a comprehensive oral assessment for CSHCN members, it did not specify who is responsible for completing the assessment or how LIBERTY ensures individuals completing assessments are appropriately qualified professionals. During the on-site interview, LIBERTY staff members were unable to demonstrate an understanding of the requirements for this element as the staff members were not familiar with the process for CSHCN assessments.		
	Recommendations: The DBA must ensure that the assessment of CSHCN is completed by appropriately qualified professional and that staff are trained on the relevant policies and procedures.		

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.208 (c)(3-4) *42 CFR §438.208(c)(3)(i-ii)* *DHCFP Contract Section 3.5.5.1 (A-C)*	8. Treatment Plans for CSHCN The DBA must produce a treatment plan for recipients with special health care needs (CHSCN) who are determined through an assessment to need a course of treatment or regular care monitoring. The treatment plan must be: a. Developed by the recipient's primary dental provider with recipient participation, and in consultation with any specialists caring for the recipient; b. Approved by the DBA in a timely manner, if approval is required by the DBA; and, c. In accordance with any applicable State QA and utilization review standards.	**Documents Submitted:** QM PP - Coordination of Dental Services **Description of Process:** Please see description of process in the above P&P.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The QM PP–Coordination of Dental Services policy specified that complex and special needs cases would be referred to a care coordinator who would work with the Specialty Referral unit to ensure coordination of dental services from a specific, agreed-on treatment plan between LIBERTY's dental director, primary dental provider, and primary care medical provider, and the member's guardian. The policy also confirmed that LIBERTY required CSHCN to have a written dental treatment plan. During the on-site interview, LIBERTY staff members were unable to demonstrate an understanding of the requirements for this element as the staff members were not familiar with the process for CSHCN treatment plans.		
	Recommendations: The DBA must ensure that treatment plans for CSHCN are developed by the recipient's primary dental provider with member participation and in consultation with any specialists caring for the recipient; and that they are approved by the DBA in a timely manner, if approval is required by the DBA, and in accordance with any applicable State quality assurance (QA) and utilization review standards.		

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.208(c)(4) *DHCFP Contract Section 3.5.5.2*	9. Direct Access to Specialists for CSHCN The DBA must have a mechanism in place to allow these (CSHCN) recipients access to a specialist through a standing referral or an approved number of visits, as deemed appropriate for the recipient's condition and identified needs.	**Documents Submitted:** QM PP - Coordination of Dental Services **Description of Process:** Please see description of process in the above P&P.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The QM PP–Coordination of Dental Services policy verified that LIBERTY had mechanisms for ensuring CSHCN had timely access to pediatric specialists, sub-specialists, ancillary therapists, community resources, and specialized equipment and supplies, including an assignment to a specialist as primary care dentist, standing referrals, or an approved number of visits appropriate for the member's condition and identified needs. During the interview session, LIBERTY staff members stated that access to specialty providers is regularly monitored to identify gaps and to assess access and availability through grievances, appeals, and call center inquiries data.		
	Recommendations: None.		
42 CFR §438.114(c)(1)(i) *42 CFR §438.114(c)(3)(ii)(A and B)* *42 CFR §438.114(d)(1)(i-ii)* *42 CFR §438.114(d)(3)* *DHCFP Contract Section 3.3.6.1–3.3.6.5*	10. Emergency Dental Services The DBA may not deny payment for emergency services treatment when a representative of the DBA instructs the recipient to seek emergency services. The DBA shall be responsible for dental related services provided in an emergency. In providing for emergency dental services and care as a covered service, the DBA shall not: a. Require prior authorization for emergency dental services and care b. Indicate that emergencies are covered only if care is secured within a certain period of time	**Documents Submitted:** UM PP - Emergency Services Expedited Dental Services UM PP - Payment to Out of Network Provider **Description of Process:** Please see description of process in the above P&P.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	c. Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered. d. Deny payment based on the member's failure to notify the DBA in advance or within a certain period of time after the care is given. e. Deny payment for emergency dental care unless it is performed under the medical benefit in a hospital, emergency room or ambulatory surgery center. f. Deny payment for treatment obtained when a member had an emergency dental condition and stabilization of condition, including cases in which the absence of immediate dental attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of an emergency dental condition.		
	Findings: The UM PP–Emergency Dental Services/Expedited Dental Services policy specified that LIBERTY would not deny payment for emergency services when a LIBERTY representative instructed a recipient to seek emergency care, or if emergency care was provided within a certain period of time, as required by this element. This policy identified LIBERTY's responsibility to provide emergency dental services 24 hours a day, seven days a week at any in- or out-of-network provider. While this policy indicated that emergency services would not require prior determination of benefits, it did not specify that post-authorization was also not required. Additionally, this policy indicated that LIBERTY would not deny payment for treatment obtained when a recipient had an emergency dental condition but did not specify that payment would not be denied when the member required stabilization of a condition, including cases in which the absence of immediate dental attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of an "emergency dental condition." This deficiency was also noted during LIBERTY's Readiness Review, which required a CAP. LIBERTY submitted a revised Emergency Dental Services/Expedited Dental Services policy as part of its CAP that included the following language:		

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	Emergency services do not require prior- nor post-authorization and are covered in cases where a prudent layperson, acting reasonably, would have believed that an emergency dental condition existed. Payment will not be denied solely on the determination that the absence of immediate dental attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of an "emergency dental condition." LIBERTY's revised policy and CAP were approved by the State, but LIBERTY did not implement the revised policy, which was confirmed by LIBERTY staff members during the on-site interview session.		
	Recommendations: LIBERTY must ensure that it does not deny payment for treatment obtained when the recipient had an emergency dental condition and stabilization of condition, including cases in which the absence of immediate dental attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of an "emergency dental condition." It is recommended that LIBERTY add to policy that post-authorization is also not required for emergency services. Further, it is recommended that LIBERTY develop mechanisms to assure that revised policies are implemented.		
42 CFR §438.114(d)(2) *42 CFR §438.114(e)* *42 CFR §438.114(f)* *DHCFP Contract Section 3.3.6.9 (A)*	11. Post-Stabilization Services The DBA is financially responsible for post-stabilization services obtained within or outside the network that are pre-approved by a network provider or organization representative.	**Documents Submitted:** UM PP - Post Out of Network Continuity of Care **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The UM PP–Post Out of Network Continuity of Care Policy acknowledged that LIBERTY is responsible for payment of any covered poststabilization services that were pre-approved by a network provider or plan representative, regardless of the treating provider's network status. Additionally, this policy also verified that a recipient's general dentist or primary care provider would be responsible for care needs after emergency services are rendered; however, LIBERTY would authorize post-continuity-of-care needs with the out-of-network provider when in the best interest of the member. This policy also outlined the procedure to notify the recipient's general dentist or primary care physician of emergency services rendered by an out-of-network provider to address continuity of care.		
	Recommendations: None.		

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.236(b)(1-4) *DHCFP Contract Section 3.6.1.1–3.6.1.3*	12. Adopting Practice Guidelines The DBA must adopt practice guidelines and protocols which: a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; b. Are adopted in consultation with contracting dental professionals; and c. Are reviewed and updated periodically as needed to reflect current practice standards.	**Documents Submitted:** UM PP - Clinical Criteria for UM Decisions 2019 Clinical Criteria Guidelines and Practice Parameters - FINAL **Description of Process:** The Clinical Criteria Guidelines recently went through a thorough review and re-haul and the draft is now pending DHCFP final comments to be finalized and sent to the Board of Directors for approval.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The UM PP– Clinical Criteria for UM Decisions policy demonstrated that LIBERTY used review criteria published by the American Dental Association and the National Association of Dental Plans. The policy further described its written criteria as being based on sound clinical principles, processes, and evidence; developed or adopted with involvement of appropriate dentists; and reviewed and approved at least annually. During the interview session, LIBERTY staff members confirmed that LIBERTY's dental director and dental consultants, representing a variety of specialties, were involved in the review and adoption of clinical guidelines and review criteria. LIBERTY's Utilization Management Committee assured all written criteria and guidelines are evidence-based and are routinely reviewed and approved.		
	Recommendations: None.		
42 CFR §438.236(c-d) *DHCFP Contract Section 3.6.2.1–3.6.2.2*	13. Dissemination of Practice Guidelines The DBA must: a. Disseminate its practice guidelines to all affected providers prior to the contract start date and, upon request, to recipients and	**Documents Submitted:** 13. NM PP - Provider Orientation UM PP - Clinical Criteria for UM Decisions	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	potential recipients, including prior authorization policies and procedures; and b. Ensure that decisions for utilization management, recipient education, coverage of services, and other areas to which the guidelines apply, are consistent with the guidelines.	UM PP - Disclosure of UM Processes and Criteria to Providers, Enrollees and the Public **Description of Process:** Please see description of process in the above P&P.	
	Findings: The UM PP–Disclosure of UM Processes and Criteria to Providers, Members and the Public policy specified that LIBERTY made its criteria available on its website for recipients and the public. Additionally, requests for utilization management (UM) processes could be requested in-person, by phone, or in writing. The UM PP– Clinical Criteria for UM Decisions policy described LIBERTY's process of reviewing all service requests against appropriate review criteria, taking into consideration the patient's condition or circumstances.		
	Recommendations: None.		
DHCFP Contract Section 3.9.8.2 (A)	14. Monitoring Care Using Clinical Care Standards/Practice Guidelines The IQAP studies and other activities monitor quality of care against clinical care or health service delivery standards or practice guidelines specified in the Quality Strategy.	**Documents Submitted:** UM PP - Inter Rater Reliability Program **Description of Process:** Please see description of process in the above P&P.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The UM PP–Inter Rater Reliability Program policy outlined LIBERTY's process for monitoring quality of care against practice guidelines. The policy specified LIBERTY's dental director is responsible for continuous monitoring and tracking of clinical staff decisions, by random sampling of clinical reviews, to ensure consistency and appropriateness of care decisions.		
	Recommendations: None.		

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
DHCFP Contract Section 3.9.8.2 (B-G)	15. Use of Clinical Care Standards/Practice Guidelines The standards/guidelines: a. Are based on reasonable scientific evidence and developed or reviewed by the DBA's providers; b. Focus on the process and outcomes of dental care delivery, as well as access to care; c. Provide a mechanism for continuously updating the standards/guidelines; d. Are included in provider manuals developed for use by DBA providers, or otherwise disseminated, including but not limited to dissemination on the provider website, to all affected providers as they are adopted and to all recipients and potential recipients upon request; e. Address preventive dental services; and f. Are developed for the full spectrum of populations enrolled in the plan.	**Documents Submitted:** UM PP - Clinical Criteria for UM Decisions 2019 Clinical Criteria Guidelines and Practice Parameters – FINAL NV Medicaid Provider Reference Guide **Description of Process:** The provider reference guide is pending DHCFP comments to be finalized and the Clinical Guidelines section will be replaced once the updated document is approved and finalized.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The UM PP–Clinical Criteria for UM Decisions policy described written criteria as being based on sound clinical principles, processes, and evidence; developed or adopted with involvement of appropriate dentists; and reviewed and approved at least annually. The NV Medicaid Provider Reference Guide outlined clinical dentistry practice parameters including those for preventive services. During the interview session, LIBERTY staff explained that providers were notified of new or revised guidelines through the provider newsletter and provider representatives.		
	Recommendations: None.		

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
DHCFP Contract Section 3.9.8.2 (H)	16. Evaluating Care Using the Clinical Care Standards/Practice Guidelines The IQAP shall use these standards/guidelines to evaluate the quality of care provided by the DBA's providers, whether the providers are organized in groups, as individuals, or in combinations thereof.	**Documents Submitted:** UM PP - UM Compliance Assessment and Evaluation **Description of Process:** Please see description of process in the above P&P.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The UM PP–Compliance Assessment and Evaluation policy outlined LIBERTY's process for monitoring compliance with the UM program, which included use of clinical care standards and practice guidelines. During the on-site interview, LIBERTY staff members stated that provider monitoring consists of various activities such as tracking and trending of grievances and appeals data to identify any quality of care issues, as well as physician- and/or member-initiated potential quality issues/incidents (PQI) reports. LIBERTY's Quality Management Improvement Committee (QMIC) oversees the monitoring activities, including implementation and outcome of any corrective actions.		
	Recommendations: None.		
DHCFP Contract Section 3.9.8.3 (A)	17. Monitoring and Evaluating Quality Qualified clinicians monitor and evaluate quality through the review of individual cases where there are questions about care, and through studies analyzing patterns of clinical care and related service.	**Documents Submitted:** Submission: UM PP - UM Compliance Assessment and Evaluation **Description of Process:** Submission: Please see description of process in the above P&P.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The UM PP–UM Compliance Assessment and Evaluation policy described the processes that LIBERTY employs to evaluate quality through consistent monitoring of compliance with LIBERTY's UM program. The policy outlined the role of the UM Committee and the dental director in evaluating quality that included tracking, trending, and reporting of grievances; appeals; access and availability to providers, specialists, and appropriate dental services; and specialty referral		

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	utilization to identify any quality-of-care patterns. Corrective action is requested of providers when noncompliance with LIBERTY's UM program is identified.		
	Recommendations: None.		
DHCFP Contract Section 3.9.19.1	18. Written Program Description for Utilization Review The DBA must have a written utilization review management program description, which includes, at a minimum, policies and procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of dental services.	**Documents Submitted:** 2019 Utilization Management Program_CLEAN **Description of Process:** Please see description of process in the above P&P.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2018 and 2019 Utilization Management Program Descriptions addressed processes to evaluate dental necessity, and the implementation of criteria from State/federal regulations, expert dental sources, and nationally recognized dental associations. The Utilization Management Program Description further described LIBERTY's process of approving or denying requests for services based on medical necessity including but not limited to time frames, requests for additional information or expert reviewer consultation, and notification requirements.		
	Recommendations: None.		
42 CFR §438.330(b)(3) *DHCFP Contract Section 3.9.19.2*	19. Scope of the Utilization Review Program The program has mechanisms to detect under-utilization as well as over-utilization.	**Documents Submitted:** 2019 Utilization Management Program_CLEAN UM PP - UM Tracking and Trending **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
		Please see description of process in the above P&P.	
	Findings: The 2018 and 2019 Utilization Management Program Descriptions and the UM PP–UM Tracking and Trending policy identified several mechanisms to analyze and evaluate utilization data and trends, and to monitor adequate, under-, and overutilization. The 2018 and 2019 Utilization Management Program Descriptions and the UM PP–UM Tracking and Trending policy further outlined the dental director's and the Utilization Management Committee's responsibility to oversee the review, analysis, and assessment of utilization data and trends. During the on-site interview session, LIBERTY staff members explained the various mechanisms to detect over- and underutilization such as through monthly UM data reports, service request denials and approvals, and volume of preventive services. LIBERTY staff members further described actions taken when potential provider utilization concerns are identified, which included but were not limited to provider counseling or retraining, a desktop or on-site audit, a comprehensive review of provider claims and trends, ongoing monitoring of potential concerns, and corrective action.		
	Recommendations: None.		
42 CFR §438.210(b)(2)(ii) *42 CFR §438.210(b)(3)* *DHCFP Contract Section 3.9.19.3 (A–D)*	20. Pre-authorization Review Requirements For DBAs with pre-authorization review programs: a. Pre-authorization decisions must be supervised by qualified dental professionals; b. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating dentist as necessary; c. The reasons for decisions are clearly documented and available to the recipient; d. The DBA's prior authorization policies and procedures must be consistent with provision of covered medically necessary	**Documents Submitted:** UM PP - Review Criteria_Referral Review, Approve, Modify or Deny **Description of Process:** Please see description of process in the above P&P.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	dental care in accordance with community standards of practice.		
	Findings: The QM PP–Appropriate Professionals policy specified that appropriately licensed healthcare professionals supervise all review decisions, that appropriately licensed professionals supervise all dental necessity denials of care, that only a licensed dentist may deny a request for dental services, and that board-certified/board-eligible specialists or academic specialists are consulted when applicable to make decisions based on dental necessity. The UM PP–Coverage and Authorization of Services, the QM PP–Coverage of EPSDT Services, and QM PP–Appropriate Professionals documents collectively outlined the procedures for authorizing dental services in accordance with dental necessity and standards of practice. The policies reviewed did not describe efforts made to obtain all necessary information, including pertinent clinical information; consultation with the treating dentist as necessary; nor did the policies cite reasons for decisions to be clearly documented and available to the member.		
	Recommendations: The DBA must ensure that its UM program includes the description of efforts made to obtain all necessary information, including pertinent clinical information; consultation with the treating dentist as necessary before rendering an authorization decision; and that reasons for decisions be clearly documented and available to the member.		
42 CFR §438.3(i) *42 CFR §438.210(e)* *42 CFR §438.230(b)(1-2)* *42 CFR §438.230(c)(1-3)* *DHCFP Contract Section 3.9.19.3 (G–I)*	21. Utilization Review Program Concerning the Utilization Review Program: a. There are mechanisms to evaluate the effects of the program using data on recipient satisfaction, provider satisfaction or other measures; b. Consistent with 42 CFR §438.6(h) and 42 CFR §423.208, DBAs must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any recipient; and,	**Documents Submitted:** 2019 Utilization Management Program_CLEAN UM PP - Satisfaction with the UM Process QM PP - Separation of Decision Making From Fiscal and Administrative Management **Description of Process:** Please see description of process in the above P&P.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	c. If the DBA delegates responsibility for utilization management, it has mechanisms to ensure that the delegate meets these standards.		
	Findings: The 2018 and 2019 Utilization Management Program Descriptions outlined various mechanisms to assess recipient and provider satisfaction through recipient satisfaction surveys, recipient grievance data, provider satisfaction surveys, and review of practitioner and provider feedback. The Separation of Decision Making from Fiscal and Administrative Management policy and associated Affirmation Statement for Incentives Form established that LIBERTY does not provide incentives to encourage barriers to care and services or provide incentives for utilization review decision makers to deny, limit, or discontinue medically necessary services to any member. Additionally, the Affirmation Statement for Incentives Form indicated that a signed affirmation statement was required from UM staff annually. During the interview session, LIBERTY staff confirmed that no utilization management functions were delegated.		
	Recommendations: None.		
42 CFR §438.210(b)(3) *42 CFR §438.406(b)(2)(ii)* *DHCFP Contract Section 3.3.1.3 (D)*	22. Clinical Expertise of Staff Denying Services Any decision made by the DBA to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a dental professional who has appropriate clinical expertise in treating the recipient's condition or disease. *Cross- reference Denials File Review Tool.*	**Documents Submitted:** UM PP - Clinical Criteria for UM Decisions QM PP - Appropriate Professionals **Description of Process:** Please see description of process in the above P&P.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The QM PP–Appropriate Professionals policy identified that LIBERTY required qualified healthcare professionals to make UM decisions on medical/dental necessity. This policy further specified that only a licensed dentist could deny a request for dental services based on dental necessity, and that board-certified/board-eligible specialists or academic specialists were consulted when applicable. During the on-site interview session, LIBERTY staff members confirmed (and the denial file reviews verified) that all authorization decisions to deny dental services were rendered by a		

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	licensed dental provider. The decision to deny a service authorization request was made by a licensed dentist in all 10 files reviewed confirming that only licensed dentists may render a decision to deny dental services. The NABD for the denial in whole, or in part, of a service authorization request was sent according to the required time frame in all 10 files reviewed. The NABD denial notification letter sent to the member in all 10 denial files reviewed did not identify the clinician who rendered the decision. The denial notification letter sent to the requesting provider, however, identified the clinician who rendered the decision. While the NABD in the denial files included reasons for the decision to deny the authorization, the reasons for the denial decision were not written in plain language. LIBERTY staff members stated during the on-site review that the NABD was revised and approved by the DHCFP on September 10, 2019, just prior to LIBERTY's compliance review. According to LIBERTY staff members, the revised NABD template letter was in the process of being updated in LIBERTY's UM software program with implementation scheduled for the end of September 2019. Please refer to Standard IX—*Grievances and Appeals*, Element 1 for additional findings.		
	Recommendations: LIBERTY must ensure that its NABD template letter sent to members and the requesting provider is written in plain language and includes all requirements identified in federal regulations.		
42 CFR §438.206(c)(1)(ii) *DHCFP Contract Section 3.6.2.4*	23. Hours of Operation The DBA must ensure that its providers offer hours of operation that are no less than the hours of operation offered to commercial recipients or comparable to Medicaid FFS, if the provider serves only Medicaid recipients.	**Documents Submitted:** N/A 9/19/19: NM PP - Access and Availability Guidelines **Description of Process:** LIBERTY has no way of track if the office is open different hours for Medicaid than its Commercial hours. Typically, an office has set hours that are not defined as Medicaid or commercial. 9/19/19 Submission: Please see description of process in the above P&P.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The NM PP–Access and Availability Guidelines policy included language which supports that LIBERTY required network providers to offer the same access and hours of operation to all recipients, regardless of plan or program type.		

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	Recommendations: None.		
42 CFR §438.206(c)(1)(iv-vi) *DHCFP Contract Section 3.6.2.6 and 3.6.2.7*	24. Monitoring The DBA must monitor providers regularly to determine compliance and take corrective action if there is a failure to comply by network providers.	**Documents Submitted:** NM PP - Access and Availability Guidelines **Description of Process:** Please see description of process in the above P&P.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The NM PP–Access and Availability policy described the process for regularly monitoring providers to determine compliance with and require corrective action for noncompliance. During the on-site interview session, LIBERTY staff members confirmed that regular monitoring of the access and availability of its provider network is performed. The Nevada Network Accessibility Activity Report provided evidence of the DBA's monitoring of its providers.		
	Recommendations: None.		

Results for Standard X: Coverage and Authorization of Services							
Total Elements	Met	=	18	X	1.00	=	18.00
	Partially Met	=	6	X	.50	=	3.00
	Not Met	=	0	X	.00	=	0.00
	Not Applicable	=	0	X	.00	=	0.00
	Total Applicable	=	24	**Total Rate**		=	21.00
Total Rate ÷ Total Applicable		=	**Total Score**				**87.5%**

Appendix B. Division of Health Care Financing and Policy
Nevada Medicaid Managed Care
SFY 2018–2019 Internal Quality Assurance Program
Corrective Action Plan Template
for LIBERTY Dental Plan of Nevada, Inc.

Compliance With Standards Review Tool CAP

Standard VIII: Continuity and Coordination of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.208(b)(2-4) *45 CFR Parts 160 and 164* *42 CFR §438.208(b)(1)* *42 CFR §438.224* *DHCFP Contract Section 3.3.6.10 (A-B)*	1. Coordination with Other vendors and Other Services Pursuant to 42 CFR §438.208(b) (2), (3), and (4) the DBA is required to implement procedures to coordinate services it may provide to the recipient with the services the recipient may receive from any other DBA. a. Upon request or notification of need, the DBA is required to communicate with other vendors serving the recipient the results of its identification and assessment of any special health care needs to ensure that services are not duplicated, and to ensure continuity of care. The DBA's procedures must ensure that, in the process of coordinating care, each recipient's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164 [(the Health Insurance Portability and Accountability Act (HIPAA)]. b. The DBA case managers are responsible for coordinating services with other appropriate Nevada Medicaid and non-Medicaid programs.	**Documents Submitted:** **Description of Process:**	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VIII: Continuity and Coordination of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	c. In addition, the DBA is responsible for ensuring continuity of services for recipients with special needs. These recipients may include but are not limited to: 3.3.1.11 d. juveniles temporarily detained by a state or county agency; Seriously Emotionally Disturbed children, adults with Severe Mental Illness and individuals with substance abuse disorders; Children with Special Health Care Needs; homeless recipients; recipients with chronic conditions; women with pregnancies, and referring orthodontic recipients to their appropriate Dental Home for periodic examinations and cleanings.		
	Findings: The policy, QM PP – Coordination of Dental Services, described LIBERTY's policy to coordinate dental healthcare services to meet an individual's specific needs to ensure timely coordination of services between the member, the plan, providers, as well as medical service providers. The policy also defined "special needs members" as those with physical and/or mental disabilities in need of dental care from providers who have special experience working with this population. The policy also described the methods to coordinate with pediatric specialists, sub-specialists, ancillary therapists, community resources, primary care dentists, and providers of specialized equipment and supplies for persons with special health care needs (SHCN). The policy, Continuity of Care System, described the process for outreaching to noncontracted providers to join LIBERTY's network. LIBERTY staff members described the use of the Guardian network to support special needs of recipients when an in-network provider was not available. Neither policy described the care coordination and continuity of services for homeless or pregnant recipients.		
	Recommendations: The DBA is responsible for ensuring continuity of services for recipients with special needs. These recipients may include homeless and pregnant recipients.		

Appendix B. Division of Health Care Financing and Policy
Nevada Medicaid Managed Care
SFY 2018–2019 Internal Quality Assurance Program
Corrective Action Plan Template
for LIBERTY Dental Plan of Nevada, Inc.

Standard VIII: Continuity and Coordination of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			

Standard VIII: Continuity and Coordination of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
DHCFP Contract Section 3.9.8.3 (D)	4. Identification of Race and Ethnicity The DBA works collaboratively with DHCFP to determine recipient race and ethnicity. The DBA organizes interventions specifically designed to reduce or eliminate disparities in health care.	**Documents Submitted:** 04. CU PP - Membership Demographic Profile **Description of Process:** Please see description in the above P&P.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The policy, 04. CU PP – Membership Demographic Profile, described the process LIBERTY used to collect and analyze enrollee population demographic data to ensure the linguistic and cultural needs of enrollees are met and to reduce health disparities and achieve health equity. The meeting minutes from the Quarter 4 2018 Cultural and Linguistic Competency Committee meeting provided evidence that the committee reviewed member race and ethnicity reporting information as part of the meeting. Most of the information reported focused on the linguistic needs of the population served and the linguistic services provided by the dental provider. The reports, however, did not contain information about disparities that may exist in the services provided or accessed by the population. For example, the reports did not show how LIBERTY examined disparities through analysis of performance measures or PIP data to determine if certain ethnicities or races have disproportionate utilization of services and if so, what LIBERTY will do to reduce and eliminate those disparities.		
	Recommendations: LIBERTY must define the ways in which it uses data to identify healthcare disparities and organize interventions specifically designed to reduce or eliminate disparities in healthcare.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			

Standard VIII: Continuity and Coordination of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
DHCFP Response (To be completed by DHCFP/HSAG.)			

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

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	form submitted with the desk review documentation is titled Request for Hearing Before Appeals Officer. This is not the correct State Fair Hearing Request form. The Nevada Medicaid Dental Program Member Handbook and the Nevada Medicaid Provider Resource Guide included information on the member's right to a SFH, how to obtain such a hearing, and the rules for representation. LIBERTY staff members confirmed that the Your Rights Under Dental Managed Care document is provided to members with the NABD letter when a decision is made to deny, reduce, terminate, or suspend a service. The appeal file reviews demonstrated that the Your Rights Under Dental Managed Care documents were sent to members with the NABD; however, the files reviewed contained three different versions of the Your Rights Under Dental Managed Care document, where all but one version had incorrect time frames for filing appeals and requesting a SFH. During the on-site interview session, LIBERTY staff members stated they were aware of the incorrect time frame to request a SFH listed in the Your Rights Under Dental Managed Care document and had recently received approval from the DHCFP for the revised Your Rights Under Dental Managed Care document and request for a SFH.		
	Recommendations: The DBA must ensure that the notice provided to members about SFH requests contains accurate, complete information that is consistent with federal regulations and provide members with the correct SFH request form.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.402(a) *DHCFP Contract Section 3.9.16.5 (A–F)*	3. Recipient Grievance and Appeals Procedures This grievance and appeals system must include: a. Procedures for registering and responding to grievances and appeals within thirty (30) calendar days. DBAs establish and monitor standards for timeliness; b. Documentation of the substance of grievances, appeals, and actions taken; c. Procedures ensuring a resolution of the grievance and providing the recipient access to the State Fair Hearing process for appeals; d. Aggregation and analysis of grievance and appeal data and use of the data for quality improvement; e. Compliance with DHCFP due process and fair hearing policies and procedures specific to NV Medicaid and NV Check Up recipients; and f. Compliance with 42 CFR §438 Subpart F Grievance and Appeals.	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process – Medicaid 02. GA PP - Grievance and Appeals Process - Medicaid - APPENDIX 2 03. Member Grievance and Appeal Form – NEVADA 04. Grievance and Appeals Process Flowchart 05. NV_Medicaid_Handbook 06. NV Medicaid Provider Reference Guide **Description of Process:** LIBERTY resolves all Medicaid member grievances and appeals within 30 calendar days of receipt, and expedited grievances and appeals are resolved within 72 hours from time of receipt. The Assistant Manager, QM, oversees the receipt and processing of all member grievances and appeals to ensure that each case is resolved in a timely manner. Additionally, weekly grievance and appeals reports are reviewed by	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	revisions to the dental request letter template instructing the provider that email encryption must be used if the dental provider chose to send dental records via email. During the on-site interview session, LIBERTY staff members were unable to explain why the original dental record request letter was still in use and the revised request letter was not implemented after the 2018 CAP was approved. An increased risk for a breach of PHI when transmitting dental records from unsecured emails remains a concern. Post-on-site review response provided by LIBERTY on September 26, 2019, specified that effective September 26, 2019, the Grievance and Appeal Nevada Medicaid records request template with the revised and 2018 CAP approved language was implemented for automation within LIBERTY's management information system (MIS) workflow and provided a sample of the template letter. Additionally, LIBERTY identified that Nevada grievance and appeal cases will be reviewed to determine if records were received by email. Providers are to be contacted to verify that dental record submissions were secure no later than October 11, 2019.		
	Recommendations: The DBA must ensure that grievance and appeal policies and procedures include accurate information that is consistent with federal regulations and the contract with the DHCFP; that members have access to the correct State Fair Hearing Request form; and when a dental provider emails dental records, that mechanisms are in place to assure protection and security of the member's PHI. Further, it is recommended that LIBERTY develop mechanisms to ensure that remediations identified in CAPs are implemented.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR Subpart F *42 CFR §438.402* *42 CFR §438.414* *DHCFP Contract Section 3.12.1*	4. System to Resolve Grievances and Appeals The DBA shall establish: a. A system for recipients, which includes a grievance process, an appeal process, and access to the State Fair Hearing system. b. A similar system to resolve disputes with providers.	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process – Medicaid 02. GA PP - Member Grievance and Appeal Form - NEVADA - APPENDIX 1 03. GA PP - Grievance and Appeals Process - Medicaid - APPENDIX 2 04. GA PP - Provider Complaint and Dispute Resolution Process - Medicare and Medicaid 05. GA PP - Provider Complaint and Dispute Resolution Process - Medicare and Medicaid - APPENDIX 1 **Description of Process:** LIBERTY's Grievance and Appeals Process ensures timely receipt, acknowledgement and resolution of all member grievances, appeals and State Fair Hearing requests. LIBERTY's established Grievance and Appeals Process ensures timely receipt, acknowledgement and resolution of provider grievances, appeals and State Hearing requests.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy outlined the DBA's procedures for processing grievances and appeals and providing access to the SFH system. The policy also outlined the process to resolve disputes with		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	providers. The policy, however, did not use the correct terminology when referencing grievances or standard or expedited appeals. Specifically, the policy referenced expedited grievances and a second-level grievance involving an appeal of the plan's initial grievance determination, neither of which are consistent with federal regulations. Please refer to Element 1 of this standard for additional findings and recommendations.		
	Recommendations: LIBERTY must ensure that policies describing the grievance and appeal processes include the correct terminology and that processes are consistent with federal regulations.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			

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

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	Recommendations: The DBA must ensure that the information included in the member handbook is accurate, complete, and consistent with federal regulations.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.402(c)(3)(i-ii) *DHCFP Contract Section 3.12.2.7*	10. Grievances and Appeals Accepted Orally or in Writing A recipient, or a provider acting on behalf of the recipient, may file an appeal or grievance either orally or in writing. a. Unless the recipient has requested an expedited resolution, an oral appeal must be followed by a written, signed appeal. b. If a grievance or appeal is filed orally, the DBA is required to document the contact for tracking purposes and to establish the earliest date of receipt. c. There is no requirement to track routine telephone inquiries.	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process – Medicaid 02. GA PP - Member Grievance and Appeal Form - NEVADA - APPENDIX 1 03. NV_Medicaid_Handbook 04. NV Medicaid Provider Reference Guide **Description of Process:** LIBERTY accepts grievance and appeals in writing, orally or in person from enrollees or authorized representatives acting on behalf of enrollees. LIBERTY notifies enrollees that oral appeals must be followed-up with a written signed appeal. LIBERTY does not dismiss the enrollee appeal based solely on the fact the written appeal was not received following the oral submission for an appeal. Information located: Pages 3-4 GA PP – Grievance and Appeals Process – Medicaid Pages 7-8 GA PP – Grievance and Appeals Process – Medicaid	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
		Pages 33-35 NV Medicaid Member Handbook Page 61 NV Medicaid Provider Reference Guide	
	Findings: The policy, GA PP–Grievance and Appeals Process (Medicaid), detailed the processes for accepting grievances and appeals either orally or in writing. The policy described the process for documenting oral receipt of grievances and appeals to establish the earliest date of receipt for tracking purposes. For appeals filed by a provider on behalf of a recipient, the policy provided that the appeal may be followed by a written, signed appeal from the recipient. The Your Rights Under Dental Managed Care document that is included with the NABD and acknowledgement letters included the statement that for oral appeals, the member must complete and sign the appeal form and return it within 15 calendar days. If the member did not return the form, LIBERTY would not process the appeal. This practice is not consistent with the intent of the federal regulations that an oral appeal should be processed as a standard appeal even if the member does not follow the oral appeal with a written, signed appeal. Although the Your Rights Under Dental Managed Care document indicated that an oral appeal would not be processed unless a written, signed appeal was received, the appeal file reviews demonstrated that oral appeals were processed as standard appeals even when a written, signed appeal was not submitted by the member. The information included in policy and the Your Rights Under Dental Managed Care document were not consistent. During the on-site interview session, LIBERTY staff members acknowledged that the grievance and appeal template letters and Your Rights Under Dental Managed Care documents contained incorrect information and time frames. The staff members further stated that grievance and appeal template letters and the Your Rights Under Dental Managed Care document were revised and approved by the DHCFP on September 10, 2019, just prior to LIBERTY's compliance review. According to LIBERTY staff members, the revised grievance and appeal template letters and Your Rights Under Dental Managed Care document were in the process of being updated in LIBERTY's grievance and appeal electronic data system with implementation scheduled for the end of September 2019.		
	Recommendations: The DBA must ensure that grievance and appeal template letters and the Your Rights Under Dental Managed Care document include all the requirements identified in federal regulations. Additionally, the DBA must ensure that information in policy and member information materials is consistent and meets federal regulations.		

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Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.10(c-d) *42 CFR §438.404(a)* *DHCFP Contract Section 3.12.4.2 (A-C)*	16. Language and Format of Written Notice of Action The notice must meet all of the following requirements: a. Be available in the State-established prevalent non-English languages; b. Be available in alternative formats for persons with special needs (visually impaired recipients, or recipients with limited reading proficiency); and c. Use easily understood language and format requirements of 42 CFR §438.404(c); 42 CFR §438.10(c) and (d).	**Documents Submitted:** 01. UM PP - Coverage and Authorization of Services 02. NV-Medicaid EOB Template 03. NV-Medicaid UM Template **Description of Process:** LIBERTY ensures that all written Notice of Actions are issued within the cultural and linguistic needs of the NV Medicaid population. Information located: Page 3 UM PP - Coverage and Authorization of Services	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The UM PP–Coverage and Authorization of Services policy included information about the requirements of the notice, which were consistent with the requirements of this element. The file reviews revealed that five NABD letters contained language that was not easily understood and had typographical errors, grammatical errors, or an incorrect spelling of the member's name.		
	Recommendations: The DBA must ensure that a notice contains easily understood language and format requirements as outlined in 42 CFR §438.404(c) and 42 CFR §438.10(c) and (d).		

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Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.404(b)(1-6) *42 CFR §438.404(c)(1)* *42 CFR §438.408(e)(1)* *42 CFR §438.408(e)(2)(i-iii)* *42 CFR §438.420(a)(i-ii)* *42 CFR §438.420(b)* *DHCFP Contract Section 3.12.4.3(A-J), 3.12.4.4*	17. Requirements of a Written Notice of Action A written Notice of Action to the recipient must meet the following requirements and must explain: a. The action the DBA or its subcontractor has taken or intends to take; b. The reasons for the action; c. The recipient's or the provider's right to file an appeal; d. The recipient's right to request a State Fair Hearing after the recipient has exhausted the DBA's internal appeal procedures; e. The procedures for exercising the recipient's rights to appeal; f. The circumstances under which expedited resolution is available and how to request it; g. The recipient's rights to have benefits continue if the appeal is filed on or before the latter of the following: within ten (10) calendar days of the DBA mailing the Notice of Action or the intended effective date or the proposed action pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which	**Documents Submitted:** 01. UM PP - Coverage and Authorization of Services 02. NV-Medicaid EOB Template 03. NV-Medicaid UM Template **Description of Process:** LIBERTY ensures that all written Notice of Actions include the federal and state regulatory language. Please reference attached exhibits Information located: Pages 3-5 UM PP - Coverage and Authorization of Services	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	2019, just prior to LIBERTY's compliance review. According to LIBERTY staff members, the revised grievance and appeal template letters and Your Rights Under Dental Managed Care document were in the process of being updated in LIBERTY's grievance and appeal electronic data system, with implementation scheduled for the end of September 2019.		
	Recommendations: The DBA must ensure that written notice of action and supplemental information included with the written notice contain the correct time frames for filing an appeal or SFH identified in federal regulations.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			

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Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.404(c)(5-6) *42 CFR §438.408(b)(1-2)* *42 CFR §438.408(d)(1)* *42 CFR §438.408(d)(2)(i)* *DHCFP Contract Section 3.12.5 – 3.12.5.3*	20. Handling of Grievances and Appeals The DBA is required to dispose of each grievance and resolve each appeal and to provide notice as expeditiously as the recipient's health condition requires within the State's established time frames specified as follows: a. Standard disposition of grievances: The DBA is allowed no more than ninety (90) calendar days from the date of receipt of the grievance. b. Standard resolution of appeals: The DBA is allowed no more than thirty (30) calendar days from the date of receipt of the appeal. c. Expedited resolution of appeals: The DBA must resolve each expedited appeal and provide notice, as expeditiously as the recipient's health condition requires, not to exceed seventy-two (72) hours after the DBA received the expedited appeal request.	**Documents Submitted:** 01. GA PP – Grievance and Appeals Process – Medicaid 02. GA PP - Grievance and Appeals Process - Medicaid - APPENDIX 2 **Description of Process:** LIBERTY's established grievance and appeals process ensure proper resolution within all federal and contractual turnaround times for standard and expedited cases. Information located: Page 6 GA PP – Grievance and Appeals Process – Medicaid Pages 10-11 GA PP – Grievance and Appeals Process – Medicaid Page 14-15 GA PP – Grievance and Appeals Process – Medicaid	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy included the provision that although Nevada allows up to 90 days to resolve grievances, LIBERTY will resolve all grievances and appeals within 30 calendar days. For resolving expedited resolution of appeals, Appendix 2 of the policy included the provision that expedited appeals must be resolved within 72 hours of the receipt of the expedited appeal. The grievance file review confirmed that all 10 grievances were resolved within the required time frame. The appeal file review showed that two of the three expedited appeal files reviewed		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	were resolved within the required 72 hours and that no notice of extension was sent for the one expedited appeal that was resolved outside the 72-hour time frame. All seven standard appeals reviewed were resolved within the 30-day time frame.		
	Recommendations: The DBA must ensure that expedited appeals are resolved within the required time frames and that notice to affected parties is provided if an extension of the resolution time frame is requested.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			

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Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.408(d)(2)(i) *42 CFR §438.410(a-b)* *42 CFR §438.410(c)(1-2)* *DHCFP Contract Section 3.12.5.3, 3.12.5.3(A-B)*	21. Expedited Review Process for Appeals The DBA is required to establish and maintain an expedited review process for appeals when the DBA determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the recipient's life or health or ability to attain, maintain, or regain maximum function. a. The DBA must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an appeal. b. If the DBA denies a request for an expedited resolution of an appeal, it must transfer the appeal to the standard timeframe of no longer than thirty (30) calendar days from the day the DBA receives the appeal (with a possible fourteen (14) calendar day extension) for resolution of appeal and give the recipient prompt oral notice of the denial and follow up within two (2) calendar days with a written notice. c. The DBA must inform the recipient of the limited time available to present evidence and allegations of fact or law, in person or in writing, in the case of the expedited resolution.	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process – Medicaid 02. GA PP - Grievance and Appeals Process - Medicaid - APPENDIX 2 **Description of Process:** LIBERTY's established grievances and appeals process accounts for circumstances in which a standard resolution could seriously jeopardize the enrollee's life or health requiring expedited resolution. Information located: Page 14-16 GA PP – Grievance and Appeals Process – Medicaid	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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	d. These time frames may be extended up to 14 calendar days if the recipient requests such an extension or the DBA demonstrates to the satisfaction of the DHCFP that there is a need for additional information and how the extension is in the recipient's interests. e. If the State grants the DBA's request for an extension, the DBA gives the recipient written notice of the reason for the delay.		
	Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy described LIBERTY's processing of expedited appeals which included all requirements of this element. While the policy identified that prompt oral notice be provided to a member when the DBA denies a request for an expedited appeal resolution, one of the 10 appeal files reviewed did not contain documentation that prompt oral notice of a decision to deny the member's request for an expedited appeal was provided to the member or member's representative.		
	Recommendations: The DBA must ensure that members receive prompt oral notice of the denial of a request for an expedited appeal resolution.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			

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Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.10(g)(2)(xi) *42 CFR §438.406(a)* *42 CFR §438.406(b)(1-2(i-ii))* *DHCFP Contract Section 3.12.5.4(A-D)(1-3)*	22. Notification of Disposition of Grievances and Appeals In handling grievances and appeals, the DBA meets the following requirements: a. The DBA must provide recipients any reasonable assistance in completing forms and taking other procedural steps, including assisting the recipient and/or the recipient's representative to arrange for non-emergency transportation services to attend and be available to present evidence at the appeal hearing. This also includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability; b. Acknowledge receipt of each grievance and appeal; c. Ensure that the individuals who make decisions on grievances and appeals were not involved in any previous level of review or decision-making; and d. Ensure that the individuals who make decisions on grievances and appeals are health care professionals who have the appropriate clinical expertise, in treating the recipient's condition or disease if the	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process – Medicaid 02. GA PP - Grievance and Appeals Process - Medicaid - APPENDIX 2 **Description of Process:** LIBERTY's Member Services Department is trained to not only appropriately respond to inquiries from members, but also offer the grievance and appeals process when found to be appropriate. This includes offering assistance completing the form, explaining the website grievance and appeals submission process and educating the member on language assistance and/or arranging non-emergency transportation, as needed. LIBERTY's established grievance and appeals process ensures written enrollee acknowledgement and disposition letters	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	grievance or appeal involves any of the following: i. An appeal of a denial that is based on medical necessity; ii. A grievance regarding the denial of an expedited resolution of an appeal; or iii. A grievance or appeal that involves clinical issues.	within all federal and state regulatory turnaround times. Information located: Pages 3-10 GA PP – Grievance and Appeals Process – Medicaid	
	Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy addressed LIBERTY's plan for processing and resolving grievances and appeals for requirements a through d of this element. The policy contained the provisions that individuals who made decisions on grievances and appeals were healthcare professionals who had the appropriate clinical expertise if the grievance or appeal involved an appeal of a denial that is based on medical necessity, a grievance regarding the denial of an expedited resolution of an appeal, or a grievance or appeal that involves clinical issues. Three of the 10 appeal files reviewed did not demonstrate that members were provided with grievance rights when LIBERTY made the decision to deny the member's expedited appeal request. The GA PP–Grievance and Appeals Process (Medicaid) policy identified that LIBERTY would acknowledge receipt of grievances and appeals within five calendar days of receipt. The review of grievance and appeal files confirmed that all acknowledgement letters were provided to the member or member's representative within five calendar days of receipt of the grievance or appeal. All 10 appeal files reviewed contained evidence that individuals who made decisions on the grievance or appeal were not involved in any previous level of review or decision making. All 10 appeal and 10 grievance files reviewed contained documentation which verified that licensed dentists rendered the appeal or grievance decision.		
	Recommendations: The DBA must ensure that when an expedited appeal request is denied by LIBERTY, the member or member's representative is provided with grievance rights.		

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Corrective Action Plan (Include required action, responsible individual, and completion date.)			
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Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.406(b)(1-3) *42 CFR §438.406(b)(4-6)* *DHCFP Contract Section 3.12.5.5(A-D)*	23. Process for Appeals The process for appeals also requires: a. That oral inquiries seeking to appeal an action are treated as appeals (in order to establish the earliest possible filing date for the appeal) and must be confirmed in writing unless the recipient requests expedited resolution; b. That the recipient is provided a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing, and that the recipient is informed by the DBA of the limited time available for this in the case of expedited resolution; c. That the recipient and his/her representative are provided the opportunity, before and during the appeals process, to examine the recipient's case file, including medical records, and any other document and records considered during the appeals process; and d. Include, as parties to the appeal, the recipient and his/her representative or the legal representative of a deceased recipient's estate.	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process – Medicaid 02. Grievance and Appeals Process Flowchart **Description of Process:** LIBERTY's appeals process is described throughout LIBERTY's policy titled "Grievance and Appeals Process-Medicaid. Please reference the attached exhibit. Information located: Pages 7-8 GA PP – Grievance and Appeals Process – Medicaid Page 12 GA PP – Grievance and Appeals Process – Medicaid Page 14 GA PP – Grievance and Appeals Process – Medicaid	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The policy, GA PP–Grievance and Appeals Process (Medicaid), detailed the processes for accepting appeals either orally or in writing. The policy described the process for documenting oral receipt of appeals to establish the earliest date of receipt for tracking purposes. For appeals filed by a provider on behalf of a recipient, the policy provided that the appeal may be followed by a written, signed appeal from the recipient. The Your Rights Under Dental Managed Care document that is		

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	included with the NABD and acknowledgement letters included the statement that for oral appeals, the member must complete and sign the appeal form and return it within 15 calendar days. If the member did not return the form, LIBERTY would not process the appeal. This practice is not consistent with the intent of the federal regulations that an oral appeal should be processed as a standard appeal even if the member does not follow the oral appeal with a written, signed appeal. Although the Your Rights Under Dental Managed Care document indicated that an oral appeal would not be processed unless a written, signed appeal was received, the appeal file reviews demonstrated that oral appeals were processed as standard appeals even when a written, signed appeal was not submitted by the member. The information included in policy and the Your Rights Under Dental Managed Care document were not consistent.		
	Recommendations: The DBA must ensure that information included in policy and member information materials is consistent and meets the federal regulations.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			

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Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.408(e)(2)(iii) *DHCFP Contract Section 3.12.5.6 (A-C)*	25. Notice for Written Appeals not Resolved in Favor of the Recipient For appeals that are not wholly resolved in favor of the recipient, the notice includes: a. The right of the recipient to request a State Fair Hearing from the DHCFP and how to do so; b. The right to request to receive benefits while the hearing is pending and how to make this request; and, c. That the recipient may be held liable for the cost of those benefits if the State Fair Hearing's Officer upholds the DBA's action.	**Documents Submitted:** 01. GA PP - Grievance and Appeals Process – Medicaid 02. Notice of Action Your Rights **Description of Process:** The Your Rights Document provides enrollees with instructions on how to file an State Fair Hearing and that they may have to pay for the cost of any continued benefits if the final decision is not in their favor. Information located: Page 11 GA PP – Grievance and Appeals Process – Medicaid Page 17 GA PP – Grievance and Appeals Process – Medicaid	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy included the provision that LIBERTY would notify the member of the right to request a SFH for appeals that are not wholly resolved in favor of the member. The document, Your Rights Under Dental Managed Care, contained information about the members' right to request a SFH and how to obtain one; the right to request the continuation of benefits and how to do so; and that the member could be held liable for the costs of treatment if the final decision is not in the member's favor. All appeal files reviewed contained written resolution notices and the Your Rights Under Dental Managed Care document; however, the notice for written appeals that are not		

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	wholly resolved in the member's favor did not include the member's right to request a SFH but provided the member with appeal rights.		
	Recommendations: The DBA must ensure that the notice for written appeals that are not wholly resolved in the member's favor include the member's right to request a SFH from the DHCFP and how to do so.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			

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

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Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.206(b)(4) *DHCFP Contract Section 3.3.5*	4. Out-of-Network Services If the DBA's provider network is unable to provide medically necessary services covered under the plan to a particular recipient, the DBA must adequately and timely cover these services out-of-network for the recipient for as long as the DBA is unable to provide them.	**Documents Submitted:** UM PP - Coverage and Authorization of Services NM PP - Access and Availability Guidelines **Description of Process:** Please see description of process in the above P&P.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The UM PP–Access and Availability Guidelines policy addressed protocols to provide services from an out-of-network provider when access to in-network services are limited. While the policy did not identify that out-of-network services would be continued for as long as LIBERTY was unable to provide reasonable access to a contracted provider, staff members stated during the on-site interview that LIBERTY would provide services until such services are no longer necessary or the out-of-network provider becomes an in-network provider.		
	Recommendations: The DBA must ensure that if the DBA's provider network is unable to provide medically necessary services covered under the plan to a particular member, the DBA must adequately and in a timely manner cover these services out-of-network for the recipient for as long as the DBA is unable to provide them.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
DHCFP Response (To be completed by DHCFP/HSAG.)			

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
DHCFP Contract Section 3.5.5.1	7. Personnel Completing the Children with Special Health Care Needs (CSHCN) Assessment The assessment of CSHCN is completed by appropriately qualified health care professionals.	**Documents Submitted:** QM PP - Coordination of Dental Services **Description of Process:** Please see description of process in the above P&P.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The QM PP–Coordination of Dental Services policy identified that LIBERTY will implement and maintain services for children with special health care needs (CSHCN) including a comprehensive oral assessment. While the policy included language about a comprehensive oral assessment for CSHCN members, it did not specify who is responsible for completing the assessment or how LIBERTY ensures individuals completing assessments are appropriately qualified professionals. During the on-site interview, LIBERTY staff members were unable to demonstrate an understanding of the requirements for this element as the staff members were not familiar with the process for CSHCN assessments.		
	Recommendations: The DBA must ensure that the assessment of CSHCN is completed by appropriately qualified professional and that staff are trained on the relevant policies and procedures.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.208 (c)(3-4) *42 CFR §438.208(c)(3)(i-ii)* *DHCFP Contract Section 3.5.5.1 (A-C)*	8. Treatment Plans for CSHCN The DBA must produce a treatment plan for recipients with special health care needs (CHSCN) who are determined through an assessment to need a course of treatment or regular care monitoring. The treatment plan must be: a. Developed by the recipient's primary dental provider with recipient participation, and in consultation with any specialists caring for the recipient; b. Approved by the DBA in a timely manner, if approval is required by the DBA; and, c. In accordance with any applicable State QA and utilization review standards.	**Documents Submitted:** QM PP - Coordination of Dental Services **Description of Process:** Please see description of process in the above P&P.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The QM PP–Coordination of Dental Services policy specified that complex and special needs cases would be referred to a care coordinator who would work with the Specialty Referral unit to ensure coordination of dental services from a specific, agreed-on treatment plan between LIBERTY's dental director, primary dental provider, and primary care medical provider, and the member's guardian. The policy also confirmed that LIBERTY required CSHCN to have a written dental treatment plan. During the on-site interview, LIBERTY staff members were unable to demonstrate an understanding of the requirements for this element as the staff members were not familiar with the process for CSHCN treatment plans.		
	Recommendations: The DBA must ensure that treatment plans for CSHCN are developed by the recipient's primary dental provider with member participation and in consultation with any specialists caring for the recipient; and that they are approved by the DBA in a timely manner, if approval is required by the DBA, and in accordance with any applicable State quality assurance (QA) and utilization review standards.		

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Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.114(c)(1)(i) *42 CFR §438.114(c)(3)(ii)(A and B)* *42 CFR §438.114(d)(1)(i-ii)* *42 CFR §438.114(d)(3)* *DHCFP Contract Section 3.3.6.1–3.3.6.5*	10. Emergency Dental Services The DBA may not deny payment for emergency services treatment when a representative of the DBA instructs the recipient to seek emergency services. The DBA shall be responsible for dental related services provided in an emergency. In providing for emergency dental services and care as a covered service, the DBA shall not: a. Require prior authorization for emergency dental services and care b. Indicate that emergencies are covered only if care is secured within a certain period of time c. Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered. d. Deny payment based on the member's failure to notify the DBA in advance or within a certain period of time after the care is given. e. Deny payment for emergency dental care unless it is performed under the medical benefit in a hospital, emergency room or ambulatory surgery center. f. Deny payment for treatment obtained when a member had an emergency dental condition and stabilization of condition, including cases in	**Documents Submitted:** UM PP - Emergency Services Expedited Dental Services UM PP - Payment to Out of Network Provider **Description of Process:** Please see description of process in the above P&P.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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

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	recommended that LIBERTY add to policy that post-authorization is also not required for emergency services. Further, it is recommended that LIBERTY develop mechanisms to assure that revised policies are implemented.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			

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Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
42 CFR §438.210(b)(2)(ii) *42 CFR §438.210(b)(3)* *DHCFP Contract Section 3.9.19.3 (A–D)*	20. Pre-authorization Review Requirements For DBAs with pre-authorization review programs: a. Pre-authorization decisions must be supervised by qualified dental professionals; b. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating dentist as necessary; c. The reasons for decisions are clearly documented and available to the recipient; d. The DBA's prior authorization policies and procedures must be consistent with provision of covered medically necessary dental care in accordance with community standards of practice.	**Documents Submitted:** UM PP - Review Criteria_Referral Review, Approve, Modify or Deny **Description of Process:** Please see description of process in the above P&P.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The QM PP–Appropriate Professionals policy specified that appropriately licensed healthcare professionals supervise all review decisions, that appropriately licensed professionals supervise all dental necessity denials of care, that only a licensed dentist may deny a request for dental services, and that board-certified/board-eligible specialists or academic specialists are consulted when applicable to make decisions based on dental necessity. The UM PP–Coverage and Authorization of Services, the QM PP–Coverage of EPSDT Services, and QM PP–Appropriate Professionals documents collectively outlined the procedures for authorizing dental services in accordance with dental necessity and standards of practice. The policies reviewed did not describe efforts made to obtain all necessary information, including pertinent clinical information; consultation with the treating dentist as necessary; nor did the policies cite reasons for decisions to be clearly documented and available to the member.		

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	Recommendations: The DBA must ensure that its UM program includes the description of efforts made to obtain all necessary information, including pertinent clinical information; consultation with the treating dentist as necessary before rendering an authorization decision; and that reasons for decisions be clearly documented and available to the member.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			

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

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Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	Recommendations: LIBERTY must ensure that its NABD template letter sent to members and the requesting provider is written in plain language and includes all requirements identified in federal regulations.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			