Division of Health Care Financing and Policy
Nevada Medicaid Managed Care

State Fiscal Year 2021
Compliance Review

for

LIBERTY Dental Plan of Nevada, Inc.

October 2021

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

According to federal requirements located within Title 42 of the Code of Federal Regulations (42 CFR) §438.358, the state, an agent that is not a Medicaid managed care entity (MCE), or its external quality review organization (EQRO) must conduct a review within a three-year period to determine a Medicaid MCE's compliance with the standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330.

To comply with the federal requirements, the Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP) contracted with Health Services Advisory Group, Inc. (HSAG) as its EQRO to conduct compliance reviews of its contracted MCEs responsible for the delivery of comprehensive dental services under the State's Medicaid managed care program.

Description of the External Quality Review of Compliance With Standards

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

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

Compliance Monitoring Standard	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard I—Disenrollment: Requirements and Limitations	✓		Review of MCE implementation of Year One and Year Two corrective action plans (CAPs)
Standard II—Member Rights and Member Information	✓		
Standard III—Emergency and Poststabilization Services	✓		
Standard IV—Availability of Services	✓		
Standard V—Assurances of Adequate Capacity and Services	✓		
Standard VI—Coordination and Continuity of Care	✓		
Standard VII—Coverage and Authorization of Services	✓		

Compliance Monitoring Standard	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard VIII—Provider Selection		✓	
Standard IX—Confidentiality		✓	
Standard X—Grievance and Appeal Systems		✓	
Standard XI—Subcontractual Relationships and Delegation		✓	
Standard XII—Practice Guidelines		✓	
Standard XIII—Health Information Systems		✓	
Standard XIV—Quality Assessment and Performance Improvement Program		✓	

Overview of Findings

Review of Standards

From a review of documents, observations, and interviews with key **LIBERTY Dental Plan of Nevada, Inc.** (**LIBERTY**) staff members as well as file reviews conducted during the desk review and virtual interviews, the reviewers assigned **LIBERTY** a score for each element and an aggregate score for each standard. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2—Methodology. If a requirement was not applicable to **LIBERTY** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards. Table 1-2 presents a summary of **LIBERTY**'s performance results.

Table 1-2—Summary of Standard Compliance Scores

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Disenrollment: Requirements and Limitations	5	5	5	0	0	**100%**
II	Member Rights and Member Information	18	18	17	1	0	**94%**
III	Emergency and Poststabilization Services	10	10	10	0	0	**100%**
IV	Availability of Services	7	7	7	0	0	**100%**
V	Assurances of Adequate Capacity and Services	4	4	4	0	0	**100%**
VI	Coordination and Continuity of Care	11	11	8	3	0	**73%**

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
VII	Coverage and Authorization of Services	15	15	12	3	0	**80%**
	Total	**70**	**70**	**63**	**7**	**0**	**90%**

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

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

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

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

LIBERTY demonstrated compliance in 63 of 70 elements, with an overall compliance score of 90 percent, indicating that most program areas had the necessary policies, procedures, and initiatives in place to carry out the majority of the functions included as part of the review, while other areas demonstrated opportunities for improvement to operationalize the elements required by federal and State regulations. Detailed findings, including recommendations for program enhancements, are documented in Appendix A.

Corrective Action Process

For any elements scored *Not Met*, **LIBERTY** is required to submit a CAP to bring the element into compliance with the applicable standard(s). The process for submitting the CAP and the criteria used to evaluate the sufficiency of the CAP are described in Section 3 of this report.

2. Methodology

Introduction

The following description of the way HSAG conducted—in accordance with 42 CFR §438.358—the external quality review (EQR) of compliance with standards for the Nevada Medicaid managed care program addresses HSAG's:

- Objective of conducting the review of compliance with standards.
- Compliance review activities and technical methods of data collection.
- Description of data obtained.
- Data aggregation and analysis.

HSAG followed standardized processes in conducting the review of the MCE's performance.

Objective of Conducting the Review of Compliance With Standards

The primary objective of HSAG's review was to provide meaningful information to DHCFP and the MCE regarding compliance with the State and federal requirements. HSAG assembled a team to:

- Collaborate with DHCFP to determine the scope of the review as well as the scoring methodology, data collection methods, desk review schedules, virtual review[2-1] activity schedules, and virtual review agenda.
- Collect and review data and documents before and during the virtual review.
- Aggregate and analyze the data and information collected.
- Prepare the findings report.

To accomplish its objective, and based on the results of collaborative planning with DHCFP, HSAG developed and used a data collection tool to assess and document the MCE's compliance with certain federal Medicaid managed care regulations, State rules, and the associated DHCFP contractual requirements. Beginning in SFY 2021, DHCFP requested that HSAG conduct compliance reviews over a three-year cycle with one-half of the standards being reviewed in Year One and the remaining half of the standards in Year Two, and a comprehensive review of each element scored as *Not Met* during Year One (SFY 2021) and Year Two (SFY 2022) during Year Three (SFY 2023). The division of standards over the three years can be found in Table 1-1. The review tool developed for this year's review (SFY 2021) included requirements that addressed the following performance areas:

- Standard I—Disenrollment: Requirements and Limitations

[2-1] Due to the current pandemic, the on-site review component of the compliance activity was held virtually via Webex.

- Standard II—Member Rights and Member Information
- Standard III—Emergency and Poststabilization Services
- Standard IV—Availability of Services
- Standard V—Assurances of Adequate Capacity and Services
- Standard VI—Coordination and Continuity of Care
- Standard VII—Coverage and Authorization of Services

DHCFP and the MCE will use the information and findings that resulted from HSAG's review to:

- Evaluate the quality and timeliness of, and access to, care and services furnished to members.
- Identify, implement, and monitor interventions to improve these aspects of care and services.

Compliance Review Activities and Technical Methods of 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 laws and on the requirements set forth in the contract between DHCFP and the MCE as they related to the scope of the review. HSAG also followed the guidelines set forth in the Centers for Medicare & Medicaid Services' (CMS') EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019[2-2] for the following activities:

Pre-Review Activities

Pre-review activities included:

- Scheduling the virtual reviews.
- Developing the compliance review tools.
- Preparing and forwarding to the MCE a pre-review information packet and instructions for completing and submitting the requested documentation to HSAG for its desk review.
- Hosting a pre-review preparation session with the MCE.
- Conducting a desk review of documents. HSAG conducted a desk review of key documents and other information obtained from DHCFP, and of documents the MCE submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the MCE's

[2-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jul 12, 2021.

operations, identify areas needing clarification, and begin compiling information before the virtual review.

- Generating a list of 10 sample records for service authorization denials and care management from the universe files submitted to HSAG from the MCE.
- Developing the agenda for the one-day virtual review.
- Providing the detailed agenda to the MCE to facilitate preparation for HSAG's virtual review.

Virtual Review Activities

Virtual review activities included:

- An opening conference, with introductions and a review of the agenda and logistics for HSAG's one-day review activities.
- A review of the documents HSAG requested that the MCE have available during the interview sessions.
- A review of service authorization denial and care management records HSAG requested from the MCE.
- A review of the data systems that the MCE used in its operation such as utilization management, care coordination, and enrollment and disenrollment.
- Interviews conducted with the MCE's key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

HSAG documented its findings in the data collection tool (compliance review tool) shown in Appendix A—Review of the Standards, which serves as a comprehensive record of HSAG's findings, performance scores assigned to each requirement, and the actions required to bring the MCE's performance into compliance for those requirements that HSAG assessed as less than fully compliant.

Description of Data Obtained

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

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- MCE-maintained records for service authorization denials.
- MCE's online member handbook and provider directory.

HSAG obtained additional information for the compliance review through interactions, discussions, and interviews with the MCE's key staff members.

Table 2-1 lists the major data sources HSAG used to determine the MCE's performance in complying with requirements and the time period to which the data applied.

Table 2-1—Description of MCE Data Sources

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during the virtual review	November 1, 2020–May 31, 2021
Information obtained through interviews	September 13, 2021
Information obtained from a review of a sample of service authorization denial records for file reviews	Listing of all denials (excluding denials of payment and concurrent reviews) between November 1, 2020–May 31, 2021
Information obtained from a review of a sample of care management records for file reviews	Listing of members newly enrolled into care management on or after September 1, 2020

Data Aggregation and Analysis

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCE's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCE during the period covered by HSAG's review. This scoring methodology is consistent with CMS' EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. 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, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

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

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.

- For those provisions with multiple components, key components of the provision could not be identified and any findings of *Not Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

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

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

For the member handbook, provider directory, member rights, appointment standards, and checklists reviewed, HSAG assessed each applicable element within the checklist as either (1) *Yes*, the element was contained within the associated document(s), or (2) *No*, the element was not contained within the document(s). Elements *Not Applicable* to the MCE were assessed as *NA*. The findings from the checklists were used to determine overall compliance with the applicable standard and element in the compliance review tool (i.e., member handbook content requirements within Standard I–Member Rights and Member Information).

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

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

- Documented findings describing the MCE's progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCE's performance for each requirement.
- The total percentage-of-compliance score calculated for each of the standards.
- The overall percentage-of-compliance score calculated across the standards.

- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.

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

3. Corrective Action Plan Process

Appendix C contains the CAP template that HSAG developed for **LIBERTY** to use in preparing its CAP to be submitted to DHCFP. The template lists each element for which HSAG assigned a score of *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 *Not Met* into compliance with the applicable standard(s). **LIBERTY**'s CAP must be submitted to DHCFP and HSAG no later than 30 calendar days of receipt of HSAG's final *State Fiscal Year 2021 Compliance Review* 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 activities/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 DHCFP. DHCFP maintains ultimate authority for approving or disapproving any corrective action strategies proposed by **LIBERTY** in its submitted CAP.

Appendix A. Review of the Standards

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

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Disenrollment Requested by the Dental Benefits Administrator (DBA)		
1. The DBA may not request disenrollment because of an adverse change in the member's health status, or because of the member's utilization of dental services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the DBA seriously impairs the entity's ability to furnish services to either this particular member or other members). 42 CFR §438.56(b)(2)	**HSAG Recommended Evidence:** • Policies and procedures • Member informational materials, such as the member handbook **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. QM PP - Disenrollment Process – MEDICAID: Page 1, Section I. b i-iv 3. LDP NV Medicaid Member Handbook Standard I: Pages 16-17, Section Eligibility and Enrollment • 2021 Member Handbook website link	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY's *Disenrollment Process – MEDICAID* policy (Evidence #2) specifies the scenarios when LIBERTY may not request disenrollment, per 42 CFR §438.56(b)(2). LIBERTY informs members via the Member Handbook (Evidence #3) to call the Nevada Medicaid District Office for questions about enrollment or disenrollment.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Member Disenrollment Request by the DBA		
2. The DBA assures DHCFP that it does not request disenrollment for reasons other than those permitted under the contract. 42 CFR §438.56(b)(3)	**HSAG Recommended Evidence:** • Policies and procedures • Example of DBA-initiated disenrollment request (if the DBA has not requested any member disenrollment, state so in the DBA Description of Process) **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. QM PP - Disenrollment Process - MEDICAID: Page 1, Section I.c	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY's *Disenrollment Process – MEDICAID* policy (Evidence #2) specifies that, should LIBERTY request member disenrollment, it must assure DHCFP that it does so for reasons permitted under the contract, per 42 CFR §438.56(b)(3). **Please note,** during the lookback period, LIBERTY did not request any member disenrollment.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element. **Recommendations**: HSAG recommends that the DBA review its present disenrollment tracking mechanisms and make modifications as necessary to have the capability to track member disenrollment reasons within its information systems.		
Required Actions: None.		

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Disenrollment Requested by the Member		
3. A member may request disenrollment as follows: a. For cause, at any time. b. Without cause, at the following times: i. During the 90 days following the date of the member's initial enrollment into the DBA, or during the 90 days following the date DHCFP sends the member notice of that enrollment, whichever is later. ii. At least once every 12 months thereafter. iii. Upon automatic reenrollment under 42 CFR §438.56(g), if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. 42 CFR §438.56(g) 42 CFR §438.56(c)(1-2)(i-iii)	**HSAG Recommended Evidence:** • Policies and procedures • Member informational materials, such as the member handbook **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. QM PP - Disenrollment Process – MEDICAID: Page 1-2, Section II.a, Section II.b.i-iii 3. LDP NV Medicaid Member Handbook Standard I: Pages 16-17, Section Eligibility and Enrollment • 2021 Member Handbook website link	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY's *Disenrollment Process – MEDICAID* policy (Evidence #2) specifies the timeframes for members to request disenrollment, per 42 CFR §438.56(g) and 42 CFR §438.56(c)(1-2)(i-iii). LIBERTY informs members via the Member Handbook (Evidence #3) to call the Nevada Medicaid District Office for questions about enrollment or disenrollment.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Procedures for Disenrollment: Request for Disenrollment		
4. The member (or his or her representative) must submit an oral or written request, as required by the DHCFP. 42 CFR §438.56(d)(1)(ii) Contract Attachment N	**HSAG Recommended Evidence:** • Policies and procedures • Member informational materials, such as the member handbook • One example of a member disenrollment request **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. QM PP - Disenrollment Process – MEDICAID: Page 2, Section III #1a-b 3. LDP NV Medicaid Member Handbook Standard I: Pages 16-17, Section Eligibility and Enrollment • 2021 Member Handbook website link	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY's *Disenrollment Process – MEDICAID* policy (Evidence #2) specifies that a member or representative must submit an oral or written request for disenrollment, per 42 CFR §438.56(d)(1)(ii) and Contract Attachment N. LIBERTY informs members via the Member Handbook (Evidence #3) to call the Nevada Medicaid District Office for questions about enrollment or disenrollment. **Please note,** during the lookback period, LIBERTY did not request any member disenrollment.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
Procedures for Disenrollment: Cause for Disenrollment		
5. The following are cause for disenrollment: a. The member moves out of the DBA's service area. b. The plan does not, because of moral or religious objections, cover the service the member seeks.	**HSAG Recommended Evidence:** • Policies and procedures • Member informational materials, such as the member handbook	☒ Met ☐ Not Met ☐ NA

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
c. The member needs related services to be performed at the same time; not all related services are available within the provider network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk. d. Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's care needs. 42 CFR §438.56(d)(2)(iii)(v)	**Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. QM PP - Disenrollment Process – MEDICAID: Page 2, Section III.2a-c, e 3. LDP NV Medicaid Member Handbook Standard I: Pages 16-17, Section Eligibility and Enrollment • 2021 Member Handbook website link	
DBA Description of Process: LIBERTY's *Disenrollment Process – MEDICAID* policy (Evidence #2) specifies the reasons that are cause for disenrollment, per 42 CFR §438.56(d)(2)(iii)(v). LIBERTY informs members via the Member Handbook (Evidence #3) to call the Nevada Medicaid District Office for questions about enrollment or disenrollment.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element. **Recommendations**: Although the DBA's QM PP – Disenrollment Process policy included the "for cause" reasons a member may disenroll, HSAG recommends that the DBA consider updating its policy to clearly delineate "for cause" reasons a member may be disenrolled, for example in one section of the policy.		
Required Actions: None.		

Standard I—Disenrollment: Requirements and Limitations						
Met	=	5	X	1	=	5
Not Met	=	0	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	5	Total Score		=	5
Total Score ÷ Total Applicable					=	100%

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Member Rights: General Rule		
1. The DBA has written policies regarding the member rights specified in 42 CFR §438.100. 42 CFR §438.100(a)(1) Contract 3.5.2.2(L)	**HSAG Recommended Evidence:** • Policies and procedures **Evidence as Submitted by the DBA:** 1. Letter to Reviewer - Policy Issue & Approval Dates 2. QM PP - Member Rights and Responsibilities: Page 1, Section: Purpose/Scope, Page 3, Section: Resource/Reference	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY's *Member Rights and Responsibilities policy* (Evidence #2) includes the specified member rights, per 42 CFR §438.100 and Contract 3.5.2.2(L).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
2. The DBA complies with any applicable federal and State laws that pertain to member rights and ensures that its employees and contracted providers observe and protect those rights. 42 CFR §438.100(a)(2) Contract 3.9.16	**HSAG Recommended Evidence:** • Policies and procedures • Provider materials, such as the provider manual, provider contract, and provider training materials • Employee training materials • Auditing/oversight mechanisms **Evidence as Submitted by the DBA:** 1. Letter to Reviewer - Policy Issue & Approval Dates 2. QM PP - Member Rights and Responsibilities: Page 1, Section: Policy, Page 3, Section: Resource/Reference	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	3. NV Medicaid Provider Reference Guide 2021.03.10 CLEAN, Pages 22-23, Section Member Rights and Responsibilities 4. NV Provider Agreement: Page 4, Section d: Compliance 5. 2021 HIPAA Compliance Training, Page 18 6. CM PP - Compliance Risk Assessment, Monitoring, and Oversight, Page 1-2, Section: Auditing and Monitoring of the Compliance Program	
DBA Description of Process: LIBERTY complies with any applicable federal and State laws that pertain to member rights and ensures that its employees and contracted providers observe and protect those rights, per 42 CFR §438.100(a)(2) and Contract 3.9.16. Member rights and responsibilities are outlined in LIBERTY's *Member Rights and Responsibilities policy* (Evidence #2) distributed to all providers and staff. Providers are educated on member rights and responsibilities, as well as their own rights and responsibilities, via the LIBERTY *Provider Reference Guide* (Evidence #3) and the *NV-specific Provider Agreement* (Evidence #4). Staff are educated on member rights and responsibilities during initial *Compliance Training* (Evidence #5) and at least annually thereafter. Compliance with applicable member rights and responsibilities laws, regulations and contractual obligations is ensured via ongoing *Compliance Risk Assessment, Monitoring and Oversight* (Evidence #6).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
Specific Rights: Basic Requirement		
3. The DBA must ensure that each managed care member is guaranteed the rights as specified in 42 CFR §438.10(b)(2) and (3)—Refer to the Member Rights Checklist. 42 CFR §438.100(b)(1-3) Contract 3.9.16.1	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • HSAG will also use the results from the Member Rights Checklist. **Evidence as Submitted by the DBA:** 1. Letter to Reviewer - Policy Issue & Approval Dates	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	2. QM PP - Member Rights and Responsibilities: Page 1, Section: The Member's Rights, Page 3: Resource/Reference section 3. LDP NV Medicaid Member Handbook Standard II, Page 13-15, Section: Member Rights and Responsibilities • 2021 Member Handbook website link	
DBA Description of Process: LIBERTY ensures that each managed care member is guaranteed the rights as specified in 42 CFR §438.10(b)(2) and (3), as noted in the Member Rights Checklist.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
Language Requirements: Basic Rule		
4. The DBA uses: a. Definitions for managed care terminology, including appeal, copayment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, health insurance, hospitalization, hospital outpatient care, medically necessary, network, nonparticipating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, specialist, and urgent care. b. Model member handbook and member notices. 42 CFR §438.10(c)(4)(i-ii)	**HSAG Recommended Evidence:** • Policies and procedures • Model member handbook or notice templates, as applicable • Member materials, such as the member handbook • Model member notice examples, such as ABD notice template, appeal resolution notice template **Evidence as Submitted by the DBA:** 1. Letter to Reviewer - Policy Issue & Approval Date 2. LDP NV Medicaid Member Handbook Standard II, Page 43-45, Section: Definitions and Useful Terms • 2021 Member Handbook website link	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	3. NV Medicaid GA Member Appeal Samples. Cite entire document. 4. NV MCD UM Member PE Sample-English Spanish. Cite entire document.	
DBA Description of Process: LIBERTY uses appropriate dental-specific terminology and provides definitions of such terms in its *Member Handbook*. Samples of the model *Member Handbook*, *Grievance & Appeal notification templates* and *UM notification templates* are provided (Evidence #2, #3, #4).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element. **Recommendations**: HSAG recommends that the DBA receive guidance from DHCFP regarding the applicability of the managed care terms identified in this element and ensure that all managed care terms determined by DHCFP to be applicable to the DBA be defined and demonstrate that the DBA uses such terminology for its Medicaid managed care program. HSAG further recommends that the DBA consult with DHCFP to determine whether a model member handbook and notices can be developed to comply with federal rule.		
Required Actions: None.		
5. Member information required in 42 CFR §438.10 may not be provided electronically by the DBA unless all of the following are met: a. The format is readily accessible; b. The information is placed in a location on the DBA's website that is prominent and readily accessible; c. The information is provided in an electronic form which can be electronically retained and printed; d. The information is consistent with the content and language requirements of 42 CFR §438.10; and e. The member is informed that the information is available in paper form without charge upon request and the DBA provides it upon request within five (5) business days. 42 CFR §438.10(c)(6)(i-v)	**HSAG Recommended Evidence:** • Policies and procedures • One example of member information that its only provided in electronic format; and subsequent communication to inform the member of the availability of the member information • Reporting or tracking mechanisms for providing member materials in paper form upon request **Evidence as Submitted by the DBA:** 1. Letter to Reviewer - Policy Issue & Approval Dates 1. QM PP - Member Health Education and Prevention - APPENDIX A: Page 1, Section: Process/Procedure #3 2. Welcome Letter NV Medicaid. Cite entire document.	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	3. Material Requests NV Medicaid. Cite entire document. 4. ID Card Requests. Cite entire document.	
DBA Description of Process: LIBERTY provides member information electronically on its website in an accessible format, per 42 CFR §438.10(c)(6)(i-v). LIBERTY's *Member Health Education and Prevention – APPENDIX A – NEVADA MEDICAID* policy (Evidence #2) ensures that member materials are available by mail, on LIBERTY's website and email (upon consent). Upon enrollment, members are directed to the electronic, accessible Provider Directory on LIBERTY's website and are directed to call Member Services for any assistance, including requesting a printed provider directory (Evidence #3). All member calls, including requests for printed Provider Directories, are captured in LIBERTY's Member Services call log system. Processes for ordering printed materials at member request are provided (Evidence #4, #5).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
Language and Format		
6. The DBA makes its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its particular service area. a. Written materials that are critical to obtaining services must also be made available in alternative formats upon request of the potential member or member at no cost, include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and include the toll-free and Telecommunications Device for the Deaf/TeleTYpewriter	**HSAG Recommended Evidence:** • Policies and procedures • Spanish member handbook • Spanish provider directory • Examples of member notices, such as ABD notice and appeal resolution notice, in English and Spanish • Taglines sent with member information materials **Evidence as Submitted by the DBA:** 1. Letter to Reviewer - Policy Issue & Approval Dates 2. CU PP - Cultural and Linguistic Competency Program Compliance: Page 3, Section: Translation Services 3. CU PP - Translation of Written Informing Member Materials: Page 1, Section: Policy; Page 2, Section: Process/Procedure	☐ Met ☒ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
(TTY/TDY) telephone number of the DBA's member/customer service unit. b. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost. 42 CFR §438.10(d)(3) Contract 3.5.1.1; 3.5.1.3	4. LDP NV Medicaid Member Handbook SPANISH: Page 19 5. Nevada Medicaid Child. Cite entire document. 6. Nevada Medicaid Adult. Cite entire document. 7. NV MCD UM Member PE Sample-English Spanish. Cite entire template(s). 8. NV Medicaid GA Member Appeal Samples. Cite entire template(s)	
DBA Description of Process: LIBERTY ensures its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, are available in the prevalent non-English languages in the given service area, per 42 CFR §438.10(d)(3) and Contract 3.5.1.1; 3.5.1.3. LIBERTY's *Cultural and Linguistic Competency Program Compliance* policy (Evidence #2) ensures that LIBERTY shall maintain its policies and procedures as well as programs to monitor and evaluate compliance of the Cultural and Linguistic Competency Program consistent with state and federal regulations. LIBERTY's *Translation of Written Informing Member Materials* policy (Evidence #3) ensures that LIBERTY shall make vital member-informing materials available to all members and potential members in each Threshold language as applicable by each Program and state at no cost to the member. Per policy (Evidence #3), vital materials include but is not limited to: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices (Evidence #4, #5, #6, #7, #8).		
HSAG Findings: The DBA included tag lines for most written critical materials; however, the taglines were not in a conspicuously visible font size in accordance with federal regulations, or in the case of the provider directory, the taglines were in a 6-point font size informing members that interpretation services were available. **Recommendations**: HSAG recommends that the DBA define "conspicuously visible" font size to be greater than a 12-point font to ensure that the taglines are clearly visible and stand out from the other text.		
Required Actions: The DBA must ensure that written materials critical to obtaining services include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided.		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
7. The DBA makes interpretation services available to each potential member and makes those services available free of charge to each member. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. Oral interpretation requirements apply to all non-English languages, not just those that DHCFP identifies as prevalent. 42 CFR §438.10(d)(4) Contract 3.5.1	**HSAG Recommended Evidence:** • Policies and procedures • Screen shot of health information system (HIS) where the primary language of the member is stored • Workflow for generating member materials/information in a member's primary language (English and Spanish) that is stored in HIS • Two examples of member notices, such as an ABD notice and appeal resolution notice, in Spanish **Evidence as Submitted by the DBA:** 1. Letter to Reviewer - Policy Issue & Approval Dates 2. CU PP - 24-Hour Access to Interpreter Services: Page 1, Section: Policy; Page 2, Section: Process/Procedure #5, #8 3. Screenshot Storage of Primary Language. Cite entire screenshot. 4. Translation Process V2. Cite entire process. 5. NV Medicaid GA Member Appeal Samples. Cite entire template(s). 6. NV MCD UM Member PE Sample-English Spanish. Cite entire template(s).	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY makes interpretation services available to each potential member and makes those services available free of charge to each member, per 42 CFR §438.10(d)(4) and Contract 3.5.1. LIBERTY's *24-Hour Access to Interpreter Services* policy (Evidence #2) ensures all enrollees with Limited English Proficient (LEP) and enrollees with disabilities access to 24-hour interpreter services at key points of contact such as after hours, through LIBERTY's Member Service Department, and face-to-face encounters with providers at no charge to the enrollee. LIBERTY's health information system (Evidence #3) stores member language preference. LIBERTY maintains a workflow (Evidence #4) to ensure completion of translation requests. Samples of member notices in Spanish are provided (Evidence #5, #6).		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
8. The DBA notifies its members: a. That oral interpretation is available for any language and how to access these services; b. That written translation is available in prevalent languages, and how to access those services; c. That auxiliary aids and services are available upon request and at no cost for members with disabilities; and d. How to access the services in §438.10(d)(5)(i) and (ii). 42 CFR §438.10(d)(5)(i-iii) Contract 3.5.1.2	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the DBA:** 1. Letter to Reviewer - Policy Issue & Approval Dates 2. CU PP - 24-Hour Access to Interpreter Services: Page 1, Section: Policy; Page 2, Section: Process/Procedure #5, #8 3. QM PP - Member Health Education and Prevention: Page 1, Section: Process/Procedure I.a; Page 1-2, Section" Process/Procedure II 4. LDP NV Medicaid Member Handbook Standard II, page 19, section: Interpreter/Translation Services • 2021 Member Handbook website link	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY notifies its members that oral interpretation, written translation, and auxiliary aids and services are available and how to access those services, per 42 CFR §438.10(d)(5)(i-iii) and Contract 3.5.1.2. LIBERTY's *24-Hour Access to Interpreter Services* policy (Evidence #2) and *Member Health Education and Prevention* policy (Evidence #3) ensures Dental health educational materials are made available in threshold/prevalent languages and members are informed of no cost language assistance services and that language assistance is provided. LIBERTY's *Member Handbook* (Evidence #4) informs members of the availability of oral translation, written translation and auxiliary aids and services and how to access these services by calling LIBERTY's Member Services.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
9. The DBA provides all written materials for potential members and members consistent with the following: a. Use easily understood language and format. b. Use a font size no smaller than 12 point. c. Make written materials in alternative formats and in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency. d. Make written materials available through auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency. e. Taglines for written materials critical to obtaining services must be printed in a conspicuously-visible font size and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. 42 CFR §438.10(d)(2);(6)(i-iii) Contract 3.5.1	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook and member newsletter • Two examples of member notices, such as an ABD notice and appeal resolution notice • Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services • Workflow and verification procedure for ensuring member materials are 508 compliant • Taglines in large print **Evidence as Submitted by the DBA:** 1. Letter to Reviewer - Policy Issue & Approval Dates 2. CU PP - Translation of Written Informing Member Materials: Page 1, Section: Purpose/Scope; Page 2. 3. LDP NV Medicaid Member Handbook Standard II, page 19, section: Interpreter/Translation Services o 2021 Member Handbook website link 4. Q4 2020 Cultural and Linguistic Committee Excerpt Redacted. Cite entire document. 5. Q1 2021 Cultural and Linguistic Committee Excerpt Redacted. Cite entire document. 6. Accessibility Web-PDF. Cite entire document. 7. NV Medicaid GA Member Appeal Samples. Cite entire document.	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	8. LDP_NV_NOLA[FINAL] - Large Font. Cite entire document.	
DBA Description of Process: LIBERTY provides all written materials for potential members and members in understandable language and format, in no less than 12 point font, and makes written material available in alternate formats and through auxiliary aids and services, and provides language assistance taglines, per 42 CFR §438.10(d)(2);(6)(i-iii) and Contract 3.5.1. LIBERTY's *Translation of Written Informing Member Materials* (Evidence #2) ensures members have equal access and ease of navigation to written member informing materials in a culturally and linguistically appropriate manner. LIBERTY's *Member Handbook* (Evidence #3) informs members of the availability of oral translation, written translation and auxiliary aids and services and how to access these services by calling LIBERTY's Member Services. Member use of translation services is tracked and reported to LIBERTY's *Cultural and Linguistic Committee* (Evidence #4, #5). LIBERTY utilizes a workflow to ensure member materials and videos posted to its website are accessible (Evidence #6). Samples of translated notices and the Notice of Language Assistance are provided (Evidence #7, #8).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element. While the DBA received a score of *Met* for this element, please refer to the findings and required actions sections identified in element 6 of this review tool.		
Required Actions: None.		
Information for All Members With DBA—General Requirements		
10. The DBA must make a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. a. Notice to the member must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice. 42 CFR §438.10(f)(1) Contract 3.5.2.4	**HSAG Recommended Evidence:** • Policies and procedures • One example of written notice to members of provider termination (include the effective date of the termination or receipt or issuance of the termination notice for this example) • Tracking or reporting mechanisms (mailing date and effective date of the termination or receipt or issuance of the termination notice must be notated) **Evidence as Submitted by the DBA:** 1. Letter to Reviewer - Policy Issue & Approval Dates	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	2. NM PP - Dental Plan Enrollee Block Transfers and Continuity of Care from Terminated or Non-Participating Providers: Page 2, Section II 3. Sample NV member Term Notification Letter. Cite entire document. 4. Sample NV Term Event Tacking, Page 2	
DBA Description of Process: LIBERTY gives written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider, per 42 CFR §438.10(f)(1) and Contract 3.5.2.4. LIBERTY's Dental Plan Enrollee Block Transfers and Continuity of Care from Terminated or Non-Participating Providers policy (Evidence #2) ensures member notification of an applicable termination sixty (60) in advance, or within five (5) days of LIBERTY notification under exigent circumstances. Sample termination letters are provided (Evidence #3). Sample provider termination tracking is provided (#4).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
11. The DBA must make available, upon request, any provider incentive plans in place as set forth in 42 CFR §438.3(i) and §438.10(f)(3). 42 CFR §438.10(f)(3); 438.3(i) Contract 3.5.2.2(R)	**HSAG Recommended Evidence:** • Policies and procedures • Summary of provider incentive plans • One example of provider incentive plans provided to a member upon request (if an example is not available, please state so under the DBA Description of Process)	☒ Met ☐ Not Met ☐ NA
	Evidence as Submitted by the DBA: 1. Letter to Reviewer- Policy Issue & Approval Dates 2. LDP NV Medicaid Member Handbook Standard II, Page 40, Section: Provider Participation ○ 2021 Member Handbook website link	

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	3. VBP 3.0 LDP. Cite entire document. 4. NV Medicaid VBP Explanation Letter 1.2020 - 5.2021. Cite entire document.	
DBA Description of Process: LIBERTY makes available, upon request, any provider incentive plans in place as set forth in 42 CFR §438.3(i) and §438.10(f)(3). LIBERTY's *Member Handbook* (Evidence #2) advises members that a copy of the provider incentive plan is available upon request and to call Member Services. The summary of LIBERTY's incentive plan *VBP* is provided (Evidence #3). The list of members requesting a copy of the incentive plan is provided (Evidence #4)		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
Information for All Members With DBA—Member Handbook		
12. The DBA must provide each member a member handbook, which serves as a summary of benefits and coverage as described in 45 CFR §147.200(a), within five (5) business days after receiving notice of the member's enrollment. 42 CFR §438.10(g)(1); 147.200(a) Contract 3.5.2.2	**HSAG Recommended Evidence:** • Policies and procedures • Tracking or reporting mechanisms (the date the DBA received notice of the member's enrollment and the mailing date of the member handbook/member enrollment materials must be notated) **Evidence as Submitted by the DBA:** 1. Letter to Reviewer - Policy Issue & Approval Dates 2. QM PP - Member Health Education and Prevention - APPENDIX A: Page 1, Section: Process/Procedure #1 3. NV Medicaid Monthly ID Card Request Report with Calculated Lag Time	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY provides each member a member handbook, which serves as a summary of benefits and coverage as described in 45 CFR §147.200(a), within five (5) business days after receiving notice of the member's enrollment. *LIBERTY's Member Health Education and*		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Prevention policy (Evidence #2) ensures that member materials are distributed to members within five (5) business days of enrollment. LIBERTY's mailing time tracking mechanism is provided (Evidence #3)		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
13. The content of the member handbook must include information that enables the member to understand how to effectively use the managed care program—Refer to the Member Handbook Checklist. 42 CFR §438.10(d (i-xvi) Contract 3.5.2.2	**HSAG Recommended Evidence:** • Member handbook • Link to member handbook on website • HSAG will also use the results of the Member Handbook Checklist. **Evidence as Submitted by the DBA:** 1. LDP NV Medicaid Member Handbook Standard II, Pages 4-5, Section: Welcome to LIBERTY Dental Plan o 2021 Member Handbook website link 2. LDP Website NV Medicaid Member Handbook Screenshot https://www.libertydentalplan.com/Resources/Documents/ma_LDP_NV_Medicaid_Member_Handbook.pdf	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY's Member Handbook includes information that enables the member to understand how to effectively use the managed care program. LIBERTY's *Member Handbook* is provided (Evidence #1). A link to the electronic Member Handbook is provided (Evidence #2).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
14. Information required by 42 CFR §438.10(g) (member handbook) is considered to be provided by the DBA if the DBA: a. Mails a printed copy of the information to the member's mailing address; b. Provides the information by email after obtaining the member's agreement to receive the information by email; c. Posts the information on the website of the DBA and advises the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or d. Provides the information by any other method that can reasonably be expected to result in the member receiving that information. 42 CFR §438.10(g)(3)(i-iv) Contract 3.5.2	**HSAG Recommended Evidence:** • Policies and procedures • One example of member information that is only provided in an electronic format; and subsequent communication to inform members of the availability of electronic information • Reporting or tracking mechanisms for providing member materials in paper form upon request **Evidence as Submitted by the DBA:** 1. Letter to Reviewer - Policy Issue & Approval Dates 2. QM PP - Member Health Education and Prevention - APPENDIX A: Page 1, Section: Process/Procedure #3 3. Welcome Letter NV Medicaid. Cite entire document.	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY provides member information electronically on its website in an accessible format, per 42 CFR §438.10(g)(3)(i-v). LIBERTY's *Member Health Education and Prevention – APPENDIX A* policy (Evidence #2) ensures that member materials are available by mail, on LIBERTY's website and email (upon consent). Upon enrollment, members are directed to the electronic, accessible Provider Directory on LIBERTY's website and are directed to call Member Services for any assistance, including requesting a printed provider directory (Evidence #3). All member calls, including requests for printed Provider Directories are captured in LIBERTY's Member Services call log system.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
15. The DBA must give each member notice of any change that DHCFP defines as significant in the information specified in 42 CFR §438.10(g), at least 30 days before the intended effective date of the change. 42 CFR §438.10(g)(4) Contract 3.5.2.3	**HSAG Recommended Evidence:** • Policies and procedures • One example of member notice due to a significant change in the information in the member handbook (if no significant change, please state so under the DBA Description of Process) **Evidence as Submitted by the DBA:** 1. Letter to Reviewer - Policy Issue & Approval Dates 2. QM PP - Member Health Education and Prevention - APPENDIX A : Page 1, Section: Process/Procedure #5.a	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY's *Member Health Education and Prevention – APPENDIX A* policy (Evidence #2) ensures that members are informed of any significant changes at least thirty (30) days before the effective date of the change. LIBERTY has not made a significant change to the Member Handbook during the audit lookback period.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
Information for All Members of DBA—Provider Directory		
16. The DBA must make available in paper form upon request and electronic form, information about its network providers—Refer to the Provider Directory Checklist. 42 CFR §438.10(h)(1)(i-viii) Contract 3.6.7	**HSAG Recommended Evidence:** • Example of paper provider directory (excerpts only) • Link to the provider directory on the website • HSAG will also use the results from the Provider Directory Checklist. **Evidence as Submitted by the DBA:** 1. Excerpt of Printed Provider Directory	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	2. https://www.libertydentalplan.com/Find-a-Dentist/Find-a-Dentist.aspx	
DBA Description of Process: LIBERTY makes available in paper form upon request and electronic form, information about its network providers via a printed and electronic Provider Directory, per 42 CFR §438.10(h)(1)(i-viii) and Contract 3.6.7. A sample of the printed Provider Directory is provided (Evidence #1). A link to the electronic Provider Directory is provided (Evidence #2).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element. **Recommendations**: While the DBA was able to demonstrate compliance with the elements of the provider directory checklist, HSAG strongly recommends that the DBA further enhance the information about provider office accommodations for people with physical disabilities listed in the provider directory to further specify the types of accessible equipment and accessible exam room the provider office has available. Such examples could include, but are not limited to, accessible exam tables, lifts, scales, bathrooms, grab bars, or other equipment. Implementation of this recommendation will be further assessed during future compliance reviews.		
Required Actions: None.		
17. Information included in— a. A paper provider directory must be updated at least— i. Monthly, if the DBA does not have a mobile-enabled, electronic directory; or ii. Quarterly, if the DBA has a mobile-enabled, electronic provider directory. b. An electronic provider directory must be updated no later than 30 calendar days after the DBA receives updated provider information. 42 CFR §438.10(h)(3)(i-ii)	**HSAG Recommended Evidence:** • Policies and procedures • Verification of a mobile-enabled electronic provider directory • Workflow to update the paper and electronic provider directories • Evidence how updates to the paper and electronic provider directories are date stamped **Evidence as Submitted by the DBA:** 1. Letter to Reviewer Policy Issue & Approval Dates 2. NM PP - Maintaining Provider Directories 3. Verification of a mobile-enabled electronic provider directory. Cite entire document. 4. LIBERTY Dental Plan_ Find A Dentist. Cite entire document.	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	5. Excerpt of Printed Provider Directory. Cite entire document.	
DBA Description of Process: LIBERTY maintains an updated Provider Directory, per 42 CFR §438.10(h)(3)(i-ii). LIBERTY's *Maintaining Provider Directories* policy (Evidence #2) outlines the process for LIBERTY to update provider demographics and publish updates to the electronic and printed Provider Directory. A sample of LIBERTY's *mobile-enabled Provider Directory* is provided (Evidence #3). Both the electronic and printed Provider Directories are date stamped; the electronic Provider Directory is updated in real-time and lists the current effective date; the printed Provider Directory is updated quarterly and lists the latest quarter (Evidence #4, #5).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
18. Provider directories must be made available on the DBA's website in a machine-readable file and format as specified by the Secretary. 42 CFR §438.10(h)(4)	**HSAG Recommended Evidence:** • Link to the provider directory on the website • Verification that the provider directory is available in a machine-readable file and format **Evidence as Submitted by the DBA:** 1. Letter to Reviewer Policy Issue & Approval Dates 2. NM PP- Maintaining Provider Directories – General Information Pg 1, 21 o https://www.libertydentalplan.com/Find-a-Dentist/Find-a-Dentist.aspx 3. LIBERTY Dental Plan_ Find A Dentist. Cite entire document.	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY make its Provider Directory available on its website, per 42 CFR §438.10(h)(4) (Evidence #2). The Provider Directory is available in a machine readable format (Evidence #2).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Recommendations: HSAG recommends that the DBA also include a link to the machine-readable format of the provider directory located under the Member Resources tab on the DBA's website to the online provider directory landing page for ease of information for members who require the use of a machine-readable format to search for a provider.		
Required Actions: None.		

Standard II—Member Rights and Member Information						
Met	=	17	X	1	=	17
Not Met	=	1	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	18	Total Score		=	17
Total Score ÷ Total Applicable					=	94%

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Definitions		
1. The DBA defines "emergency dental condition" as a dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate dental attention to result in the following: a. *A dental or oral condition that requires immediate services for relief of symptoms and stabilization of the condition; such conditions include severe pain; hemorrhage; acute infection; traumatic injury of the teeth and surrounding tissues; or unusual swelling of the face and gums.* 42 CFR §438.114(a) Contract 2.	**HSAG Recommended Evidence:** • Policy and procedure • Member informational materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the DBA:** 1. Note to Reviewer - Policy Issue & Approval Date 2. UM PP - Emergency Dental Services Expedited Dental Services, Page 1, Section: Definitions 3. LDP NV Medicaid Member Handbook Standard III: Page 32, Section: Emergency Service • 2021 Member Handbook website link 4. NV Medicaid Provider Reference Guide_2021.03.10 CLEAN: Page 27, Section: After Hours and Emergency Services Availability	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY's definition of "emergency dental condition" aligns with 42 CFR §438.114(a) and Contract 2. LIBERTY's *Emergency Dental Services Expedited Dental Services* policy (Evidence #2) defines "emergency dental condition" consistent with this requirement. "Emergency dental condition" information is available to members within the *LDP NV Medicaid Member Handbook* (Evidence #3), and to providers within the *NV Medicaid Provider Reference Guide* (Evidence #4).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
2. The DBA defines "emergency services" for covered inpatient and outpatient services that are as follows: a. Furnished by a provider that is qualified to furnish these services under this Title. b. Needed to evaluate or stabilize an emergency dental condition. 42 CFR §438.114(a) Contract 2.	**HSAG Recommended Evidence:** • Policy and procedure • Member informational materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the DBA:** 1. Note to Reviewer - Policy Issue & Approval Dates 2. UM PP - Emergency Dental Services Expedited Dental Services, Page 2, Section: Definitions 3. NV Medicaid Provider Reference Guide 2021.03.10 CLEAN: Page 26, section: Appointment Availability and Accessibility Standard: After-Hours/Emergency Availability	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY's definition of "emergency services" aligns with 42 CFR §438.114(a) and Contract 2. LIBERTY's *Emergency Dental Services Expedited Dental Services* policy (Evidence #2). Emergency services information is available to members within the *LDP NV Medicaid Member Handbook* (Evidence #3) and to providers within the *NV Medicaid Provider Reference Guide* (Evidence #4).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
3. The DBA defines "poststabilization care services" as covered services, related to an emergency dental condition that are provided after a member is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR §438.114(e), to improve or resolve the member's condition.	**HSAG Recommended Evidence:** • Policy and procedure • Member informational materials, such as the member handbook • Provider materials, such as the provider manual	☒ Met ☐ Not Met ☐ NA

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.114(a) Contract 2.	**Evidence as Submitted by the DBA:** 1. Note to Reviewer - Policy Issue & Approval Dates 2. UM PP - Emergency Dental Services Expedited Dental Services, Page 1, Section: Policy; Page 3, Section: Processing A Request for Initial Expedited Determination 3. NV Medicaid Provider Reference Guide_2021.03.10 CLEAN**:** Page 60 Section: Program Scope: Continuity of Care 4. LDP NV Medicaid Member Handbook Standard III: Page 32, Section: Emergency Services	
DBA Description of Process: LIBERTY's definition of "poststabilization care services" aligns with 42 CFR §438.114(a) and Contract 2. LIBERTY's *Emergency Dental Services Expedited Dental* policy (Evidence #2) supports this requirement. Information on emergency services is available to members within the *LDP NV Medicaid Member Handbook* (Evidence #3) and to providers within the *NV Medicaid Provider Reference Guide* (Evidence #4).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element. **Recommendations:** Although the DBA's policy, provider reference guide, and member handbook included language to meet the intent of the DBA's definition of "poststabilization care services," HSAG strongly recommends that the DBA update its member and provider documents to include a definition specific to "poststabilization care services." Implementation of this recommendation will be further assessed during future compliance reviews.		
Required Actions: None.		
Coverage and Payment		
4. The DBA must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the DBA. 42 CFR §438.114(c)(1)(i) Contract 3.3.6	**HSAG Recommended Evidence:** • Policies and procedures • Member informational materials, such as the member handbook • Provider materials, such as the provider manual	☒ Met ☐ Not Met ☐ NA

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	• Claim algorithm for emergency services **Evidence as Submitted by the DBA:** 1. Note to Reviewer - Policy Issue & Approval Dates 2. UM PP - Emergency Dental Services Expedited Dental Services, Page 3, Section: Processing A Request for Initial Expedited Determination 3. LDP NV Medicaid Member Handbook Standard III: Pages 33, Sections: Emergency Services & What services are covered under emergency care? • 2021 Member Handbook website link 4. Claim Algorithm for Emergency Services	
DBA Description of Process: LIBERTY covers and pays for emergency services regardless of whether the provider who furnishes the services has a contract with LIBERTY, per 42 CFR §438.114(c)(1)(i) and Contract 3.3.6. LIBERTY's *Emergency Dental Services Expedited Dental Services* policy (Evidence #2), together with LIBERTY's claim algorithm for emergency services (Evidence #5) ensure LIBERTY's compliance with this requirement. Information on out of network emergency services is available to members within the *LDP NV Medicaid Member Handbook* (Evidence #3) and to providers within the *NV Medicaid Provider Reference Guide* (Evidence #4).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
5. The DBA may not deny payment for treatment obtained under either of the following circumstances: a. A member had an emergency dental condition, including cases in which the absence of immediate dental attention would not have had the outcomes specified in (1), (2), and (3) of the definition of "emergency dental condition" in 42 CFR §438.114(a).	**HSAG Recommended Evidence:** • Policies and procedures • Member informational materials, such as the member handbook • Provider materials, such as the provider manual • Claim algorithm for emergency services	☒ Met ☐ Not Met ☐ NA

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
b. A representative of the DBA instructs the member to seek emergency services. 42 CFR §438.114(c)(1)(ii)(A-B) Contract 3.3.6.1; 3.3.6.5	**Evidence as Submitted by the DBA:** 1. Note to Reviewer - Policy Issue & Approval Dates 2. UM PP - Emergency Dental Services Expedited Dental Services, Page 1, Section: Definitions; Page 2, Section: Policy; Page 3, Section: Processing A Request for Initial Expedited Determination 3. Post-Out of Network Continuity of Care, Page 2, Section: Process and Procedure 4. Claim Algorithm for Emergency Services 5. LDP NV Medicaid Member Handbook Standard III: Pages 33, Section: Emergency Services • 2021 Member Handbook website link 6. NV Medicaid Provider Reference Guide_2021.03.10 CLEAN: Page 15, Section: "Clean" Claims, ¶ 3	
DBA Description of Process: LIBERTY does not deny payment for treatment obtained under the circumstances specified in 42 CFR §438.114(c)(1)(ii)(A-B) and Contract 3.3.6.1; 3.3.6.5. LIBERTY's *Emergency Dental Services Expedited Dental Services* and *Post Out of Network Continuity of Care* policies (Evidence #2, #3), together with LIBERTY's claim algorithm for emergency services (Evidence #4) ensure LIBERTY's compliance with this requirement. Information on emergency services is available to members within the *LDP NV Medicaid Member Handbook* (Evidence #5) and to providers within the *NV Medicaid Provider Reference Guide* (Evidence #6).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
6. The DBA may not: a. Limit what constitutes an "emergency dental condition" with reference to 42 CFR §438.114(a), on the basis of lists of diagnoses or symptoms; and b. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the DBA or DHCFP of the member's screening and treatment within 10 calendar days of presentation for emergency services. 42 CFR §438.114(d)(1)(i-ii) Contract 3.3.6.3	**HSAG Recommended Evidence:** • Policies and procedures • Member informational materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the DBA:** 1. Note to Reviewer - Policy Issue & Approval Dates 2. UM PP - Emergency Dental Services Expedited Dental Services, Page 2, Section: Policy; Page 3, Section: Processing A Request for Initial Expedited Determination 3. NV Medicaid Provider Reference Guide_2021.03.10 CLEAN: Page 15, Section: "Clean" Claims, ¶ 4. LDP NV Medicaid Member Handbook Standard III: Pages 33, Section: Emergency Services • 2021 Member Handbook website link	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY does not limit what constitutes an "emergency dental condition" on the basis of lists of diagnoses or symptoms, or refuse to cover emergency services for the reasons set forth in 42 CFR §438.114(d)(1)(i-ii) and Contract 3.3.6.3. LIBERTY's *Emergency Dental Services Expedited Dental Services* policy (Evidence #2) supports LIBERTY's compliance with this requirement. Providers are informed of the requirement that emergency services do not require authorization via the *NV Medicaid Provider Reference Guide (*Evidence# 3), and members are informed via the *LDP NV Medicaid Member Handbook* (Evidence# 4).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
7. A member who has an emergency dental condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member. 42 CFR §438.114(d)(2) Contract 3.3.6.2	**HSAG Recommended Evidence:** • Policies and procedures • Member informational materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the DBA:** 1. Note to Reviewer - Policy Issue & Approval Dates 2. UM PP - Emergency Dental Services Expedited Dental Services, Page 2, Definitions; Page 2, Section: Policy; Page 3, Section: Processing A Request for Initial Expedited Determination 3. NV Provider Agreement 2016.07.26 - 8.12.2021, Page 6, Section 2.7 4. LDP NV Medicaid Member Handbook Standard III: page 33, Section: What services are covered under emergency care? • 2021 Member Handbook website link	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY does not hold members who have an emergency dental condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member, per 42 CFR §438.114(d)(2) and Contract 3.3.6.2. LIBERTY's *Emergency Dental Services Expedited Dental Services* policy and *NV Provider Agreement* (Evidence #2, #3) support LIBERTY's compliance with this requirement. Information on emergency services is available to members via the *LDP NV Medicaid Member Handbook* (Evidence# 4).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
8. The attending emergency dentist, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in 42 CFR §438.114(b) as responsible for coverage and payment. 42 CFR §438.114(d)(3)	**HSAG Recommended Evidence:** • Policies and procedures • Member informational materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the DBA:** 1. Note to Reviewer - Policy Issue & Approval Dates 2. UM PP - Emergency Dental Services Expedited Dental Services: Page 2, Section: Policy; Page 5, Section: Reporting Requirements 3. LDP NV Medicaid Member Handbook Standard III: Page 32, Section: Emergency Service • 2021 Member Handbook website link 4. NV Medicaid Provider Reference Guide_2021.03.10 CLEAN: Page 27, Section: After Hours and Emergency Services Availability	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY's processes align with 42 CFR §438.114(d)(3) as specified in LIBERTY's *Emergency Dental Services Expedited Dental Services* policy (Evidence# 2). Information on emergency services is available to members within the *LDP NV Medicaid Member Handbook* (Evidence #3) and to providers within the *NV Medicaid Provider Reference Guide* (Evidence #4).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Coverage and Payment: Poststabilization Care Services		
9. Poststabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR §422.113(c). The DBA: a. Is financially responsible (consistent with 42 CFR §422.214) for poststabilization care services obtained within or outside the DBA that are pre-approved by a plan provider or other DBA representative; b. Is financially responsible for poststabilization care services obtained within or outside the DBA that are not pre-approved by a plan provider or other DBA representative, but administered to maintain, improve, or resolve the member's stabilized condition if— i. The DBA does not respond to a request for pre-approval within one (1) hour; ii. The DBA cannot be contacted; or iii. The DBA representative and the treating dentist cannot reach an agreement concerning the member's care and a plan dentist is not available for consultation. In this situation, the DBA must give the treating dentist the opportunity to consult with a plan dentist and the treating dentist may continue with care of the member until a plan dentist is reached or one of the criteria in 42 CFR §422.113(c)(3) is met; and c. Must limit charges to members for poststabilization care services to an amount no greater than what the DBA would charge the member if he or she had obtained the services through the DBA.	**HSAG Recommended Evidence:** • Policies and procedures • Member informational materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the DBA:** 1. Note to Reviewer - Policy Issue & Approval Dates 2. UM PP - Emergency Dental Services Expedited Dental Services, Page 3, Section: Processing A Request for Initial Expedited Determination 3. Post-Out of Network Continuity of Care, Page 2, Section: Process and Procedure 4. LDP NV Medicaid Member Handbook Standard III: Page 32, Section: Emergency Service • 2021 Member Handbook website link 5. NV Medicaid Provider Reference Guide_2021.03.10 CLEAN: Page 27, Section: After Hours and Emergency Services Availability	☒ Met ☐ Not Met ☐ NA

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §422.113(c)(2)(i-iv); 438.114(e) Contract 3.3.6.9(A-C); (E)		
DBA Description of Process: LIBERTY covers and pays for poststabilization care services in accordance with 42 CFR §422.113(c)(2)(i-iv); 438.114(e) and Contract 3.3.6.9(A-C); (E). LIBERTY's *Emergency Dental Services Expedited Dental Services* and *Post-Out of Network Continuity of Care* policies support LIBERTY's compliance with this requirement (Evidence #2, #3). Information on emergency services is available to members within the *LDP NV Medicaid Member Handbook* (Evidence #4) and to providers within the *NV Medicaid Provider Reference Guide* (Evidence #5).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
10. The DBA's financial responsibility for poststabilization care services it has not pre-approved ends when— a. A plan provider with privileges at the treating hospital assumes responsibility for the member's care; b. A plan provider assumes responsibility for the member's care through transfer; c. A DBA representative and the treating dentist reach an agreement concerning the member's care; or d. The member is discharged. 42 CFR §422.113(c)(3)(i-iv); 438.114(e) Contract 3.3.6.9(D)	**HSAG Recommended Evidence:** • Policies and procedures • Member informational materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the DBA:** 1. Note to Reviewer - Policy Issue & Approval Dates 2. UM PP - Emergency Dental Services Expedited Dental Services, Page 3, Section: Processing A Request for Initial Expedited Determination 3. Post-Out of Network Continuity of Care, Page 2, Section: Process and Procedure	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: Please note: 438.114(e) is applicable to pre-paid ambulatory health plans (like LIBERTY) only to the extent that services required to treat an emergency medical condition fall within the scope of the services for which LIBERTY is responsible.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		

Standard III—Emergency and Poststabilization of Services						
Met	=	10	X	1	=	10
Not Met	=	0	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	10	Total Score		=	10
Total Score ÷ Total Applicable					=	100%

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Delivery Network		
1. The DBA maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities. 42 CFR §438.206(b)(1) Contract 3.6	**HSAG Recommended Evidence:** • Provider contract • Analysis of provider network linguistic capabilities **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. NM PP - Monitoring Provider Distribution Standards and Adequacy_Redacted: Pages 1-2, Section: All sections 3. NM PP - Monitoring Network Adequacy Primary Care Dentists & Specialist: Page 1, Section: Process/Procedure I 4. NV Provider Agreement: Pages 1-11, Section: All sections 5. Q4 2020 Cultural and Linguistic Committee Excerpt_Redacted: Pages 1-3, Section: All sections 6. Q1 2021 Cultural and Linguistic Committee Excerpt_Redacted: Pages 1-3, Section: All sections	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities, per 42 CFR §438.206(b)(1) and Contract 3.6. LIBERTY policies *Monitoring Provider Distribution Standards and Adequacy* (Evidence #2) and *Monitoring Network Adequacy for Primary Care Dentists and Specialist* (Evidence #3) ensures ongoing network adequacy. In addition, LIBERTY, provides the *NV Provider Agreement* (Evidence #4) and Cultural and Linguistic Committee minutes (Evidence #5, #6) as evidence of ongoing monitoring.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
2. The DBA provides for a second opinion from a network provider, or arranges for the member to obtain one outside the network, at no cost to the member. 42 CFR §438.206(b)(3) Contract 3.3.1.8	**HSAG Recommended Evidence:** • Policy and procedure • Member materials, such as the member handbook • Second opinion tracking/analysis **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. GA PP - Second Opinions: Page 3, Section: Member or Provider Initiated Second Opinions, #5 3. LDP NV Medicaid Member Handbook Standard IV, Page 30, Section: What if I want a second opinion? • 2021 Member Handbook website link 4. HSAG Audit - GA Second Opinion Universe	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY provides for a "second opinion" from a network provider or arranges for the member to obtain one outside the network, at no cost to the member, per 42 CFR §438.206(b)(3) and Contract 3.3.1.8. LIBERTY's *Second Opinions* policy (Evidence #2) ensures member access to a qualified dentist to complete the second opinion. LIBERTY's *NV Medicaid Member Handbook* (Evidence #3) includes instructions for members to request a second opinion. Member requests for a second opinion are provided (Evidence #4).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
3. If the provider network is unable to provide necessary services, covered under the contract, to a particular member, the DBA must adequately and in a timely manner cover these services out of network for the member, for as long as the DBA's provider network is unable to provide them. 42 CFR §438.206(b)(4)	**HSAG Recommended Evidence:** • Policy and procedure • Member materials, such as the member handbook • Services provided out of network tracking/analysis	☒ Met ☐ Not Met ☐ NA

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Contract 3.3.1.7	**Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. MSR PP - Out of Network Approval Process: Page 1, Section: Process/Procedure 3. NM PP – Out of Network Providers: Page 1, Section: Purpose/Scope, Policy 4. NM PP – Access and Availability Guidelines: Pages 1-8, Section: All sections 5. LDP NV Medicaid Member Handbook Standard IV: Page 30, Section: Do I need to submit claims?; Page 34, Section: Directions for what to do in an emergency • 2021 Member Handbook website link	
DBA Description of Process: LIBERTY adequately and in a timely manner covers services out of network for the member, for as long as the DBA's provider network is unable to provide them, per 42 CFR §438.206(b)(4) and Contract 3.3.1.7. LIBERTY's *Out of Network Approval Process* policy (Evidence #2) provides the process for obtaining an approval to allow a member, without an out of network (OON) benefit, to seek treatment OON as an exception due to provider coverage gaps. Gaps include access and availability. LIBERTY's *Out of Network Providers* policy (Evidence #3) establishes a process for when enrollees require access to out of network providers to render covered dental benefits and services. LIBERTY's *Access and Availability Guidelines* policy (Evidence #4) ensures member to provider access ratios. LIBERTY's *NV Medicaid Member Handbook* (Evidence #5) includes instructions for members to request out of network services.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
4. The DBA requires out-of-network providers to coordinate with the DBA for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network. 42 CFR §438.206(b)(5)	**HSAG Recommended Evidence:** • Policy and procedure • Member materials, such as the member handbook • One example of an executed single case agreement	☒ Met ☐ Not Met ☐ NA

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Contract 3.3.1.9	**Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. NM PP – Out of Network Providers: Page 1, Section: Purpose/Scope, Policy 3. Single Case Agreement: Page 2, Section: 13 4. NM PP - Access and Availability Guidelines: Pages: 1-8, Section: All sections: 5. LDP NV Medicaid Member Handbook Standard IV: Page 30, Section: Do I need to submit claims?; Page 34, Section: Directions for what to do in an emergency • 2021 Member Handbook website link	
DBA Description of Process: LIBERTY requires out-of-network providers to coordinate with LIBERTY for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network, per 42 CFR §438.206(b)(5) and Contract 3.3.1.9. LIBERTY's *Out of Network Providers* policy (Evidence #2) establishes a process for when enrollees require access to out of network providers to render covered dental benefits and services. Provider agreement are provided (Evidence #3). LIBERTY's *Access and Availability Guidelines* policy (Evidence #4) ensures ongoing monitoring and corrective action related to access and availability of services. LIBERTY's *LDP NV Medicaid Member Handbook* (Evidence #5) ensures members are made aware of claims processing requirements.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
Timely Access		
5. The DBA must do the following: a. Meet and require its network providers to meet standards for timely access to care and services, taking into account the urgency of the need for services.	**HSAG Recommended Evidence:** • Policy and procedure • Provider materials, such as the provider manual and provider contract	☒ Met ☐ Not Met ☐ NA

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
i. *The DBA has written policies and procedures regarding appointment standards and disseminated the standards to all network providers*—Refer to the Access Standards: Appointment Times Checklist. ii. *The DBA must assign a specific staff member of its organization to ensure compliance with these standards by the network.* b. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service (FFS), if the provider serves only Medicaid members. c. Make services included in the contract available 24 hours a day, seven days a week, when medically necessary. d. Establish mechanisms to ensure compliance by network providers. e. Monitor network providers regularly to determine compliance. f. Take corrective action if there is a failure to comply by a network provider. 42 CFR §438.206(c)(1)(i-vi) Contract 3.6.5.8(D)(1)	• Summary of results of provider monitoring (secret shopper surveys) • Example of corrective action when a provider failed to meet access standards • Standards for timely access to care and services (provider manual, executed contract agreement) • HSAG will use the results of the review from the Appointment Times Checklist. **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. NM PP - Access and Availability Guidelines: Page 2, Section: Policy; Page 3, Section Process/Procedure: III & VII 3. NM PP – Monitoring Network Adequacy for Primary Care Dentists and Specialists Geo Access: Pages 1-4, Section: All sections 4. NM PP - Out of Network Providers: Page 1, Section: Policy; Page 2, Section: Process/Procedure: Provider Coverage Gap, b-c 5. NV Medicaid Provider Reference Guide_2021.03.10 CLEAN: Pages 25-26, Section: Appointment Availability and Accessibility Standard; Page 60, Section: Program Content and Committees: Access and Availability (AA) 6. NV Provider Agreement Executed: Pages 1-11, Section: All sections 7. 2020 Access and Availability Charter: Pages 1-3, Section: All sections	

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	8. QM Committee report Secret Shopper Calls: Page 1, Section: Activity Report Summary entire	
DBA Description of Process: LIBERTY complies with 42 CFR §438.206(c)(1)(i-vi) and Contract 3.6.5.8(D)(1) with regard to service availability as outlined in LIBERTY's Access and Availability Guidelines (Evidence #2), Monitoring Network Adequacy for Primary Care Dentist and Specialist Geo Access (Evidence #3) and NM PP - Out of Network Providers (Evidence #4) policies. LIBERTY's NV Medicaid Provider Reference Guide (Evidence #5) and provider agreement (Evidence #6) ensures provider access and appointment availability. LIBERTY monitors standards for the quality and adequacy of the provider network as specified in the 2020 Access and Availability Charter (Evidence #7) and conducts secret shopper calls (Evidence #8) at minimum annually and more frequently as needed to ensure provider availability and takes corrective action, when appropriate.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
Access and Cultural Considerations		
6. The DBA participates in DHCFP's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex. 42 CFR §438.206(c)(2) Contract 3.3.1.12; 3.6.8; 3.10.2.2(A)(2)	**HSAG Recommended Evidence:** • Policy and procedure • Provider materials, such as the provider manual and provider contract • Analysis of provider network linguistic capabilities • Analysis of provider network cultural competence • Cultural competency plan **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. CU PP - Cultural and Linguistic Competency Program Compliance: Page 2, Section: Policy 3. NM PP- Identification and Monitoring of Network Linguistic Capabilities: Page 1-3, Section: All sections	☒ Met ☐ Not Met ☐ NA

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	4. NM PP – Provider Orientation: Pages 2-3, Section: Process/Procedure: II NV Provider Agreement: Page 4, Section 2.2(d)i 5. NV Provider Agreement: Page 4, Section 2.2(d)i 6. NV Medicaid Provider Reference Guide_2021.03.10 CLEAN: Page 8, Section: Provider Compliance and Training; Page 11, Section: Primary Care Dental Home Assignment, ¶ 3; Page 32, Section: Culturally Competent Care; Page 32-33, Section: Language Assistance Services; Page 61, Section: Program Content and Committees: Cultural and Linguistic Competency (CLC) 7. Excerpt Provider Directory Online: Page 1, Section: All sections 8. Excerpt of Paper Provider Directory: Pages 1-2, Section: All sections 9. Q4 2020 Cultural and Linguistic Competency Committee Excerpt_Redacted, Page 3, Section: All sections 10. Q1 2021 Cultural and Linguistic Committee Excerpt_Redacted, Page 3, Section: All sections 11. QM Committee report Secret Shopper Calls: Pages 1-2, Section: All sections 12. NV member linguistic needs_provider cababilities_Q4 2020_Q2 2021. Cite entire document.	
DBA Description of Process: LIBERTY participates in DHCFP's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex, per 42 CFR §438.206(c)(2) and Contract 3.3.1.12; 3.6.8; 3.10.2.2(A)(2). LIBERTY's *Cultural and Linguistic Competency Program Compliance* policy (Evidence #2) ensures LIBERTY shall collaborate and participate with applicable state and regulatory agencies in an effort to promote the delivery of care in a		

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
culturally competent manner. LIBERTY's *Identification and Monitoring of Network Linguistic Capabilities* policy (Evidence #3) outlines the process for identification and monitoring bilingual and linguistic capabilities of network providers and their office staff to provide meaningful access and availability to Limited English Proficiency (LEP) enrollees. LIBERTY's *Provider Orientation* policies (Evidence #4) ensure provider training and compliance with cultural competency requirements. LIBERTY's *NV Medicaid Provider Reference Guide* (Evidence #6) specifies upon initial enrollment, LIBERTY will assign members to the nearest Primary Care Dentist based on such factors as language, cultural preference, previous history of the member or another family member, etc. LIBERTY's *provider agreement* (Evidence #5) ensures providers shall not discriminate and LIBERTY's provider agreement ensures providers shall not discriminate and evidence of Cultural and Competency Training is listed within the provider directory (Evidence #7, #8). Oversight of access and availability standards is provided (Evidence #9, #10, #11, #12).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
Accessibility Considerations		
7. The DBA must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. 42 CFR §438.206(c)(3)	**HSAG Recommended Evidence:** • Policy and procedure • Provider materials such as the provider manual and provider contract • Analysis of provider network capability to provide services to members with physical or mental disabilities **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. Fully Executed agreement and supporting documents: Page 9, Section 2.2(d)I; Page 21, Section: 7a 3. Site Survey Form – NV: Pages 1-3, Section: All sections 4. NM PP – Provider Orientation: Pages 2-3, Section: Process/Procedure II	☒ Met ☐ Not Met ☐ NA

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	5. Excerpt of Paper Provider Directory: Pages 1-2, Section: All sections 6. NV Medicaid Provider Reference Guide_2021.03.10 CLEAN: Page 28, Section: Facility Physical Access for the Disabled **7.** ADA Monitoring	
DBA Description of Process: LIBERTY ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities, per 42 CFR §438.206(c)(3). LIBERTY's NV Provider Agreement (Evidence #2) ensures providers shall not discriminate based on disability. LIBERTY's NV Site Survey Form (Evidence #3) is used to review provider offices to ensure compliance with applicable standards. LIBERTY's *Provider Orientation* policy (Evidence #4) ensures provider training on the needs of enrollees with special needs. LIBERTY's *Provider Directory* (Evidence #5) ensure members are aware of accommodations when selecting a provider. LIBERTY's Provider Reference Guide (Evidence #6) ensures facility physical access for the disabled, appointment wait times and cultural and linguistic competency. Oversight of provider ADA accessibility (Evidence #7) is provided.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		

Standard IV—Availability of Services						
Met	=	7	X	1	=	7
Not Met	=	0	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	7	Total Score		=	7
Total Score ÷ Total Applicable					=	100%

Standard V—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
Basic Rule		
1. The DBA gives assurances to DHCFP and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with DHCFP's standards for access to care under 42 CFR §438.207, including the standards at §438.68 and §438.206(c)(1). a. The DBA must submit documentation to DHCFP, in a format specified by DHCFP, to demonstrate that it complies with the following requirements: i. Offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of members for the service area. ii. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. 42 CFR §438.68; 438.206(c)(1); 438.207(a) Contract 3.6.2.10	**HSAG Recommended Evidence:** • Policies and procedures • Time/distance analysis • Member/provider ratio analysis • Exceptions approved by DHCFP - none **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue and Approval Dates 2. CM PP - Compliance Reporting Tracking System (CRTS). Cite entire document. 3. CRTS 10273 Dental Network Adequacy (System Screen Shots) 4. CRTS 10267 Geo Access Report (System Screen Shots) 5. LDP_8402_NetworkAdequacyDental_2021.05.11 6. Delivery Receipt for LDP 8402 Network Adequacy Dental 7. LDP 8407 NV Medicaid Geo Access Report 2021.04.30 8. Delivery Receipt for LDP 8407 Geo Access Report	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY's external reporting processes comply with the requirement that LIBERTY assure DHCFP, through supporting documentation, that it has the capacity to serve the expected enrollment in its service area consistent with DHCFP's standards for access to care under 42 CFR §438.207, §438.68 and §438.206(c)(1). The *Compliance Reporting Tracking System* policy together with system screenshots (Evidence #2, #3, #4) demonstrate LIBERTY's process for logging and monitoring external reporting requirements, including the requirement to submit a *Dental Network Adequacy* report to DHCFP on a quarterly basis (Evidence #5, #6) and a *Geo Access Report* to DHCFP on a monthly basis (Evidence #7, Evidence #8). **Please note**, during the look back period, LIBERTY did not request or receive any exceptions from DHCFP concerning standards for access to care.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		

Standard V—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
Timing of Documentation		
2. Each DBA must submit the documentation described in 42 CFR §438.207(b) as specified by DHCFP, but no less frequently than the following: a. At the time it enters into a contract with DHCFP. b. On an annual basis. c. At any time there has been a significant change (as defined by DHCFP) in the DBA's operations that would affect the adequacy of capacity and services, including— i. Changes in DBA services, benefits, geographic service area, composition of or payments to its provider network; or ii. Enrollment of a new population in the DBA. 42 CFR §438.207(c)(1-3) Contract 3.6.2.10(A-B)	**HSAG Recommended Evidence:** • Policy and procedure • Most recent annual assurances of adequate capacity and services submission to DHCFP • Assurances of adequate capacity and services submission to DHCFP due to a significant change (if there is not a significant change, state so in the DBA Description of Process) **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue and Approval Dates 2. 2020 Access and Availability Charter 3. CM PP - Compliance Reporting Tracking System (CRTS). Cite entire document. 4. CRTS 10273 Dental Network Adequacy (System Screen Shots) 5. CRTS 10267 Geo Access Report (System Screen Shots) 6. LDP_8402_NetworkAdequacyDental_2021.05.11 7. Delivery Receipt for LDP 8402 Network Adequacy Dental 8. LDP 8407 NV Medicaid Geo Access Report 2021.04.30 9. Delivery Receipt for LDP 8407 Geo Access Report	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY's external reporting processes comply with applicable federal and state law concerning submitting the documentation described in 42 CFR §438.207(b) upon entering into a contract with DHCFP; on at least an annual basis; and any time a significant change affects the adequacy of LIBERTY's capacity and services. **Please note,** during the look back period LIBERTY did not enter into a contract with DHCFP and has not experienced a significant change that would affect the adequacy of capacity and services. LIBERTY's Access & Availability Committee (Evidence #2) monitors the adequacy and capacity of services, and ensures any significant changes are reported to DHCFP, consistent with 42 CFR §438.207(b) and (c)(1-3) and Contract 2.6.2.10(A-B). LIBERTY's *Compliance Reporting Tracking System* policy together with system screenshots		

Standard V—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
(Evidence #3, #4, #5) demonstrate LIBERTY's process for logging and monitoring recurring external reporting requirements, including the requirement to submit a *Dental Network Adequacy* report to DHCFP on a quarterly basis (Evidence #6, #7) and a *Geo Access Report* to DHCFP on a monthly basis (Evidence #8, Evidence #9).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
Network Adequacy		
3. *The DBA must have at least one (1) full-time equivalent (FTE) dentist per one thousand five hundred (1,500) members per geographic service area.* *a. The DBA's dental provider network must also include at a minimum, pediatric dentist, dental hygienists, and oral surgeons in each geographic service area sufficient to provide necessary access to care.* *b. In clinical practice settings where a dentist provides direct supervision of dental residents who have a temporary permit from the State Board of Dentistry in good standing, the DBA may request and the DHCFP may authorize the capacity to be increased as follows: one (1) dental resident per one thousand (1,000) members per vendor.* *c. The DBA should provide access to at least two (2) specialists (i.e., those who are not PCPs) one (1) specialist per one thousand five hundred members per service area (1:1500).* *i. These ratios may be adjusted by the DHCFP for under-served areas, upon the analysis of dental specialist availability by specific service area.*	**HSAG Recommended Evidence:** • Policies and procedures • Most recent dental provider-to-member ratio analysis • GeoAccess mapping report **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue and Approval Dates 2. 2020 Access and Availability Charter. Cite entire document. 3. NM PP - Access and Availability Guidelines; Page 3, Section VI: Ratio of Specialty Care Dentists to Enrollees 4. NM PP - Monitoring Network Adequacy for Primary Care Dentists and Specialists - GEO Access - 8.12.2021_Redacted: Page 1; Sections: *Purpose & Scope* and *Policy*. Page 2, Section 3: *Proximity of Specialty Dentists to Primary Care Dentists* 5. UM PP - Coverage and Authorization of Services. Page 3, Section A.6. Coverage of Services.	☒ Met ☐ Not Met ☐ NA

Standard V—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
ii. *If a member is unable to arrange specialty care from a network provider, the DBA must arrange for services with a provider outside the DBA's network.* Contract 3.6.5.1; 3.6.5.4(A); 3.6.5.7		
DBA Description of Process: LIBERTY's Access & Availability Committee (Evidence #2) ensures LIBERTY's compliance with the network adequacy requirements set forth in Contract 3.6.5.1; 3.6.5.4(A); 3.6.5.7 (Evidence #2). LIBERTY's *Access & Availability Guidelines*, *Coverage & Authorization of Services,* and *Monitoring Network Adequacy for Primary Care Dentists & Specialists* policies demonstrate LIBERTY's compliance with this requirement.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
4. *The DBA must offer every enrolled member a primary dental provider (PDP) or primary dental care site located within a reasonable distance from the enrolled member's place of residence. A county having a population of 100,000 or more must have a radius of not more than 25 miles between the subscriber or individual enrollee and PDP without the written request of the member. In accordance with CFR §438.68, at a minimum, the vendor must follow time and distance standards for the below provider types:* *a. General Dentistry/Adult and Pediatric—30 minutes/20 miles.* *b. On a quarterly basis, use GeoAccess mapping and data-driven analyses to ensure compliance with access standards, and take appropriate corrective action, if necessary, to comply with such access standards.* Contract 3.5.4.2	**HSAG Recommended Evidence:** • Policies and procedures • Most recent time and distance monitoring report • GeoAccess mapping report **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue and Approval Dates 2. 2020 Access and Availability Charter. Cite entire document. 3. NM PP – Monitoring Network Adequacy for Primary Care and SP: Geo Access Section III, page 3 4. NM PP – Access and Availability Guidelines: a. see page 3, section VII (requirement 4b) b. see page 4, section VIII (requirement 4b) 5. LDP 8407 NV Medicaid Geo Access Report 2021.04.30 6. Delivery Receipt for LDP 8407 Geo Access Report	☒ Met ☐ Not Met ☐ NA

Standard V—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
DBA Description of Process: LIBERTY's Access & Availability Committee (Evidence #2) ensures LIBERTY's compliance with the network adequacy requirements set forth in Contract 3.5.4.2. LIBERTY's *Monitoring Network Adequacy for Primary Care Dentists & Specialists* and *Access & Availability Guidelines* policies (Evidence #3, #4) demonstrate LIBERTY's compliance with this requirement, together with the Geo Access Report LIBERTY submits to DHCFP on a monthly basis (Evidence #5, #6).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		

Standard V—Assurances of Adequate Capacity and Services						
Met	=	4	X	1	=	4
Not Met	=	0	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	4	Total Score		=	4
Total Score ÷ Total Applicable					=	100%

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Care and Coordination of Services for All DBA Members		
1. The DBA must ensure that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. The member must be provided information on how to contact his or her designated person or entity. 42 CFR §438.208(b)(1) Contract 3.5.4.1	**HSAG Recommended Evidence:** • Policies and procedures • Member handbook • Tracking/reporting of member care coordination activities **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. CM PP - Coordination of Dental Services - NV, Page 2, Section: Process/Procedure 3. LDP NV Medicaid Member Handbook Standard VI, Page 21, Section: How can I find a dentist; Page 32, Section: What Kind of quality control or improvement is done by LIBERTY? o 2021 Member Handbook website link	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY ensures that each member has an ongoing source of care, consistent with 42 CFR §438.208(b)(1) and Contract 3.5.4.1. LIBERTY's *Coordination of Dental Services – NV* policy (Evidence #3) ensures LIBERTY's compliance with this requirement, and LIBERTY members are notified of care coordination via the *LDP NV Medicaid Member Handbook*.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
2. The DBA must coordinate the services the DBA furnishes to the member: a. With the services the member receives from any other DBA, PIHP, or MCO; b. With the services the member receives in FFS Medicaid; and c. With the services the member receives from community and social support providers. 42 CFR §438.208(b)(2)(i-iv) Contract 3.3.6.10	**HSAG Recommended Evidence:** • Policies and procedures • Two case examples of care coordination with another DBA, FFS Medicaid, or community or social support provider. Examples must be with different entities. **Evidence as Submitted by the DBA:** 1. CM PP - Coordination of Dental Services - NV, Page 1, Section: Policy; Page 2, Section: Process/Procedure 2. NV Medicaid Care Management Cases	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY coordinates the services it furnishes to the member with services the member receives from other sources, consistent with 42 CFR §438.208(b)(2)(i-iv) and Contract 3.3.6.10. LIBERTY's *Coordination of Dental Services* policy supports LIBERTY's compliance with this requirement as evidenced by two submitted case examples (Evidence #1, #2).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
3. The DBA shall: a. Make a best effort to conduct an initial screening of each member's needs, within ninety (90) days of the effective date of enrollment for all new members. b. Make subsequent attempts to conduct an initial screening of each member's needs if the initial attempt to contact the member is unsuccessful. 42 CFR §438.208(b)(3)	**HSAG Recommended Evidence:** • Policies and procedures • Initial oral health screening template • One case example of a completed initial oral health screening • Internal tracking mechanisms **Evidence as Submitted by the DBA:** 1. CM PP - Oral Health Risk Assessments, Page 1, Section: Process/Procedure 1-1a 2. Welcome Call Purpose NV Medicaid	☐ Met ☒ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	3. Welcome Call Script NV Medicaid 4. Feb 2021 NV Medicaid Campaign Summary	
DBA Description of Process: LIBERTY makes best efforts to conduct an initial screening of each member's needs consistent with 42 CFR §438.208(b)(3). LIBERTY's *Oral Health Risk Assessments* policy specifies the process of conducting outreach to members within the first ninety (90) days of the effective date of enrollment (Evidence #1, #2, #3, #4).		
HSAG Findings: The Oral Health Risk Assessments [OHRA] policy indicated that the DBA conducts outreach to each member within the first 90 days of the effective date of enrollment to conduct an initial screening to determine a member's care needs. However, the OHRA standing operating procedure (SOP) indicated that the OHRA is completed on all care management members (as opposed to all newly enrolled members as stated in the OHRA policy). Discussion during the interview session confirmed that the DBA is not conducting outreach on all newly enrolled members in an effort to complete the initial OHRA. Additionally, the OHRA SOP suggested that the DBA tracked the number of completed OHRAs; however, documentation did not support that this was occurring, which was confirmed by DBA staff members during the interview session. After the interview session, the DBA provided a narrative indicating that the federal requirement does not define "best efforts" and its contract with DHCFP does not require the administration of or define the provision of an OHRA; therefore, the DBA's process for sending members a welcome packet and making welcome calls to each member meets the requirement. However, while the welcome packet and welcome call educated members to contact member services for assistance, documentation and discussion with staff members did not confirm that an initial screening of each member's needs was completed. Further, the Case Management and Care Coordination Program Description suggested that each new member received a welcome letter and an OHRA form with a separate postage-paid envelope. However, the welcome letter did not include any information on completing an OHRA, and DBA staff members did not confirm that the OHRA was part of the member welcome packet. **Recommendations:** HSAG recommends that the DBA immediately develop mechanisms to conduct an initial screening of each member's needs within 90 days of the effective date of enrollment. The DBA could consider including the OHRA in each member's initial welcome packet for the members to complete and return to the DBA, and incorporating the OHRA during the initial welcome call to members. In addition to developing a reporting mechanism to track completion rates and completion timeliness, HSAG recommends that the DBA develop a process of screening the completed OHRAs to identify members who may have a special health care need and may benefit from care management.		
Required Actions: The DBA must make a best effort to conduct an initial screening of each member's needs within 90 days of the effective date of enrollment for all new members and make subsequent attempts to conduct an initial screening of each member's needs if the initial attempt to contact the member is unsuccessful.		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
4. *The DBA is required to conduct Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings of its members under the age of twenty-one (21) years at six (6)-month intervals to members of orthodontic services.* a. *The screening must meet EPSDT requirements found in the Medicaid Services Manual (MSM) Chapter 1500, as well as 1905(r) of the Social Security Act and 42 CFR §441.50 through §441.62.* Contract 3.3.1; 3.3.3.1	**HSAG Recommended Evidence:** • Policies and procedures • Monitoring reports **Evidence as Submitted by the DBA:** 1. UM PP - Coverage of EPSDT Services, Pages 1-4, Cite entire document 2. UM PP - EPSDT Services APPENDIX B - NV MEDICAID, Pages 1-2, Cite entire document	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY's *Coverage of EPSDT Services* policy and *Appendix B - NV MEDICAID (Evidence #1, #2)* specifies the process of conducting EPSDT screenings for members under the age of twenty-one (21), per Contract 3.3.1; and 3.3.3.1. Please note, element 4a is not applicable to LIBERTY as LIBERTY is not delegated to administer orthodontics to Nevada Medicaid members under the age of twenty-one (21).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element. **Recommendations:** DBA staff members explained that while the DBA refers and coordinates care for members receiving orthodontic services, DHCFP is responsible for authorization and payment of those services. Therefore, HSAG recommends that the DBA consult with DHCFP on its expectations for the DBA to conduct EPSDT screenings of its members under the age of 21 years at six-month intervals for members receiving orthodontic services.		
Required Actions: None.		
5. The DBA must share with DHCFP or other DBAs, PIHPs, and MCOs serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities. 42 CFR §438.208(b)(4) Contract 3.3.6.10	**HSAG Recommended Evidence:** • Policies and procedures • Two case examples of the DBA sharing assessment results: one with another MCE serving the member and one with **Evidence as Submitted by the DBA:**	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	1. CM PP - Coordination of Dental Services – NV, Page 2, Section: Process/Procedure 2. Care Coordination of Services DBA Members	
DBA Description of Process: LIBERTY shares with other entities serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities, per 42 CFR §438.208(b)(4) and Contract 3.3. 6.10. LIBERTY's *Coordination of Dental Services - NV* policy (Evidence #1) supports LIBERTY's compliance with this requirement as evidenced by the care coordination case examples provided (Evidence #2).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element. **Recommendations:** HSAG requested evidence of communication back to a referring external entity when resolving a care coordination referral. After the interview session, the DBA explained that it was unable to retrieve the response sent to the MCE as their secure email system only allows retrieval for 90 days. While the DBA provided a different case example, the initial case in question confirmed a gap in the DBA's process for maintaining care coordination documentation; therefore, HSAG recommends that the DBA enhance mechanisms to ensure all communication is documented and saved in member records.		
Required Actions: None.		
6. The DBA must ensure that each provider furnishing services to members maintains and shares, as appropriate, a member dental record in accordance with professional standards. *a. The DBA shall have written policies and procedures to maintain confidentiality, accessibility and availability, record-keeping, and a record review process for all dental records.* *b. The DBA shall assist the member or the parent/legal guardian of the member in obtaining a copy of the member's dental records, upon written request, from the provider.* *c. Records shall be furnished in a timely manner upon receipt of such a request but not more than thirty (30) calendar days from the date of receipt.* 42 CFR §438.208(b)(5)	**HSAG Recommended Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Oversight of provider medical record practices, such as audits, site visits, etc. **Evidence as Submitted by the DBA:** 1. QM PP - Enrollee Record Maintenance & Review Strategy, Page 1, Section: Dental Plan Enrollee Record Maintenance 2. NV Provider Agreement, Page 5, Section: 2.5a-2.5b, 2.6a-2.6b; Page 8, Section: 4.3c	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Contract 3.7.1-3	3. NV Medicaid Provider Reference Guide_2021.03.10 CLEAN, Page 22, Section: Member Rights and Responsibilities; Page 32, Section Dental Records Availability 4. Clinical Chart Audit Sample. Cite entire document.	
DBA Description of Process: LIBERTY ensures that each provider furnishing services to members maintains and shares, as appropriate, a member dental record in accordance with professional standards per, 42 CFR §438.208(b)(5); and Contract 3.7.1-3. LIBERTY's *Enrollee Record Maintenance and Review Strategy* policy and Provider Agreement (Evidence #1, #2) support LIBERTY's compliance with this requirement, as evidenced by the Clinical Chart Audit sample provided (Evidence #3).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
Special Health Care Needs: Assessment		
7. The DBA shall implement mechanisms to comprehensively assess each Medicaid member identified by DHCFP or the DBA as having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. 42 CFR §438.208(c)(2)	**HSAG Recommended Evidence:** • Policies and procedures • Tracking and reporting mechanisms for method of identification **Evidence as Submitted by the DBA:** 1. CM PP - Coordination of Dental Services - NV, Page 2, section: Follow-up Assessment 2. CM PP - Oral Health Risk Assessments, Page 1, Section: Policy	☐ Met ☒ Not Met ☐ NA
DBA Description of Process: LIBERTY has implemented mechanisms to comprehensively assess each Medicaid member identified by DHCFP or the DBA as having special health care needs, per 42 CFR §438.208(c)(2). LIBERTY's *Coordination of Dental Services* and *Oral Health Risk Assessments* policies (Evidence #1, #2) support LIBERTY's compliance with this requirement.		
HSAG Findings: Documentation and discussion with staff members did not demonstrate a standardized process for completing a comprehensive assessment of members who have been identified as having a special health care need. After the interview session, a screenshot of a Health Risk		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Assessment was provided; however, it aligned with the initial OHRA and did not demonstrate that the DBA comprehensively assessed the member's needs. For example, the assessment indicated that the member had a special health care need; however, the special health care need was not identified or assessed.		
Required Actions: The DBA must implement mechanisms to comprehensively assess each member identified as having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring.		
Special Health Care Needs: Treatment/Service Plans		
8. For members with special health care needs as required by DHCFP: a. The DBA's treatment or service plan shall be approved by the DBA in a timely manner, if this approval is required by the DBA. b. The DBA's plan shall be developed in accordance with any applicable DHCFP quality assurance and utilization review standards. c. DBA's treatment or service plan shall be reviewed and revised upon reassessment of functional need, at least every 12 months, or when the member's circumstances or needs change significantly, or at the request of the member. 42 CFR §438.208(c)(3)(iii-v) Contract 3.5.5.1	**HSAG Recommended Evidence:** • Policies and procedures • Comprehensive dental assessment template • One case example of a completed comprehensive dental assessment • Job descriptions for staff conducting comprehensive dental assessments • Training requirements for staff conducting comprehensive dental assessments • Reports/tracking of special health care needs **Evidence as Submitted by the DBA:** 1. CM PP - Coordination of Dental Services - NV, Page 1, Section: Policy; Page 3, Section: Services for Children who are under 21 years of age with Special Health Care Needs 2. CM PP - Oral Health Risk Assessments, Page 1, Section: Policy 3. SOP QM CM Oral Health Risk Assessment, Cite entire document 4. CM Job Descriptions	☐ Met ☒ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	5. NV Case Example for Completed OHRA-Event Viewer 6. Case Management-NV Medicaid, 2021 Template	
DBA Description of Process: LIBERTY complies with the requirements under 42 CFR §438.208(c)(3)(iii-v) and Contract 3.5.5.1 concerning members with special health care needs. LIBERTY's *Coordination of Dental Services – NV* policy and related materials (Evidence #1, #2, #3, #5) support LIBERTY's compliance with this requirement, as evidenced by the case example provided (Evidence #4).		
HSAG Findings: Information obtained through the review of documentation, the system demonstration, and discussion during the interview session was conflicting as it related to processes for the development and implementation of dental treatment and/or care plans. The Coordination of Dental Services policy required the DBA to produce a treatment plan for children with special health care needs. The care management job descriptions also required care managers to ensure treatment plans and dental care plans are included in a member's record. During the system demonstration, DBA staff members were unable to produce a treatment plan or a dental care plan. When asked to view the provider's treatment plan, DBA staff members directed HSAG reviewers to a list of claims history but not a treatment plan. Further, the DBA provided a blank nursing care plan; however, a completed version was not available. DBA staff members verbalized that they have recently identified opportunities for enhancing its care management program. Lastly, the Case Management and Care Coordination Program Description indicated that members in care management receive an individualized plan of care that includes prioritized goals that consider member and caregiver goals, preferences, and desired level of involvement in the care management plan; barriers to meeting goals or complying with the plan; referrals to resources and follow-up processes; development and communication of member self-management plans; assessment of member progress against the care management plan; and pre- and post-stabilization of dental care services. Documentation did not confirm that the DBA had implemented processes to develop an individualized care plan as stated in the program description.		
Required Actions: For members with special health care needs, the DBA must develop a treatment or service plan in accordance with any applicable DHCFP quality assurance and utilization review standards. The DBA's treatment or service plan must be reviewed and revised upon reassessment of functional need, at least every 12 months, or when the member's circumstances or needs change significantly, or at the request of the member.		
Direct Access to Specialists		
9. For members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, the DBA must have a mechanism in place to allow members to directly access a specialist as appropriate for the member's condition and identified needs.	**HSAG Recommended Evidence:** • Policies and procedures **Evidence as Submitted by the DBA:** 1. CM PP - Coordination of Dental Services - NV, Page 2, Section: Process/Procedure	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.208(c)(4)		
DBA Description of Process: LIBERTY has a mechanism in place to allow members with special health care needs determined through an assessment to directly access a specialist as appropriate for the member's condition and identified needs, in compliance with 42 CFR §438.208(c)(4), and as specified in LIBERTY's *Coordination of Dental Services – NV* policy (Evidence #1).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
Information Technology System for Care Coordination		
10. *The DBA must have an integrated database that allows DBA staff that may be contacted by a member to have immediate access to and review of the most recent information within the DBA's information systems relevant to the case.* *a. The integrated database may include the following:* *i. Administrative data;* *ii. Call center communications;* *iii. Service authorizations; and* *iv. Case notes.* *b. The information technology system must also have the capability to share relevant information (utilization reports, etc.) with the member, the primary dental provider (PDP), and other service providers.* Contract 3.9.20.1	**HSAG Recommended Evidence:** Policy and procedure **Evidence as Submitted by the DBA:** 1. MSR PP - Call Documentation, Page 1, Section: Process/Procedure	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY maintains an integrated database that complies with the requirements of Contract 3.9.20.1. LIBERTY's *Call Documentation* policy (Evidence #1) specifies the process to ensure staff have immediate access and ability to review the most recent case information within LIBERTY's information systems when contacted by a member in accordance with this requirement, and to share relevant information the member, the primary dental provider and other service providers.		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
Transition of Care Policy and Procedure		
11. The DBA shall implement a transition of care policy that is consistent with federal requirements and at least meets the DHCFP-defined transition of care policy. The DBA must demonstrate the following components are implemented to ensure continuity of care during transitions: a. The enrolled member has access to services consistent with the access he or she previously had and is permitted to retain his or her current provider if that provider is enrolled in Nevada Medicaid. b. The enrolled member is referred to appropriate providers of services that are in the network. c. The entity (DBA or DHCFP) previously serving the enrolled member, fully and in a timely manner complies with requests for historical utilization data from the new entity in compliance with federal and State law. d. Consistent with federal and State law, the enrolled member's new provider(s) are able to obtain copies of the enrolled member's medical records, as appropriate. e. Any other necessary procedures as specified by CMS to ensure continued access to services to prevent serious detriment to the enrolled member's health or reduce the risk of hospitalization or institutionalization. 42 CFR §438.62(b)(1)(i-v) Contract 3.4.6	**HSAG Recommended Evidence:** Policy and procedure **Evidence as Submitted by the DBA:** 1. QM PP - Transition of Care (Benefits End Maxed): Pages 1-2, Section: Continuation of Services with Terminated or Nonparticipating Provider 2. UM PP - Continuity and Coordination of Care, page 1, section: Purpose/Scope	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
DBA Description of Process: LIBERTY has implemented a transition of care policy that is consistent with federal requirements and meets the DHCFP-defined transition of care policy. LIBERTY's *Transition of Care* and *Continuity and Coordination of Care* policies (Evidence #1, #2) support LIBERTY's compliance with ensuring continuity of care during transitions, per 42 CFR §438.62(b)(1)(i-v).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		

Standard VI—Coordination and Continuity of Care						
Met	=	8	X	1	=	8
Not Met	=	3	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	11	Total Score		=	8
Total Score ÷ Total Applicable					=	73%

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Coverage		
1. The DBA must ensure that services identified in 42 CFR §438.210(a)(1) be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to members under FFS Medicaid, as set forth in §440.230, and for members under the age of 21, to the same extent that services are furnished to individuals under the age of 21 under FFS Medicaid. 42 CFR §438.210(a)(1-2); 440.230 Contract 3.3.1.1	**HSAG Recommended Evidence:** • Policies and procedures **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. UM PP - Coverage and Authorization of Services: Page 3, Section A.5.b 3. UM PP - Coverage of EPSDT Services. Cite entire document. 4. UM PP - Coverage of EPSDT Services - APPENDIX B - NV MEDICAID. Cite entire document.	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with parity requirements, per 42 CFR §438.210(a)(1-2), 440.230, and Contract 3.3.1.1. LIBERTY's *Coverage and Authorization of Services* policy (Evidence #2) ensures dental necessity determinations are made in a consistent manner based on sound clinical evidence that is no more restrictive in amount, duration, and scope than the definitions provided by governing State or Federal statutes/regulations. LIBERTY's *Coverage of EPSDT Services* policy and appendix (Evidence #3, #4) ensure EPSDT services are provided as set forth by Federal law.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
2. The DBA— a. Must ensure that the services are sufficient in amount, duration, or scope to reasonably 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 member.	**HSAG Recommended Evidence:** • Policies and procedures • Utilization management plan • Monitoring/oversight of UM/UR functions • New hire and ongoing training for staff **Evidence as Submitted by the DBA:**	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.210(a)(3)(i-ii) Contract 3.3.1.1(A-B)	1. Note to Reviewer – Policy Issue & Approval Dates 2. UM PP - Coverage and Authorization of Services: Page 1, Section: Purpose/Scope, Page 2, Section: Policy 3. 2020 UM Work Plan. Cite entire document. 4. 2021 UM Work Plan. Cite entire document. 5. Q1 2021 - NV QA Audit Committee Report. Cite entire document. 6. UM PP - Inter Rater Reliability Program: Page 1, Section: Purpose/Scope 7. Q4 2020 - LDP National Inter Rater Reliability. Cite entire document. 8. Q1 2021 - LDP National Inter Rater Reliability. Cite entire document. 9. UM Staff Attestation - NV (Examples). Cite entire document. 10. New Hire Manual - Clinical Services (Excerpts). Cite entire document.	
DBA Description of Process: LIBERTY ensures that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished and does 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 member, per 42 CFR §438.210(a)(3)(i-ii), and Contract 3.3.1.1(A-B). LIBERTY's *Coverage and Authorization of Services* policy (Evidence #2) ensures that LIBERTY provides coverage for dental services based solely on appropriateness of care, existence of coverage and in a manner sufficient in duration and scope reasonably expected to achieve the purpose for which the services are furnished. LIBERTY's UM Work Plan (Evidence #3, #4), QA Audit Committee Report (Evidence #5), Inter Rater Reliability Program (Evidence #6, #7, #8) and UM Staff Training (Evidence #8, #9, #10) demonstrate LIBERTY's ongoing monitoring and oversight of UM functions to ensure compliance with this requirement.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
3. The DBA may place appropriate limits on a service— a. On the basis of criteria applied under the State plan, such as medical necessity; or b. For the purpose of utilization control, provided that— i. The services furnished can reasonably achieve their purpose, as required in 42 CFR §438.210(a)(3)(i); ii. The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports (LTSS) are authorized in a manner that reflects the member's ongoing need for such services and supports. 42 CFR §438.210(a)(4)(i-ii)(A-B) Contract 3.3.1.1(C)	**HSAG Recommended Evidence:** • Policies and procedures • Utilization management plan • Member materials, such as the member handbook **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. UM PP - Coverage and Authorization of Services: Page 1, Section: Purpose/Scope, Page 3, Section A.5.b 3. 2020 UM Work Plan. Cite entire document. 4. 2021 UM Work Plan. Cite entire document. 5. LDP_NV_Medicaid_Member_Handbook_Standard VII, pages 26-28, section: What does your dental plan cover?; pages 28-29, section: What services does your plan not cover? • 2021 Member Handbook website link	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY places appropriate limits on a service, on the basis of criteria applied under the State plan, such as medical necessity; or for the purpose of utilization control, per 42 CFR §438.210(a)(4)(i-ii)(A-B) and Contract 3.3.1.1(C). LIBERTY's *Coverage and Authorization of Services* policy (Evidence #2) ensures that 1) LIBERTY provides coverage for dental services based solely on appropriateness of care, existence of coverage and in a manner sufficient in duration and scope reasonably expected to achieve the purpose for which the services are furnished; and 2) Dental necessity determinations are made in a consistent manner based on sound clinical evidence that is no more restrictive in amount, duration, and scope than the definitions provided by governing State or Federal statutes/regulations. LIBERTY's UM Work Plan (Evidence #3, #4) supports this requirement. LIBERTY's Member Handbook (Evidence #5) lists services that are or are not covered.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
4. The DBA specifies what constitutes "medically (dental) necessary services" in a manner that— a. Is no more restrictive than that used in the DHCFP Medicaid program, including quantitative and nonquantitative treatment limits, as indicated in DHCFP statutes and regulations, the DHCFP Plan, and other DHCFP policy and procedures; and b. Addresses the extent to which the DBA is responsible for covering services that address: i. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. ii. The ability for a member to achieve age-appropriate growth and development. iii. The ability for a member to attain, maintain, or regain functional capacity. 42 CFR §438.210(a)(5)(i-ii)(A-C) Contract 3.3.1.2	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. UM PP - Coverage and Authorization of Services: Page 1, Section: Definitions. 3. LDP_NV_Medicaid_Member_Handbook_Standard VII, page 24, section: Benefits and Services: What your dental plan covers • 2021 Member Handbook website link	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY specifies what constitutes "medically (dental) necessary services", per 42 CFR §438.210(a)(5)(i-ii)(A-C) and Contract 3.3.1.2. LIBERTY's *Coverage and Authorization of Services* policy (Evidence #2) specifies the definition of medical necessity consistent with this requirement, and LIBERTY's Member Handbook (Evidence #3) explains when care is medically necessary.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Authorization of Services		
5. For the processing of requests for initial and continuing authorizations of services, the DBA shall— a. Have in place, and follow, written policies and procedures. b. *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.* c. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions. d. Consult with the requesting provider for dental services when appropriate. e. Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's dental, behavioral health, or LTSS needs. 42 CFR §438.210(b)(1-3) Contract 3.3.1.3(A-B, D); 3.9.19.1; 3.9.19.2	**HSAG Recommended Evidence:** • Policies and procedures • Utilization Review Management Program Description • Utilization reports • Results of interrater reliability (IRR) activities • One case example of a peer-to-peer (P2P) consult • HSAG will also use the results of the service authorization denial file review. **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. UM PP - Coverage and Authorization of Services, Page 1, Section Purpose/Scope, Page 3, Section A.5.b, Page 4, Section B.2.a, Page 4, Section B.2.c.i. 3. SOP Peer to Peer Calls. Cite entire document. 4. Peer to Peer Example. Cite entire document. 5. 2021 Utilization Management Program Description: Page 4, Section: Utilization Management Program 6. UM PP - Inter Rater Reliability Program: Pge 1, Section: Purpose/Scope 7. Q4 2020 - LDP National Inter Rater Reliability. Cite entire document. 8. Q1 2021 - LDP National Inter Rater Reliability. Cite entire document.	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	9. 2020 Q4 - LDP NV UM Report_Redacted. Cite entire document. 10. 2021 Q1 - LDP NV UM Report_Redacted. Cite entire document. 11. Q1 2021 - NV QA Audit Committee Report. Cite entire document.	
DBA Description of Process: LIBERTY has in place, and follows, written policies and procedures and its written utilization review management program description, to ensure consistent application of review criteria, consultation with the requesting provider and to ensure decisions are made by appropriate staff, per 42 CFR §438.210(b)(1-3) and Contract 3.3.1.3(A-B, D); 3.9.19.1; 3.9.19.2. LIBERTY's *Coverage and Authorization of Services* policy and Utilization Management Program Description (Evidence #2, #5) support these requirements, as cited. LIBERTY's Peer-to-Peer review procedure are provided, together with a peer-to-peer example (Evidence #3, #4). Oversight of clinical decision making is provided (Evidence #6, #87 #8, #9, #10, #11).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
Notice of Adverse Benefit Determination		
6. The DBA must notify the requesting provider, and give the member written notice of any decision 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. The member's notice must meet the requirements of §438.404. The notice must explain the following: a. The adverse benefit determination (ABD) the DBA has made or intends to make. b. The reasons for the ABD, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's ABD. Such information includes	**HSAG Recommended Evidence:** • Policies and procedures • ABD notice template • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. UM PP – Coverage and Authorization of Services, Page 4, Section B.2.c	☐ Met ☒ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits. c. The member's right to request an appeal of the DBA's ABD, including information on exhausting the DBA's one level of appeal described at 42 CFR §438.402(b) and the right to request a State fair hearing consistent with 42 CFR §438.402(c). d. The procedures for exercising the rights specified in 42 CFR §438.404(b). e. The circumstances under which an appeal process can be expedited and how to request it. f. The member's right to have benefits continue pending resolution of the appeal; how to request that benefits be continued; and the circumstances, consistent with State policy, under which the member may be required to pay the costs of these services. 42 CFR §438.402(b-c); 438.404(b)(1-6) Contract 3.12.4.1; 3.12.4.3	3. UM PP - Process for Adverse Determinations, Page 3, Section Process/Procedure 4 4. NV MCD UM Member PE Sample-Eng. Cite entire document. 5. NV MCD UM Member PE Sample-Spa. Cite entire document.	
DBA Description of Process: LIBERTY notifies the requesting provider, and gives the member written notice of any decision by LIBERTY to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested, per 42 CFR §438.402(b-c); 438.404(b)(1-6) and Contract 3.12.4.1; 3.12.4.3. LIBERTY's *Coverage and Authorization of Services* and *Process for Adverse Determination* policies (Evidence #2, #3) ensure notification requirements are met. Samples of member notification templates are provided (Evidence #4, #5).		
HSAG Findings: The DBA's Coverage and Authorization of Services policy indicated that its adverse benefit determination (ABD) notices would include a description on the right to request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's ABD; however, the ABD notices reviewed as part of the case file review did not contain this information.		
Required Actions: The DBA must notify the requesting provider and give the member written notice of any decision 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. The notice must include all content required by 42 CFR §438.404, including a description of the member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's ABD.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Timing of Notice of Adverse Benefit Determination		
7. For termination, suspension, or reduction of previously authorized Medicaid-covered services, the DBA must mail the notice at least ten (10) days before the date of action. Additionally, the DBA must mail the notice no later than the date of action when: a. The DBA has factual information confirming the death of a member; b. The DBA receives a clear written statement signed by a member that: i. No longer wishes services; or ii. Gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information; c. The member has been admitted to an institution where he or she is ineligible under the plan for further services; d. The member's whereabouts are unknown, and the post office returns agency mail directed to him or her indicating no forwarding address; e. The DBA establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth; f. A change in the level of medical care is prescribed by the member's physician; g. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Social Security Act; or	**HSAG Recommended Evidence:** • Policies and procedures • ABD template(s) • Tracking and reporting mechanism(s) • HSAG will also use the results of the service authorization denial file review. **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. UM PP - Coverage and Authorization of Services, Page 3, Section B.2 3. UM PP - Timeliness Standards For UM Decisions: Page 4, Exhibit A. 4. NV MCD UM Mem PE Sample-Eng. Cite entire document. 5. NV MCD UM Mem PE Sample-Spa. Cite entire document. 6. UM PP - Tracking and Trending, Page 1, Section: Purpose/Scope, Page 4. 7. 2020 Q4 - Internal Audit Report_Redacted. Cite entire document. 8. 2021 Q1 - Internal Audit Report_Redacted. Cite entire document. 9. Sample Nevada Medicaid UM Timeliness Report 10. Q1 2021 - NV QA Audit Committee Report. Cite entire document.	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
h. The date of action will occur in less than ten (10) days, in accordance with 42 CFR §483.15(b)(4)(ii) and (b)(8), which provides exceptions to the thirty (30)-day notice requirements of 42 CFR §483.15(b)(4)(i) of this chapter. 42 CFR §431.211 42 CFR §431.213 42 CFR §438.404(c)(1) Contract 3.12.4.4-5		
DBA Description of Process: LIBERTY mails notifications in accordance with 42 CFR §431.211, 42 CFR §431.213, 42 CFR §438.404(c)(1) and Contract 3.12.4.4-5. LIBERTY's *Coverage and Authorization of Services* and *Timeliness Standards For UM Decisions* policy (Evidence #2, #3) ensures compliance with notification timeframes. ABD templates are provided (Evidence #4, #5). Evidence of tracking, reporting and oversight mechanisms to ensure timeliness of notifications is provided (Evidence #6, #7, #8, #9, #10).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element. **Recommendations:** Although the Coverage and Authorization of Services policy indicated that a written notice is sent to the requesting provider and the member anytime the DBA makes the decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested, the policy did not include language to support an ABD is also sent for reductions, suspensions, or terminations of previously authorized services and the associated time frames for sending the ABD notice. Although the DBA referenced the Timeliness Standards For UM Decisions policy as evidence to support compliance, this policy was not included in the documents submitted for the desk review process. HSAG requested additional information during the interview session to support compliance for this element, including the Timeliness Standards For UM Decisions policy; however, the policy was not submitted as requested. Instead, the DBA submitted the Withdrawal/Reduction of Services Request for Initial Determinations standard operating procedure (SOP) and a template notice for use when the DBA receives a request for a termination, suspension, or reduction of previously authorized services. The Withdrawal/Reduction of Services Request for Initial Determinations SOP included the process the DBA would take if the DBA receives a request from the member or provider to withdrawal or reduce previously approved services. The documented process included the steps the DBA would take, including sending a member and provider notification at least 10 calendar days before the date of action, when the action is termination, suspension, or reduction of previously authorized covered services. The SOP further stated that the DBA may shorten the time frame to five days if probable recipient fraud activity has been verified. The sample ABD notice included a service explanation indicating, "We have canceled the request for this service due to your request. If you would like this code looked at in the future, please have your dentist submit a new request." Although this documentation meets the intent of this requirement, HSAG strongly recommends that the DBA enhance its SOP, policies, and ABD notice service explanations to clearly support that terminations, reductions, and suspensions of previously authorized services are not only appropriate when the request to		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
terminate services are made by the member. The DBA may also terminate, reduce, and suspend services when services no longer meet medical necessity criteria, or if one of the exceptions noted in 42 CFR §431.213 or 42 CFR §431.214 apply. HSAG further recommends that the DBA's SOP and policies also include the exceptions to the 10-day advance notice as described in the applicable rules noted within this recommendation. Implementation of these recommendations will be further assessed during future compliance reviews.		
Required Actions: None.		
8. The DBA may shorten the period of advance notice to five (5) days before the date of action if: a. The DBA has facts indicating that action should be taken because of probable fraud by the member; and b. The facts have been verified, if possible, through secondary sources. 42 CFR §431.214 42 CFR §438.404(c)(1) Contract 3.12.4.4	**HSAG Recommended Evidence:** • Policies and procedures • ABD template(s) • Tracking and reporting mechanism(s) **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. UM PP - Coverage and Authorization of Services 3. NV MCD UM Mem PE Sample-Eng. Cite entire document. 4. NV MCD UM Mem PE Sample-Spa. Cite entire document. 5. UM PP - Tracking and Trending, Page 1, Section: Purpose/Scope, Page 4.	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY mails notifications in accordance with 42 CFR §431.214, 42 CFR §438.404(c)(1) and Contract 3.12.4.4. LIBERTY's *Coverage and Authorization of Services* - APPENDIX A (Evidence #2) specifies allowances to shorten the period of advance notice. Samples of member notification templates are provided (Evidence #3, #4). Evidence of tracking and reporting is provided (Evidence #5).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element. **Recommendations:** As indicated in element 7, HSAG strongly recommends that the DBA enhance its SOP, policies, and ABD notice service explanations to clearly support that terminations, reductions, and suspensions of previously authorized services are not only appropriate when the request to terminate services are made by the member. The DBA may also terminate, reduce, and suspend services when services no longer meet medical necessity criteria, or if one of the exceptions noted in 42 CFR §431.213 or 42 CFR §431.213 apply, including when the DBA has facts indicating that action should be taken		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
because of probable member fraud. HSAG further recommends that the DBA's SOP and policies also include the exceptions to the 10-day advance notice as described in the applicable rules noted within this recommendation. Implementation of these recommendations will be further assessed during future compliance reviews.		
Required Actions: None.		
9. For the denial of payment, the DBA must mail the notice at the time of any action affecting the claim. 42 CFR §438.404(c)(2) Contract 3.12.4.6	**HSAG Recommended Evidence:** • Policies and procedures • ABD template(s) • Tracking and reporting mechanism(s) • Workflow for payment denial on a claim to trigger an ABD notice • One case example of an ABD notice sent to a member for the denial of payment on a claim **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. CL PP - Mailing of Member and Provider Notifications. Cite entire document. 3. HSAG ABD CL EOB Sample-Eng. Cite entire document. 4. HSAG ABD CL EOB Sample-Spa. Cite entire document. 5. HSAG_NV_Medicaid ABD Live Sample. Cite entire document. 6. Claims Processing Workflow with funding process- 012618. Cite entire document. 7. Claim Action Timeliness Report. Cite entire document.	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
DBA Description of Process: For payment denials, LIBERTY mails the notice at the time of any action affecting the claim, per 42 CFR 438.404(c)(2) and Contract 3.12.4.6. LIBERTY's *Mailing of Member and Provider Notifications* policy (Evidence #2) describes the process for mailing member and provider notification, as cited. Sample notification templates and a live redacted ABD are provided (Evidence #3, #4, #5), as well as claims processing workflow and Claim Action Timeliness Report (Evidence #6, #7).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
10. For service authorization decisions not reached within the applicable time frame for standard or expedited requests (which constitutes a denial and is thus an ABD), the DBA must provide notice on the date that the time frames expire. 42 CFR §438.404(c)(5) Contract 3.12.4.7	**HSAG Recommended Evidence:** • Policies and procedures • ABD template(s) • Tracking and reporting mechanism(s) • One case example of an ABD notice sent to a member due to the DBA's failure to make a timely service authorization decision • HSAG will also use the results of the service authorization denial file review. **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. UM PP - Coverage and Authorization of Services: Page 3, Section B.2 3. UM PP - Timeliness Standards for UM Decisions: Page 4, Exhibit A 4. NV MCD UM Mem PE Sample-Eng. Cite entire document. 5. NV MCD UM Mem PE Sample-Spa. Cite entire document. 6. UM PP - Tracking and Trending, Page 1, Section: Purpose/Scope, Page 4.	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	7. Sample Nevada Medicaid UM Timeliness Report	
DBA Description of Process: LIBERTY complies with notification timeframes, per 42 CFR §438.404(c)(5) and Contract 3.12.4.7. LIBERTY's *Coverage and Authorization of Services* and *Timeliness Standards for UM Decisions* policies (Evidence #2, #3) specifies timeframes for notifications. Samples of member notification templates are provided (Evidence #4, #5). Evidence of tracking, reporting and oversight mechanisms to ensure timeliness of notifications is provided (Evidence #6, #7). **Please note,** during the look back period, LIBERTY processed all cases within the required time frame, therefore no case example is available.		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element. **Recommendations:** Although the DBA submitted policies for review to support compliance, the policy was either unavailable (Timeliness Standards for UM Decisions policy) or did not include the time frame the DBA adheres to when sending an ABD notice for service authorization determinations that have not been made within the standard or expedited time frames (Coverage and Authorization of Services policy). During the interview session, DBA staff members verbalized the process that would occur should a time frame not be met. After the site review, the DBA provided a sample ABD notice that included a denied service line explanation stating, "LIBERTY Dental Plan has 14 calendar days to process the request that was sent in by your dentist. If LIBERTY does not decide within 14 days, the request will be denied. LIBERTY Dental Plan was not able to decide by the time frame allowed. The request is denied." Although this language meets the intent of the requirement, HSAG strongly recommends that the DBA enhance its existing written documentation to clearly outline the process for sending ABD notices when decisions are made untimely. Additionally, staff members should be trained on this requirement to confirm all DBA utilization management staff members have an understanding that non-compliance with decision time frames constitute a denial, which requires an ABD notice. Implementation of these recommendations will be further assessed during future compliance reviews.		
Required Actions: None.		
Standard Authorization Decisions		
11. For standard authorization decisions, the DBA must provide notice as expeditiously as the member's condition requires and within DHCFP-established time frames that may not exceed 14 calendar days following receipt of the request for service.	**HSAG Recommended Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Service authorization log • HSAG will also use the results of the service authorization denial file review.	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.210(d)(1)(i-ii) Contract 3.12.3.1	**Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. UM PP - Coverage and Authorization of Services: Page 3, Section B.2 3. UM PP - Timeliness Standards for UM Decisions: Page 4, Exhibit A. 4. Sample Nevada Medicaid UM Timeliness Report 5. UM PP - Tracking and Trending, Page 1, Section: Purpose/Scope, Page 4. 6. 2020 Q4 - Internal Audit Report Redacted. Cite entire document. 7. 2021 Q1 - Internal Audit Report Redacted. Cite entire document.	
DBA Description of Process: LIBERTY complies with notification timeframes, per 42 CFR §438.210(d)(1)(i-ii) and Contract 3.12.3.1. LIBERTY's *Coverage and Authorization of Services* and *Timeliness Standards for UM Decisions* policies (Evidence #2, #3) specifies timeframes for notifications. A sample Nevada Medicaid UM Timeliness Report is provided (Evidence #4), as well as evidence of tracking, reporting and oversight mechanisms to ensure timeliness of notifications (Evidence #5, #6, #7).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		
Expedited Authorization Decisions		
12. For cases in which a provider indicates, or the DBA determines, that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the DBA must make an expedited authorization decision and provide notice as expeditiously as the member's health	**HSAG Recommended Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Service authorization log	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
condition requires and no later than seventy-two (72) hours after receipt of the request for service. 42 CFR §438.210(d)(2)(i-ii) Contract 3.12.3.2	• HSAG will also use the results of the service authorization denial file review. **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. UM PP - Emergency Dental Services Expedited Dental Services: Page 4 3. Sample Nevada Medicaid UM Timeliness Report 4. UM PP - Tracking and Trending, Page 1, Section: Purpose/Scope, Page 4. 5. 2020 Q4 - Internal Audit Report_Redacted. Cite entire document. 6. 2021 Q1 - Internal Audit Report_Redacted. Cite entire document.	
DBA Description of Process: LIBERTY complies with expedited timeframes, per 42 CFR §438.210(d)(2)(i-ii) and Contract 3.12.3.2. LIBERTY's *Emergency Dental Services Expedited Dental Services* policy (Evidence #2) ensures compliance with expedited timeframes, as cited. A sample Nevada Medicaid UM Timeliness Report is provided (Evidence #3), as well as evidence of tracking, reporting and oversight mechanisms to ensure timeliness of notifications (Evidence #4, #5, #6).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Extension of Time Frames		
13. The DBA may extend the review of a standard or expedited service authorization time frame up to fourteen (14) additional calendar days if— a. The member, or the provider, requests extension; or b. The DBA justifies (to DHCFP upon request) a need for additional information and how the extension is in the member's interest. 42 CFR §438.404(c)(4)(i-ii) Contract 3.12.3.1-2	**HSAG Recommended Evidence:** • Policies and procedures • Extension notice template(s) • One redacted copy of an extension notice and corresponding benefit determination notice **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. UM PP - Emergency Dental Services Expedited Dental Services, Page 4	☐ Met ☒ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with extension timeframes, per 42 CFR §438.404(c)(4)(i-ii) and Contract 3.12.3.1-2. LIBERTY's *Emergency Dental Services Expedited Dental Services* policy (Evidence #2) ensures compliance with extension timeframes, as cited. **Please note,** during the look back period, LIBERTY processed all cases within the initial required time frame, therefore no case example is available.		
HSAG Findings: Although the Emergency Dental Services/Expedited Dental Services policy indicated that the DBA may extend the 72-hour expedited authorization time frame by up to 14 calendar days if the member requests an extension or if the need for additional information and an extension is in the member's best interest, no evidence was submitted to support the extension process for a standard authorization. After the site review, the DBA provided the NV Medicaid Notice of Delay SOP and a sample extension notice that would be sent to the member if an extension was taken by the DBA. The Notice of Delay SOP was specific only to when a provider or member requested an extension advising they have additional information regarding the request. This SOP did not include the process that the DBA would take if they need additional information to support an authorization determination. The sample extension notice, although it indicated "Initial Notice of Delay," provided the member with appeal rights, instead of grievance rights as required by the regulation. Additionally, language within the notice appeared to require the member to send in records, which may be confusing to the member as the request for records should be to the provider. **Recommendations:** HSAG recommends that the DBA enhance its written documentation to describe the process that the DBA will take should it need to extend resolution time frames. The documentation should include the reasons that would constitute an extension and outline the steps the DBA would follow to be compliant with the extension requirements (e.g., written notice with grievance rights).		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Required Actions: The DBA may extend the review of a standard or expedited service authorization time frame up to 14 additional calendar days if the member, or the provider, requests an extension; or the DBA justifies (to DHCFP upon request) a need for additional information and how the extension is in the member's interest. The DBA's must submit documentation of the extension process and procedures.		
14. If the DBA meets the criteria set forth for extending the time frame for standard or expedited service authorization decisions, it must: a. Give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision; and b. Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 CFR §438.404(c)(4)(i-ii) Contract 3.12.3.1-2	**HSAG Recommended Evidence:** • Policies and procedures • Extension notice template(s) • One redacted copy of an extension notice and the corresponding benefit determination notice **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. UM PP - Emergency Dental Services Expedited Dental Services: Page 4 3. UM PP - Coverage and Authorization of Services: Page 4	☐ Met ☒ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with extension notification requirements, per 42 CFR §438.404(c)(4)(i-ii) and Contract 3.12.3.1-2. LIBERTY's *Emergency Dental Services Expedited Dental Services* and *Coverage and Authorization of Services* policies (Evidence #2, #3) ensure compliance with extension notification requirements, as cited. **Please note,** during the look back period, LIBERTY processed all cases within the initial required time frame, therefore no case example is available.		
HSAG Findings: The Coverage and Authorization of Services policy was provided as evidence; however, this policy did not include any documentation regarding the process that must occur when the time frame for standard or expedited service authorization decisions is extended. Although the Emergency Dental Services/Expedited Dental Services policy indicated that an extension can occur, this policy did not include the steps the DBA must take, including giving written notice to the member of the reason for extending the time frame and the member's right to file a grievance if he or she disagrees. After the site review, the DBA provided the NV Medicaid Notice of Delay SOP and a sample extension notice that would be sent to the member if an extension was taken by the DBA. The Notice of Delay SOP was specific only to when a provider or member requested an extension advising they have additional information regarding the request. This SOP did not include the process that the DBA would take if they need additional information to support an authorization determination. The sample extension notice, although it indicated "Initial Notice of Delay," provided the member with appeal rights, instead		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
of grievance rights as required by the regulation. Additionally, language within the notice appeared to require the member to send in records, which may be confusing to the member as the request for records should be to the provider. **Recommendations:** HSAG recommends that the DBA enhance its written documentation to describe the process that the DBA will take should it need to extend resolution time frames. The documentation should include the reasons that would constitute an extension and outline the steps the DBA would follow to be compliant with the extension requirements (e.g., written notice with grievance rights).		
Required Actions: If the DBA meets the criteria set forth for extending the time frame for standard or expedited service authorization decisions, it must give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision; and issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.		
Compensation for Utilization Management Activities		
15. The DBA must provide that, consistent with 42 CFR §§438.3(i), and 422.208, 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 member. 42 CFR §438.210(e) Contract 3.9.19.3(H)	**HSAG Recommended Evidence:** • Policies and procedures • New hire and ongoing training for staff • One example of a staff attestation **Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. UM PP - Coverage and Authorization of Services: Page 3, Section A.5.b.iii and Page 4, Section B 2b 3. UM PP - Appropriate Professionals: Pages 2-3, Section 10.a-e) 4. UM Staff Attestation - NV (Examples). Cite entire document.	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY ensures 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 member, per 42 CFR §438.210(e) and Contract 3.9.19.3(H). LIBERTY's *Coverage and Authorization of Services* and *Appropriate Professionals* policies (Evidence #2, #3) ensure that Financial or other incentives to deny, limit, or discontinue medically/dentally necessary services to any member is prohibited and all staff,		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
individuals and entities that are involved in utilization management activities make an affirmative statement regarding the policy each year. A sample staff attestation is provided (Evidence #4).		
HSAG Findings: HSAG has determined that the DBA has met the requirements for this element.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services						
Met	=	12	X	1	=	12
Not Met	=	3	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	15	Total Score		=	12
Total Score ÷ Total Applicable					=	80%

Appendix B. Corrective Action Plan

Following this page is a document HSAG developed for **LIBERTY** to use in preparing its CAP. For each of the requirements listed as *Not Met*, identify the following:

- Intervention(s) planned by your organization to achieve compliance with the requirement, including how the MCE will measure the effectiveness of the intervention.
- Individual(s) responsible for ensuring that the planned interventions are completed.
- Proposed timeline for completing each planned intervention.
- Evidence of compliance. This could include proposed revisions to policies and procedures, report templates, or other documentation, as needed.

This plan is due to DHCFP and HSAG no later than 30 calendar days following receipt of this final *State Fiscal Year 2021 Compliance Review* report.

SFY 2020–21 Compliance With Standards Review Tool CAP Template

Standard II—Member Rights and Member Information			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA[B-1]**	**Score**
Language and Format			
42 CFR §438.10(d)(3) Contract 3.5.1.1; 3.5.1.3	6. The DBA makes its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its particular service area. a. Written materials that are critical to obtaining services must also be made available in alternative formats upon request of the potential member or member at no cost, include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and include the toll-free and Telecommunications Device for the Deaf/TeleTYpewriter (TTY/TDY) telephone number of the DBA's member/customer service unit.	**Evidence as Submitted by the DBA:** 1. Letter to Reviewer - Policy Issue & Approval Dates 2. CU PP - Cultural and Linguistic Competency Program Compliance: Page 3, Section: Translation Services 3. CU PP - Translation of Written Informing Member Materials: Page 1, Section: Policy; Page 2, Section: Process/Procedure 4. LDP NV Medicaid Member Handbook SPANISH: Page 19 5. Nevada Medicaid Child. Cite entire document. 6. Nevada Medicaid Adult. Cite entire document. 7. NV MCD UM Member PE Sample-English Spanish. Cite entire template(s). 8. NV Medicaid GA Member Appeal Samples. Cite entire template(s)	☐ Met ☒ Not Met ☐ NA

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

Standard II—Member Rights and Member Information			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA[B-1]**	**Score**
	b. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost.		
	DBA Description of Process: LIBERTY ensures its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, are available in the prevalent non-English languages in the given service area, per 42 CFR §438.10(d)(3) and Contract 3.5.1.1; 3.5.1.3. LIBERTY's *Cultural and Linguistic Competency Program Compliance* policy (Evidence #2) ensures that LIBERTY shall maintain its policies and procedures as well as programs to monitor and evaluate compliance of the Cultural and Linguistic Competency Program consistent with state and federal regulations. LIBERTY's *Translation of Written Informing Member Materials* policy (Evidence #3) ensures that LIBERTY shall make vital member-informing materials available to all members and potential members in each Threshold language as applicable by each Program and state at no cost to the member. Per policy (Evidence #3), vital materials include but is not limited to: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices (Evidence #4, #5, #6, #7, #8).		
	HSAG Findings: The DBA included tag lines for most written critical materials; however, the taglines were not in a conspicuously visible font size in accordance with federal regulations, or in the case of the provider directory, the taglines were in a 6-point font size informing members that interpretation services were available. **Recommendations**: HSAG recommends that the DBA define "conspicuously visible" font size to be greater than a 12-point font to ensure that the taglines are clearly visible and stand out from the other text.		
	Required Actions: The DBA must ensure that written materials critical to obtaining services include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			

Appendix B. Corrective Action Plan
Nevada Division of Health Care Finance and Policy
State Fiscal Year 2021 MCE Compliance Review
for LIBERTY Dental Plan of Nevada, Inc.

Standard II—Member Rights and Member Information			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA[B-1]**	**Score**
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard VI—Coordination and Continuity of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
Care and Coordination of Services for All DBA Members			
42 CFR §438.208(b)(3)	3. The DBA shall: a. Make a best effort to conduct an initial screening of each member's needs, within ninety (90) days of the effective date of enrollment for all new members. b. Make subsequent attempts to conduct an initial screening of each member's needs if the initial attempt to contact the member is unsuccessful.	**Evidence as Submitted by the DBA:** 1. CM PP - Oral Health Risk Assessments, Page 1, Section: Process/Procedure 1-1a 2. Welcome Call Purpose NV Medicaid 3. Welcome Call Script NV Medicaid 4. Feb 2021 NV Medicaid Campaign Summary	☐ Met ☒ Not Met ☐ NA
	DBA Description of Process: LIBERTY makes best efforts to conduct an initial screening of each member's needs consistent with 42 CFR §438.208(b)(3). LIBERTY's *Oral Health Risk Assessments* policy specifies the process of conducting outreach to members within the first ninety (90) days of the effective date of enrollment (Evidence #1, #2, #3, #4).		
	HSAG Findings: The Oral Health Risk Assessments [OHRA] policy indicated that the DBA conducts outreach to each member within the first 90 days of the effective date of enrollment to conduct an initial screening to determine a member's care needs. However, the OHRA standing operating procedure (SOP) indicated that the OHRA is completed on all care management members (as opposed to all newly enrolled members as stated in the OHRA policy). Discussion during the interview session confirmed that the DBA is not conducting outreach on all newly enrolled members in an effort to complete the initial OHRA. Additionally, the OHRA SOP suggested that the DBA tracked the number of completed OHRAs; however, documentation did not support that this was occurring, which was confirmed by DBA staff members during the interview session. After the interview session, the DBA provided a narrative indicating that the federal requirement does not define "best efforts" and its contract with DHCFP does not require the administration of or define the provision of an OHRA; therefore, the DBA's process for sending members a welcome packet and making welcome calls to each member meets the requirement. However, while the welcome packet and welcome call educated members to contact member services for assistance, documentation and discussion with staff members did not confirm that an initial screening of each member's needs was completed. Further, the Case Management and Care Coordination Program Description suggested that each new member received a welcome letter and an OHRA form with a separate postage-paid envelope. However, the welcome letter did not include any information on completing an OHRA, and DBA staff members did not confirm that the OHRA was part of the member welcome packet.		

Standard VI—Coordination and Continuity of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	Recommendations: HSAG recommends that the DBA immediately develop mechanisms to conduct an initial screening of each member's needs within 90 days of the effective date of enrollment. The DBA could consider including the OHRA in each member's initial welcome packet for the members to complete and return to the DBA, and incorporating the OHRA during the initial welcome call to members. In addition to developing a reporting mechanism to track completion rates and completion timeliness, HSAG recommends that the DBA develop a process of screening the completed OHRAs to identify members who may have a special health care need and may benefit from care management.		
	Required Actions: The DBA must make a best effort to conduct an initial screening of each member's needs within 90 days of the effective date of enrollment for all new members and make subsequent attempts to conduct an initial screening of each member's needs if the initial attempt to contact the member is unsuccessful.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard VI—Coordination and Continuity of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
Special Health Care Needs: Assessment			
42 CFR §438.208(c)(2)	7. The DBA shall implement mechanisms to comprehensively assess each Medicaid member identified by DHCFP or the DBA as having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring.	**Evidence as Submitted by the DBA:** 1. CM PP - Coordination of Dental Services - NV, Page 2, section: Follow-up Assessment 2. CM PP - Oral Health Risk Assessments, Page 1, Section: Policy	☐ Met ☒ Not Met ☐ NA
	DBA Description of Process: LIBERTY has implemented mechanisms to comprehensively assess each Medicaid member identified by DHCFP or the DBA as having special health care needs, per 42 CFR §438.208(c)(2). LIBERTY's *Coordination of Dental Services* and *Oral Health Risk Assessments* policies (Evidence #1, #2) support LIBERTY's compliance with this requirement.		
	HSAG Findings: Documentation and discussion with staff members did not demonstrate a standardized process for completing a comprehensive assessment of members who have been identified as having a special health care need. After the interview session, a screenshot of a Health Risk Assessment was provided; however, it aligned with the initial OHRA and did not demonstrate that the DBA comprehensively assessed the member's needs. For example, the assessment indicated that the member had a special health care need; however, the special health care need was not identified or assessed.		
	Required Actions: The DBA must implement mechanisms to comprehensively assess each member identified as having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			

Standard VI—Coordination and Continuity of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard VI—Coordination and Continuity of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
Special Health Care Needs: Treatment/Service Plans			
42 CFR §438.208(c)(3)(iii-v) Contract 3.5.5.1	8. For members with special health care needs as required by DHCFP: a. The DBA's treatment or service plan shall be approved by the DBA in a timely manner, if this approval is required by the DBA. b. The DBA's plan shall be developed in accordance with any applicable DHCFP quality assurance and utilization review standards. c. DBA's treatment or service plan shall be reviewed and revised upon reassessment of functional need, at least every 12 months, or when the member's circumstances or needs change significantly, or at the request of the member.	**Evidence as Submitted by the DBA:** 1. CM PP - Coordination of Dental Services - NV, Page 1, Section: Policy; Page 3, Section: Services for Children who are under 21 years of age with Special Health Care Needs 2. CM PP - Oral Health Risk Assessments, Page 1, Section: Policy 3. SOP QM CM Oral Health Risk Assessment, Cite entire document 3. CM Job Descriptions 4. NV Case Example for Completed OHRA-Event Viewer 5. Case Management-NV Medicaid, 2021 Template	☐ Met ☒ Not Met ☐ NA
	DBA Description of Process: LIBERTY complies with the requirements under 42 CFR §438.208(c)(3)(iii-v) and Contract 3.5.5.1 concerning members with special health care needs. LIBERTY's *Coordination of Dental Services – NV* policy and related materials (Evidence #1, #2, #3, #5) support LIBERTY's compliance with this requirement, as evidenced by the case example provided (Evidence #4).		
	HSAG Findings: Information obtained through the review of documentation, the system demonstration, and discussion during the interview session was conflicting as it related to processes for the development and implementation of dental treatment and/or care plans. The Coordination of Dental Services policy required the DBA to produce a treatment plan for children with special health care needs. The care management job descriptions also required care managers to ensure treatment plans and dental care plans are included in a member's record. During the system demonstration, DBA staff members were unable to produce a treatment plan or a dental care plan. When asked to view the provider's treatment plan, DBA staff members directed		

Standard VI—Coordination and Continuity of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	HSAG reviewers to a list of claims history but not a treatment plan. Further, the DBA provided a blank nursing care plan; however, a completed version was not available. DBA staff members verbalized that they have recently identified opportunities for enhancing its care management program. Lastly, the Case Management and Care Coordination Program Description indicated that members in care management receive an individualized plan of care that includes prioritized goals that consider member and caregiver goals, preferences, and desired level of involvement in the care management plan; barriers to meeting goals or complying with the plan; referrals to resources and follow-up processes; development and communication of member self-management plans; assessment of member progress against the care management plan; and pre- and post-stabilization of dental care services. Documentation did not confirm that the DBA had implemented processes to develop an individualized care plan as stated in the program description.		
	Required Actions: For members with special health care needs, the DBA must develop a treatment or service plan in accordance with any applicable DHCFP quality assurance and utilization review standards. The DBA's treatment or service plan must be reviewed and revised upon reassessment of functional need, at least every 12 months, or when the member's circumstances or needs change significantly, or at the request of the member.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard VII—Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
Notice of Adverse Benefit Determination			
42 CFR §438.402(b-c); 438.404(b)(1-6) Contract 3.12.4.1; 3.12.4.3	6. The DBA must notify the requesting provider, and give the member written notice of any decision 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. The member's notice must meet the requirements of §438.404. The notice must explain the following: a. The adverse benefit determination (ABD) the DBA has made or intends to make. b. The reasons for the ABD, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's ABD. Such information includes medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits. c. The member's right to request an appeal of the DBA's ABD, including information on exhausting the DBA's one level of appeal described at 42 CFR §438.402(b) and the right to request a State fair hearing consistent with 42 CFR §438.402(c). d. The procedures for exercising the rights specified in 42 CFR §438.404(b). e. The circumstances under which an appeal process can be expedited and how to request it.	**Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. UM PP – Coverage and Authorization of Services, Page 4, Section B.2.c 3. UM PP - Process for Adverse Determinations, Page 3, Section Process/Procedure 4 4. NV MCD UM Member PE Sample-Eng. Cite entire document. 5. NV MCD UM Member PE Sample-Spa. Cite entire document.	☐ Met ☒ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	f. The member's right to have benefits continue pending resolution of the appeal; how to request that benefits be continued; and the circumstances, consistent with State policy, under which the member may be required to pay the costs of these services.		
	DBA Description of Process: LIBERTY notifies the requesting provider, and gives the member written notice of any decision by LIBERTY to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested, per 42 CFR §438.402(b-c); 438.404(b)(1-6) and Contract 3.12.4.1; 3.12.4.3. LIBERTY's *Coverage and Authorization of Services* and *Process for Adverse Determination* policies (Evidence #2, #3) ensure notification requirements are met. Samples of member notification templates are provided (Evidence #4, #5).		
	HSAG Findings: The DBA's Coverage and Authorization of Services policy indicated that its adverse benefit determination (ABD) notices would include a description on the right to request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's ABD; however, the ABD notices reviewed as part of the case file review did not contain this information.		
	Required Actions: The DBA must notify the requesting provider and give the member written notice of any decision 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. The notice must include all content required by 42 CFR §438.404, including a description of the member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's ABD.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			

Standard VII—Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard VII—Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
Extension of Time Frames			
42 CFR §438.404(c)(4)(i-ii) Contract 3.12.3.1-2	13. The DBA may extend the review of a standard or expedited service authorization time frame up to fourteen (14) additional calendar days if— a. The member, or the provider, requests extension; or b. The DBA justifies (to DHCFP upon request) a need for additional information and how the extension is in the member's interest.	**Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. UM PP - Emergency Dental Services Expedited Dental Services, Page 4	☐ Met ☒ Not Met ☐ NA
	DBA Description of Process: LIBERTY complies with extension timeframes, per 42 CFR §438.404(c)(4)(i-ii) and Contract 3.12.3.1-2. LIBERTY's *Emergency Dental Services Expedited Dental Services* policy (Evidence #2) ensures compliance with extension timeframes, as cited. **Please note,** during the look back period, LIBERTY processed all cases within the initial required time frame, therefore no case example is available.		
	HSAG Findings: Although the Emergency Dental Services/Expedited Dental Services policy indicated that the DBA may extend the 72-hour expedited authorization time frame by up to 14 calendar days if the member requests an extension or if the need for additional information and an extension is in the member's best interest, no evidence was submitted to support the extension process for a standard authorization. After the site review, the DBA provided the NV Medicaid Notice of Delay SOP and a sample extension notice that would be sent to the member if an extension was taken by the DBA. The Notice of Delay SOP was specific only to when a provider or member requested an extension advising they have additional information regarding the request. This SOP did not include the process that the DBA would take if they need additional information to support an authorization determination. The sample extension notice, although it indicated "Initial Notice of Delay," provided the member with appeal rights, instead of grievance rights as required by the regulation. Additionally, language within the notice appeared to require the member to send in records, which may be confusing to the member as the request for records should be to the provider. **Recommendations:** HSAG recommends that the DBA enhance its written documentation to describe the process that the DBA will take should it need to extend resolution time frames. The documentation should include the reasons that would constitute		

Standard VII—Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	an extension and outline the steps the DBA would follow to be compliant with the extension requirements (e.g., written notice with grievance rights).		
	Required Actions: The DBA may extend the review of a standard or expedited service authorization time frame up to 14 additional calendar days if the member, or the provider, requests an extension; or the DBA justifies (to DHCFP upon request) a need for additional information and how the extension is in the member's interest. The DBA's must submit documentation of the extension process and procedures.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard VII—Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
Extension of Time Frames			
42 CFR §438.404(c)(4)(i-ii) Contract 3.12.3.1-2	14. If the DBA meets the criteria set forth for extending the time frame for standard or expedited service authorization decisions, it must: a. Give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision; and b. Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.	**Evidence as Submitted by the DBA:** 1. Note to Reviewer – Policy Issue & Approval Dates 2. UM PP - Emergency Dental Services Expedited Dental Services: Page 4 3. UM PP - Coverage and Authorization of Services: Page 4	☐ Met ☒ Not Met ☐ NA
	DBA Description of Process: LIBERTY complies with extension notification requirements, per 42 CFR §438.404(c)(4)(i-ii) and Contract 3.12.3.1-2. LIBERTY's *Emergency Dental Services Expedited Dental Services* and *Coverage and Authorization of Services* policies (Evidence #2, #3) ensure compliance with extension notification requirements, as cited. **Please note,** during the look back period, LIBERTY processed all cases within the initial required time frame, therefore no case example is available.		
	HSAG Findings: The Coverage and Authorization of Services policy was provided as evidence; however, this policy did not include any documentation regarding the process that must occur when the time frame for standard or expedited service authorization decisions is extended. Although the Emergency Dental Services/Expedited Dental Services policy indicated that an extension can occur, this policy did not include the steps the DBA must take, including giving written notice to the member of the reason for extending the time frame and the member's right to file a grievance if he or she disagrees. After the site review, the DBA provided the NV Medicaid Notice of Delay SOP and a sample extension notice that would be sent to the member if an extension was taken by the DBA. The Notice of Delay SOP was specific only to when a provider or member requested an extension advising they have additional information regarding the request. This SOP did not include the process that the DBA would take if they need additional information to support an authorization determination. The sample extension		

Standard VII—Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	notice, although it indicated "Initial Notice of Delay," provided the member with appeal rights, instead of grievance rights as required by the regulation. Additionally, language within the notice appeared to require the member to send in records, which may be confusing to the member as the request for records should be to the provider. **Recommendations:** HSAG recommends that the DBA enhance its written documentation to describe the process that the DBA will take should it need to extend resolution time frames. The documentation should include the reasons that would constitute an extension and outline the steps the DBA would follow to be compliant with the extension requirements (e.g., written notice with grievance rights).		
	Required Actions: If the DBA meets the criteria set forth for extending the time frame for standard or expedited service authorization decisions, it must give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision; and issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted