Division of Health Care Financing and Policy
Nevada Medicaid Managed Care

State Fiscal Year 2019–2020 Compliance Review

for

SilverSummit Healthplan, Inc.

December 2020

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

According to federal requirements located within Title 42 of the Code of Federal Regulations (CFR), 42 CFR §438.358, the state, an agent that is not a Medicaid managed care entity, or its external quality review organization (EQRO) must conduct a review to determine a managed care organization's (MCO's) compliance with the standards set forth in 42 CFR §438—Managed Care Subpart D and the quality assessment and performance improvement requirements described in 42 CFR §438.330. To comply with the federal requirements, the Nevada Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (the DHCFP) contracted with Health Services Advisory Group, Inc. (HSAG), to conduct compliance reviews of the MCOs managing the acute, primary, behavioral health, pharmacy, and other medical services for Nevada Medicaid and Nevada Check Up members. Nevada Check Up is the State's Child Health Insurance Program (CHIP) managed care program.

The purpose of the state fiscal year (SFY) 2019–2020 Compliance Review was to assess each MCO's compliance with the federal compliance review standards and the State contract requirements found in the DHCFP Contract 3260. The SFY 2019–2020 Compliance Review focused on the requirements for managed care operations. The review period was July 1, 2019 through December 31, 2019. This report details **SilverSummit Healthplan, Inc.** (**SilverSummit**)'s compliance review results as documented in the following compliance review tools:

- **Standards**: State and federal managed care requirements, which were categorized into four contract standards.
- **Corrective Action Plan (CAP) Review**: standards reviewed during the previous two years (SFY 2017–2018 and SFY 2018–2019) that received a score of *Partially Met* or *Not Met* and required the MCO to submit a CAP.

SilverSummit had an overall compliance score of 94 percent for all elements evaluated in the SFY 2019–2020 Compliance Review. Additionally, 11 out of 11 CAP elements were determined to be complete, indicating these prior deficiencies were remediated. Based on the findings of the review, **SilverSummit** demonstrated strong compliance with the federal and State requirements contained in its managed care contract.

2. Background

In July 2016, the State of Nevada, Purchasing Division, on behalf of the DHCFP, a Division of the State of Nevada, Department of Health and Human Services, solicited responses from qualified vendors to provide risk-based capitated MCO services designed in support of Title XIX (Medicaid) and Title XXI (CHIP—also known as "Nevada Check Up") medical assistance programs. In response to Request for Proposal (RFP) 3260, the DHCFP contracted with three MCOs to provide services to Medicaid and Nevada Check Up recipients.

Mandatory Activity

According to 42 CFR §438.358, which describes the activities related to EQRs, a state or its EQRO must conduct a review within a three-year period to determine a Medicaid MCO's compliance with federal standards and standards established by the State for access to care, structure and operations, and quality measurement and improvement. These standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR §438. To meet this requirement, the DHCFP contracted with HSAG to initiate a new three-year cycle of reviews starting in SFY 2017–2018, to complete a comprehensive review of compliance with State and federal standards within the three-year period. The full review schedule is detailed in Table 2-1.

Table 2-1—Nevada Compliance Review Cycle for SilverSummit

Standard	Year 1 SFY 2017–2018	Year 2 SFY 2018–2019	Year 3 SFY 2019–2020
Provider Network Management			
I. Credentialing and Recredentialing	✓		
II. Availability and Accessibility of Services	✓		
III. Subcontracts and Delegation	✓		
IV. Provider Dispute and Complaint Resolution	✓		
V. Provider Information	✓		
Member Services and Experiences			
VI. Member Rights and Responsibilities		✓	
VII. Member Information		✓	
VIII. Continuity and Coordination of Care		✓	
IX. Grievances and Appeals		✓	
X. Coverage and Authorization of Services		✓	

Standard	Year 1 SFY 2017–2018	Year 2 SFY 2018–2019	Year 3 SFY 2019–2020
Managed Care Operations			
XI. Internal Quality Assurance Program			✓
XII. Cultural Competency Program			✓
XIII. Confidentiality			✓
XIV. Enrollment and Disenrollment			✓
XV. Program Integrity*			✓*

* Standard XV—Program Integrity was not reviewed by HSAG as the State conducted this review.

Purpose of the Review

The purpose of the SFY 2019–2020 Compliance Review was to determine **SilverSummit**'s compliance with federal and State Medicaid managed care standards related to managed care operations. The review period was July 1, 2019, through December 31, 2019. Additionally, the SFY 2019–2020 Compliance Review included a review of elements found to be deficient in years 1 and 2 of the compliance review cycle. The purpose of this review was to ensure that all action plans put in place to remediate the deficiencies were implemented, and that all elements within each of the standards reviewed during the three-year cycle are compliant.

3. Methodology

Compliance Review Process

The compliance standards were derived from the requirements as set forth in the *Department of Health and Human Services, Division of Health Care Financing and Policy Request for Proposal No. 3260 for Managed Care*, and all attachments and amendments in effect during the review period of July 1, 2019, through December 31, 2019. HSAG followed the guidelines set forth in CMS' *EQR Protocol 3: Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019[3-1] to create the process, tools, and interview questions used for the SFY 2019–2020 Compliance Review.

Methods for Data Collection

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and requirements outlined in the contract between the DHCFP and the MCOs. HSAG conducted the following activities as part of the compliance review:

Pre-review activities included:

- Developing the compliance review tools.
- Preparing and forwarding to each MCO a customized desk review form, instructions for completing the form, and instructions for submitting the requested documentation to HSAG for its desk review.
- Developing the managed care entity (MCE) questionnaire.
- Conducting a technical assistance session to assist the MCO in preparing for the compliance review.
- Scheduling the review.
- Developing the agenda for the review.
- Providing the detailed agenda and the data collection (compliance review) tool to each MCO to facilitate preparation for HSAG's review.
- Conducting a desk review of documents. HSAG conducted a desk review of key documents and other information obtained from the DHCFP, and of documents that each MCO submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of each MCO's operations, identify areas needing clarification, and begin compiling information before the virtual review.

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 9, 2020.

Virtual review activities included:[3-2]

- An opening conference with introductions as well as a review of the agenda and logistics for HSAG's review activities.
- A review of the data systems that each MCO used in its operations, which includes, but is not limited to, quality improvement tracking and quality measure reporting.
- Interviews conducted with each MCO's key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their general findings.

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

Post review activities: HSAG reviewers aggregated findings to produce this comprehensive compliance review report. In addition, HSAG created a CAP template, shown in Appendix C, which contains the findings and required actions for each element scored *Partially Met* or *Not Met*. When submitting its CAP to the DHCFP, the MCO must use this template to propose its plan to bring all elements scored *Partially Met* or *Not Met* into compliance with the applicable standard(s). **SilverSummit** must submit its CAP to the DHCFP **within 30 calendar days of receiving this report.**

Description of Data Obtained

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

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- The provider manual and other MCO communication to providers and subcontractors.
- Narrative and/or data reports across a broad range of performance and content areas.
- Written plans that guide specific operational areas, which included but were not limited to utilization management, quality management, health management, and cultural competency.
- An MCE questionnaire.

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with each MCO's key staff members during the virtual review.

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

Compliance Standards Reviewed

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

Table 3-1—Compliance Standards

Standard #	Standard Name	Number of Elements
XI	Internal Quality Assurance Program	21
XII	Cultural Competency Program	17
XIII	Confidentiality	11
XIV	Enrollment and Disenrollment	8
	Total Number of Elements	**57**

Data Aggregation and Analysis

Compliance Standards

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which each MCO's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCO during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *EQR Protocol 3: Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019 (cited earlier in the report). The protocol describes the scoring as follows:

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

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

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

Aggregating the Scores

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

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

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

Compliance Standards

From a review of documents, observations, and interviews with key health plan staff conducted during the virtual evaluation, the reviewers assigned **SilverSummit** a score for each element and an aggregate score for each standard. Table 4-1 presents **SilverSummit**'s scores for the compliance standards. Details regarding **SilverSummit**'s compliance with the four standards, including the score that **SilverSummit** received for each element within each standard, are found in Appendix A, SFY 2019–2020 Compliance Review Tool for **SilverSummit**.

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

Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				M	*PM*	*NM*	*NA*	
XI	Internal Quality Assurance Program	21	20	19	1	0	1	98%
XII	Cultural Competency Program	17	17	15	2	0	0	94%
XIII	Confidentiality	11	11	11	0	0	0	100%
XIV	Enrollment and Disenrollment	8	8	5	2	1	0	75%
Total Compliance Score		**57**	**56**	**50**	**5**	**1**	**1**	**94%**

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

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

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

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

The findings from the compliance review show how well an MCO has interpreted federal regulations and the managed care contract requirements and developed the necessary policies, procedures, and plans to carry out the required functions of the MCO. **SilverSummit** achieved full compliance in one of the four standards reviewed, demonstrating strengths and adherence to all requirements measured in the area of Confidentiality. The area with the greatest opportunity for improvement was related to Enrollment and Disenrollment, as this area received a performance score under 90 percent.

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

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

CAP Review

SilverSummit was required to submit to the DHCFP a CAP for all elements scored *Partially Met* or *Not Met* in years 1 and 2 of the three-year compliance review cycle. To ensure the MCO had implemented plans of action to remediate the previously identified deficiencies, the DHCFP requested that HSAG conduct a follow-up review of the CAPs developed as a result of the deficiencies identified through the SFY 2017–2018 and SFY 2018–2019 compliance reviews.

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

Table 4-2—Summary of Scores for the SFY 2017–2018 and SFY 2018–2019 CAP Reviews

Standard #	Standard Name	Total CAP Elements	Total Number of Elements Scored	
			M	*NM*
I	Credentialing and Recredentialing	NA	NA	NA
II	Availability and Accessibility of Services	1	1	0
III	Subcontracts and Delegation	NA	NA	NA
IV	Provider Dispute and Complaint Resolution	NA	NA	NA
V	Provider Information	NA	NA	NA
VI	Member Rights and Responsibilities	3	3	0
VII	Member Information	1	1	0
VIII	Continuity and Coordination of Care	3	3	0
IX	Grievances and Appeals	2	2	0
X	Coverage and Authorization of Services	1	1	0
	Total	**11**	**11**	**0**

M=*Met* and ***NM***=*Not Met*

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

Total Number of Elements Scored: The number of elements that received a score of *M* or *NM* for each standard reviewed.

NA: The MCO did not have any deficiencies noted for this standard during the SFY 2017–2018 and SFY 2018–2019 reviews.

Of the 11 total elements reviewed, the MCO demonstrated compliance and received a score of *Met* for all elements reviewed. Details regarding **SilverSummit**'s compliance with the CAP review are found in Appendix B, 2020 Corrective Action Plan Compliance Review Tool.

5. Corrective Action Plan

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

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

- The completeness of the CAP document in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific plans of action/interventions that the MCO will implement to bring the element into compliance.
- The degree to which the planned activities/interventions meet the intent of the requirement.
- The degree to which the planned interventions are anticipated to bring the MCO 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 MCO until approved by the DHCFP. Implementation of the CAP may begin once approval is received. The DHCFP maintains ultimate authority for approving or disapproving any corrective action strategies proposed by **SilverSummit** in its submitted CAP.

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
42 CFR §438.330(a)(1) *DHCFP Contract Section 3.10.6, 3.10.6.1-2, 3.10.6.4, 3.10.6.5*	1. Written IQAP Description The MCO must establish and implement an ongoing comprehensive IQAP. *a) The MCO must have a written description of its IQAP.* *b) The written description must contain a detailed set of QA objectives, which are developed annually and include a timetable for implementation and accomplishment.* *c) The written description must provide for continuous performance of the activities, including tracking of issues over time.* *d) The written description must specify quality of care studies and other activities to be undertaken over a prescribed period of time, and methodologies and organizational arrangements to be used to accomplish them. Individuals responsible for the studies and other activities must be clearly identified and qualified to develop the studies and analyze outcomes.*	**Documents Submitted:** *Element 1a* • NV.QI.01 Internal Quality Assurance Program (entire document) • 2019 IQAP Work Plan (entire document) *Element 1b* • NV.QI.01 Internal Quality Assurance Program (pgs. 2-3 Objectives) *Element 1c* • NV.QI.01 Internal Quality Assurance Program (pgs. 23, 31-32) *Element 1d* • NV.QI.01 Internal Quality Assurance Program (pgs. 31-32) • PIP Follow Up After ED Visit Mental Health Diagnosis (Modules 1 through 5) • PIP Increase 3 to 6 YO Well Child Visits (Modules 1 through 5) • PIP Increase Health Risk Screenings (Module 2, data collection responsibilities)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		• PIP Increase Postpartum Visits (14 to 56 days) (Module 1) • PIP Increased Primary Care Access for Homeless Population (Module 1) **Description of Process:** The *NV.QI.01 Internal Quality Assurance Program* and the *2019 IQAP Work Plan* provide the MCO's full IQAP description. Pages 2-3 of the *NV.QI.01 Internal Quality Assurance Program* provide the established QA objectives. These are not all-inclusive, but establish a system that promotes continuous quality improvement, clinical indicators that are evidenced based, conducting studies based on our member's needs, etc. Pages 31-32 of the *NV.QI.01 Internal Quality Assurance Program* detail Performance Improvement Activities including our approach to identifying, data, methodology, committees and responsible parties. • *Increase Postpartum Visits (14 to 56 days)* includes Module 1 • *Increase Health Risk Screenings* includes Module 1 and Module 2	

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		• *Increased Primary Care Access for Homeless Population* includes Module 1 and Module 2 • Two State-issued PIPS (*Follow Up After ED Visit Mental Health Diagnosis* and *Increase 3 to 6 YO Well Child Visits*) includes Modules 1-5; both were completed and finalized in 2019. The *2019 IQAP Work Plan* details the activities undertaken by SSHP in 2019 to meet the scope, goals, and objectives of the IQAP.	
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** As the MCO continues to service the Medicaid population in the State of Nevada, HSAG recommends that it consider long-term trends in activities; for example, a three-year or a five-year trend, which could provide meaningful and actionable data on positive or negative trends over time. Additionally, HSAG recommends that the MCO consider developing an Internal Quality Assurance Program (IQAP) description and work plan specific to the Medicaid line of business (LOB) in addition to the evaluation.		
	Required Actions: None.		
42 CFR §438.330(a)(1) *DHCFP Contract Section 3.10.6.3 (A-B)*	2. Scope *a) The scope of the IQAP must be comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service. Scope must also include availability, accessibility, coordination, and continuity of care.*	**Documents Submitted:** *Element 2a* • NV.QI.01 Internal Quality Assurance Program (pgs. 1-2) *Element 2b* • Annual Population Assessment report (pgs.1, 24)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	b) *The IQAP methodology must provide for review of the entire range of care provided by the MCO, including services provided to Children with Special Health Care Needs (CSHCN), by assuring that all demographic groups, care settings (e.g., inpatient, ambulatory, including care provided in private practice offices and home care); and types of services (e.g., preventive, primary, specialty care, and ancillary) are included in the scope of the review. The review of the entire range of care is expected to be carried out over multiple review periods and not on a concurrent basis. (The DHCFP expects that this review occurs no less than annually.)*	• Continuity and Coordination Process and Monitoring report (p.1) • Practitioner Accessibility of Services report **Description of Process:** Pages 1 and 2 of the *NV.QI.01 Internal Quality Assurance Program* describe the scope of the IQAP, including both the quality and safety of clinical care, and the quality of services provided by SSHP. The *Practitioner Accessibility of Services* report addresses availability and accessibility of care as evaluated through the CAHPS[A-2] survey and telephone surveys. The *Continuity and Coordination Process and Monitoring* report provides a summary of focus areas for Children with Special Health Care Needs including behavioral health and medical care. The *Annual Population Assessment* report outlines the analysis completed on the needs and characteristics of our membership including those identified with special needs.	

[A-2] CAHPS® refers to the Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** HSAG recommends that the MCO clearly define its CSHCN population in its IQAP description. This should align with the State's definition.		
	Required Actions: None.		
42 CFR §438.330(b)(3) *DHCFP Contract Section 3.10.8.1 (D)*	3. Over- and Under-Utilization of Services The comprehensive IQAP must include mechanisms to asses both underutilization and overutilization of services, and to follow up appropriately. *a) If fraud and abuse is suspected, a referral must be made to the MCO's PIU and the DHCFP SUR Unit for appropriate action.*	**Documents Submitted:** • 2019 IQAP Program Evaluation (pgs.1, 3, 6, 35- 37) • BH QI Utilization Performance Metrics • Medicaid Frequent Flyer Aug 2019 • Member Characteristics and Utilization • Opioid Prescribing Practices letter • SIU Preliminary Report (pgs.1, 8) • SIU Preliminary Report Claims Detail **Description of Process:** The *Member Characteristics and Utilization*, the *BH QI Utilization Performance Metrics*, and the *Medicaid Frequent Flyer* reports are used to detect over- and under-utilization The *SIU Preliminary Report* and the associated *SIU Preliminary Report Claims Detail* give details on providers that have been identified as billing excessively. Cases are referred to the DHCFP SUR unit as appropriate.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		The *Opioid Prescribing Practices* letter notified a provider that they may not be prescribing appropriately and may be over utilizing a medication outside the DUR standards The *2019 IQAP Program Evaluation* details SSHP's activities to assess under- and over-utilization of services. Page 1 describes our systematic approach to over and underutilization. Page 3 describes our 2019 activities related to over utilization of ER services. Page 6 provides details of number of cases under investigation by SIU for possible over utilization. Pages 35 to 37 provide details about or Disease Management (DM) program, the members participating in DM programs, and the pilot On.Demand diabetes management program.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.330(b)(4) *DHCFP Contract Section 3.10.8.3 (B)*	4. Special Health Care Needs The comprehensive IQAP must include mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *a) Multi-disciplinary teams are required, when appropriate, to analyze and address systems issues.*	**Documents Submitted:** *Requirement 4* • NV.QI.01 Internal Quality Assurance Program (p.1) • Annual Quality Program Evaluation (2019)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		• Continuity and Coordination Process and Monitoring report • PIT Committee Minutes (pgs.17, 19) **Description of Process:** Page 1 of the *NV.QI.01 Internal Quality Assurance Program* describes our systematic approach to quality in meeting the needs of our members. The *Continuity and Coordination Process and Monitoring report* evaluates the effectiveness of SSHP's coordination between medical and behavioral care. The *Annual Quality Program Evaluation* provides details around Performance Improvement Projects to Increase PCP Visits for the Homeless Population (page 18) ; and five different HEDIS[A-3] measures focused on during 2019 related to the special health care needs of our members: • Antipsychotics in Children and Adolescents (pgs. 39-40) • Behavioral Health Disorders (pgs. 43-44) • ADHD Medication (pgs. 44-46)	

[A-3] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		• Co-Existing Medical and BH Disorders (pgs. 46-47) • Special Needs of Members with SPMI (pgs. 48-49) The *PIT Committee Minutes* demonstrate use of a multi-disciplinary team that reviews and analyzes our effectiveness in meeting the special health care needs of our members.	
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendation:** HSAG recommends that the MCO clearly define its special health care needs population in its IQAP. This should align with the State's definition.		
	Required Actions: None.		
42 CFR §438.330(b)(5)	5. Long-Term Services and Supports (LTSS) For MCOs providing LTSS: a) The IQAP must include mechanisms to assess the quality and appropriateness of care furnished to members using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the recipient's treatment/service plan. b) Participate in efforts by DHCFP to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per §§441.302 and 441.730(a) of this chapter) that are based, at a minimum, on the requirements on DHCFP for home and community-based waiver programs.	**Documents Submitted:** **Description of Process:** SSHP did not provide LTSS services during this audit period.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	Findings: This element was informational only and, therefore, deemed *N/A* for this review. The MCO should be prepared to have this element scored during future compliance reviews.		
	Required Actions: None.		
42 CFR §438.330(c)(2)(i-iii)	6. Performance Measurement The MCO must annually: a) Measure and report to DHCFP on its performance, using standard measures required by DHCFP. b) Submit to DHCFP data, specified by DHCFP, which enables DHCFP to calculate the MCO's performance using the standard measures identified by DHCFP. c) Perform a combination of the above activities.	**Documents Submitted:** *Requirement 6* • PIP Follow Up After ED Visit Mental Health Diagnosis (pgs. 1, 7, 12, 23-25, 36, 49, 59, 65) • PIP Increase Health Risk Screenings (pgs. 1, 2, 3, 4) • PIP Increase 3 to 6 YO Well Child Visits (pgs.1, 7, 12, 34, 35, 43, 49) • PIP Increase Postpartum Visits (14 to 56 days) (page 1) • PIP Increased Primary Care Access for Homeless Population (pgs.1, 3-6) **Description of Process:** Three PIPs (*Increase Postpartum Visits, Increase Health Risk Screenings,* and *Increased Primary Care Access for Homeless Population*) are internal PIPs identified from members of the PIT committee as areas of opportunity to improve member outcomes. These three PIPs were started in 2019 and are in various stages using the rapid cycle process. The two other PIPs (*Follow Up After ED Visit Mental Health Diagnosis* and *Increase 3 to 6*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		YO Well Child Visits) are the State-assigned PIPs that were conducted and completed from 2017-2019.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.10.8.1	7. Quality Indicators *Quality indicators are measurable variables relating to a specified clinical or health services delivery area, which are reviewed over a period of time to monitor the process or outcomes of care delivered in that area. The MCO is required to:* *a) Identify and use quality indicators that are objective, measurable, and based on current knowledge and clinical experience.* *b) Monitor and evaluate quality of care through studies which include, but are not limited to, the quality indicators also specified by the CMS, with respect to the priority areas selected by DHCFP.* *c) Ensure methods and frequency of data collection; ensure data accuracy; and ensure data is effective and sufficient to detect the need for program change.*	**Documents Submitted:** *Elements 7a and 7b* • PIP Follow Up After ED Visit Mental Health Diagnosis (pgs.1, 7, 12, 23-25, 36, 49, 59, 65) • PIP Increase 3 to 6 YO Well Child Visits (pgs.1, 7, 12, 34, 35, 43, 49) • PIP Increase Health Risk Screenings (pgs. 1, 2, 3, 4) • PIP Increase Postpartum Visits (14 to 56 days) (page 1) • PIP Increased Primary Care Access for Homeless Population (pgs. 3, 4, 6, 7) *Element 7c* • BH QI Utilization Performance Metrics • Denodo Process Flow • HEDIS Data Rates Nov 2019 • Medicaid Frequent Flyer Aug 2019 • Member Characteristics and Utilization	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		Description of Process: For elements 7a and 7b, • *Increase Postpartum Visits (14 to 56 days)* includes Module 1 • *Increase Health Risk Screenings* includes Module 1 and Module 2 • *Increased Primary Care Access for Homeless Population* includes Module 1 and Module 2 • Two State-issued PIPS (*Follow Up After ED Visit Mental Health Diagnosis* and *Increase 3 to 6 YO Well Child Visits*) includes Modules 1-5; both were completed and finalized in 2019. For element 7c, the *Denodo Process Flow* is used by SSHP to ensure our method of HEDIS data collection is accurate and complete. The *HEDIS Data Rates Nov 2019* are used to determine program changes needed related to members and quality health care. *The Member Characteristics and Utilization* report is used to detect under and over utilization. *BH QI Utilization Performance Metrics* provide data for evaluating over- and underutilization.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	Recommendations: While performance standards or goals were included in the IQAP evaluation, HSAG recommends that the MCO consider identifying and including objective and measurable goals in its IQAP work plan. The annual IQAP evaluation should coincide with those goals identified in the work plan. Additionally, HSAG recommends that the MCO enhance processes to set meaningful, objective, and measurable data-driven performance indicators.		
	Required Actions: None.		
42 CFR §438.330(d)(1), (2)(i-iv) *DHCFP Contract Section 3.10.7.6-7*	8. Performance Improvement Projects (PIPs) The comprehensive IQAP must include PIPs, including any PIPs that focus on clinical and non-clinical areas. Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and recipient satisfaction and must include the following elements: a) Measurement of performance using objective quality indicators. b) Implementation of interventions to achieve improvement in the access to and quality of care. c) Evaluation of the effectiveness of the interventions based on the performance measures. d) Planning and initiation of activities for increasing or sustaining improvement.	**Documents Submitted:** • Annual Quality Program Evaluation (2019) • NV.QI.01 Internal Quality Assurance Program • PIP Follow Up After ED Visit Mental Health Dx • PIP Increase 3 to 6 YO Well Child Visits • PIP Increase Health Risk Screenings • PIP Increase Postpartum Visits (14 to 56 days) • PIP Increased Primary Care Access for Homeless **Description of Process:** Pages 31-32 of the *NV.QI.01 Internal Quality Assurance Program* detail the process for Performance Improvement Projects. Pages 16-20 of the *Annual Quality Program Evaluation (2019)* provides overall details of	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		the three internal PIPs and two State-mandated PIPS. • *PIP Increase Postpartum Visits (14 to 56 days)* includes Module 1. • *PIP Increase Health Risk Screenings* includes Module 1 and Module 2. • *PIP Increased Primary Care Access for Homeless* includes Module 1 and Module 2. • *PIP Increase 3 to 6 YO Well Child Visits* includes Modules 1 through 5. • The State-issued PIPS (*PIP Follow Up After ED Visit Mental Health Dx* and *PIP Increase 3 to 6 YO Well Child Visits*) include Modules 1 through 5, and both were completed and finalized in 2019.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.330(d)(3) *DHCFP Contract Section 3.10.7.5*	9. Implementation of PIPs The MCO is required to report the status and results of each project to DHCFP as requested, but not less than once per year. *a) The MCO is required to annually conduct and report on a minimum of two clinical PIPs and three non-clinical PIPs.*	**Documents Submitted:** • Annual Quality Program Evaluation (2019) • NV.QI.01 Internal Quality Assurance Program • PIP Follow Up After ED Visit Mental Health Dx • PIP Increase 3 to 6 YO Well Child Visits	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	b) *Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, high-volume services, high-risk services, and continuity and coordination of care; non-clinical PIPs include projects focusing on availability, accessibility, and cultural competency of services, interpersonal aspects of care, and appeals, grievances, and other complaints.*	• PIP Increase Health Risk Screenings • PIP Increase Postpartum Visits (14 to 56 days) • PIP Increased Primary Care Access for Homeless **Description of Process:** Pages 31-32 of the *NV.QI.01 Internal Quality Assurance Program* detail the mechanism for implementing Performance Improvement Projects. Pages 16-20 of the *Annual Quality Program Evaluation (2019)* provides a broad overview of the 2019 three internal PIPs and two State-mandated PIPS. • *PIP Increase Postpartum Visits (14 to 56 days)* includes Module 1. • *PIP Increase Health Risk Screenings* includes Module 1 and Module 2. • *PIP Increased Primary Care Access for Homeless* includes Module 1 and Module 2, and provides a detailed status report. The State-issued PIPS (*PIP Follow Up After ED Visit Mental Health Dx* and *PIP Increase 3 to 6 YO Well Child Visits*) include Modules 1 through 5, and both were completed and finalized in 2019.	

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		• *PIP Increase 3 to 6 YO Well Child Visits* includes Modules 1 through 5. • *PIP Follow Up After ED Visit Mental Health Dx* includes Modules 1 through 5)	
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** HSAG recommends that the MCO adhere to CMS EQR *Protocol 8. Implementation of Additional Performance Improvement Projects: An Optional EQR-Related Activity, October 2019* when conducting PIPs and ensure this is appropriately documented. Additionally, as the MCO is specifically required to conduct two clinical and three non-clinical PIPs annually, HSAG recommends that the MCO clearly identify in its IQAP the clinical and/or non-clinical focus for each PIP conducted to ensure adherence to the requirements of this element.		
	Required Actions: None.		
42 CFR §438.330(e)(2) *DHCFP Contract Section 3.10.8.7 (A-C)*	10. Program Evaluation The MCO must develop a process to evaluate the impact and effectiveness of its own IQAP. *a) The MCO must conduct regular and periodic examination of the scope and content of the IQAP to ensure that it covers all types of services in all settings.* *b) At the end of each calendar year, a written report on the IQAP must be prepared and submitted to DHCFP which addresses quality assurance studies and other activities completed; trending of clinical and service indicators and other performance data; demonstrated improvements in quality; areas of deficiency and recommendations for corrective action; and an evaluation of the overall effectiveness of the IQAP.*	**Documents Submitted:** • 2019 Annual Population Assessment • 2019 IQAP Work Plan • 2019 Practitioner Accessibility of Services • Annual Quality Program Evaluation (2019) • Continuity and Coordination Process Monitoring **Description of Process:** The *Annual Quality Program Evaluation (2019)* includes these sections, which apply to all elements: Overview of IQAP activities for 2019 (page 1); Program Effectiveness (pp. 11-12);	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	c) *The report should include evidence that quality assurance activities have contributed to significant improvements in the care delivered to members.*	Quality Improvement Activities (PIPs) with a broad overview and results (pp. 16-20); HEDIS Indicators with focus on P4P program for State (pp. 20-21) and areas of opportunity; Patient Safety and Quality of Care investigations and opportunities for improvement (pp. 21-23); Population Characteristics and areas of improvement (pp. 12-15); Member Satisfaction Survey results and areas of opportunity (pp. 32-35); Disease Management Programs and initiatives and areas of opportunity (pp. 35-37); Clinical Practice Guidelines and evaluation of two clinical practice areas and results and areas of opportunity (pp. 37-39); Evaluation and tracking and trending of Appeals and Grievances and areas of opportunity (pp. 50-51); and Preventive Health Outcomes and guidelines including CMS 416 annual report, analysis, and areas of opportunity (pp. 54-55). The *2019 IQAP Work Plan* details the activities completed in 2019. The *2019 Practitioner Accessibility of Services* includes actions and opportunities for improvement.	

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Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		The *2019 Annual Population Assessment* includes actions and opportunities for improvement.	
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** HSAG recommends that the MCO include in its IQAP specified time frames for periodically reviewing the IQAP activities; for example, a quarterly update documented in its IQAP work plan on progress or barriers in meeting its goals. Additionally, HSAG noted for the secret shopper activity that the results presented in 2018 and 2019 were identical. SSHP staff members expressed that they also had concerns with the quality of the data from the vendor that completed the survey and has since moved the implementation of the secret shopper activity in-house. As the activity will be completed by SSHP staff members, HSAG recommends that SSHP ensure a solid methodology for the activity to avoid unintentional bias.		
	Required Actions: None.		
DHCFP Contract Section 3.10.6.6 (A-B)	11. Provider Review *a) Review by physicians and other health professionals of the process followed in the provision of health services must be conducted.* *b) The MCO must provide feedback to health professionals and MCO staff regarding performance and patient health care outcomes.*	**Documents Submitted:** • Provider Report Newsletter Issue 3 2019 • QIC Meeting Minutes Q4 2019 • SSHP Provider Website QI Program Information • SSHP Provider Website Scorecard **Description of Process**: Feedback to health professionals and MCO staff regarding performance and patient health care outcomes is provided through: • *SSHP Website Provider Scorecard*, showing results from the 2019 CAHPS Survey and BH Survey, which include adult and child results	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		• *Provider Report Newsletter Issue 3 2019* articles, "How we measure quality", "Our members' satisfaction matters", "HEDIS for child well visits" • *QIC Meeting Minutes Q4 2019* provides Member Experience Analysis for Physical and BH. • *Provider Website QI Program Information*	
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** As MCO staff members confirmed its intent to publish the IQAP evaluation on its website each year, HSAG recommends that the MCO follow-up to ensure this has occurred for the 2019 IQAP evaluation. HSAG also recommends that the MCO consider including periodic updates on the IQAP through a provider newsletter or bulletins. These updates should not only be general information of IQAP activities but actual performance and outcomes of those activities.		
	Required Actions: None.		
DHCFP Contract Section 3.10.8.4, 3.10.8.5 (A-F)	12. Implementation of Corrective Actions *The IQAP must include written procedures for taking corrective action, as determined under the IQAP, whenever inappropriate or substandard services are furnished, or services that should have been furnished were not. These written corrective action procedures must include:* *a) Specification of the types of problems requiring corrective action.* *b) Specification of the person(s) or body responsible for making the final determinations regarding quality problems.* *c) Specific actions to be taken; provision of feedback to appropriate health professionals, providers and staff.*	**Documents Submitted:** • NV.QI.01 Internal Quality Assurance Program • CC.QI.17 Potential Quality of Care Incidents **Description of Process:** *No Corrective Action Plans have been conducted at this time* Page 9 of NV.QI.01 *Internal Quality Assurance Program* details the Peer Review Committee responsibilities for Corrective	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	d) The schedule and accountability for implementing corrective actions. *e) The approach to modifying the corrective action if improvements do not occur.* *f) Procedures for terminating the affiliation with the physician, or other health professional or provider.*	Action Plans; page 10 details the Credentialing Committee responsibilities. Page 25 describes Quality of Care issues and Adverse Events that are subject to the CAP process. Details about performance improvement activities are provided on pages 31-32. Policy CC.QI.17 *Potential Quality of Care Incidents* describes the process followed when inappropriate or substandard care is furnished. Page 1 describes the types of QOC incidents; pages 2-3 and 6 describe the individuals responsible for reviewing the incident; page 7 descries the follow-up activities.	
	Findings: The 2019 Quality Program Description identified the Peer Review Committee (PRC) as the responsible entity for reviewing potential inappropriate services rendered by providers such as quality of care (QOC) incidents, and adverse and sentinel events. The 2019 Quality Program Description also required the PRC to make recommendations for corrective actions. The Potential Quality of Care Incidents policy identified types of incidents that may be reviewed, the responsibilities of the Medical Director and PRC, and the process for recording recommendations and notifying the provider of the resolution. The MCO's expectations related to specific processes for monitoring and evaluating corrective actions to ensure required changes have been made, monitoring changes in practice patterns, assuring timely follow-up on identified issues to ensure actions for improvement have been effective, and the approach to modifying the corrective action if improvements do not occur were not well defined in policy. Policy indicated that once an IAP is successfully completed, no further action is necessary, suggesting that ongoing monitoring after the completion of the IAP may not be completed. **Recommendations:** After the review, the MCO submitted a draft Peer Review Committee and Process policy, which addressed the requirements of this element and provided specificity regarding provisions for monitoring corrective action implementation, follow-up activities, expectations for satisfactory behavioral changes by a provider, and continued monitoring. HSAG recommends that the MCO proceed with finalizing this draft policy and submit it as part of the MCO's corrective action plan for this element. Additionally, HSAG recommends that the MCO consider a standardized format for documenting all activities conducted to monitor		

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	and evaluate the corrective action to assure required changes have been made, monitor changes in practice patterns, assure timely follow-up on identified issues to ensure actions for improvement have been effective, and modify the corrective action if improvements do not occur.		
	Required Actions: The IQAP must include written procedures for taking corrective action, as determined under the IQAP, whenever inappropriate or substandard services are furnished, or services that should have been furnished were not. These written corrective action procedures must include: • The approach to modifying the corrective action if improvements do not occur. The MCO must also: • Monitor and evaluate the plans of correction (POC) to assure required changes have been made. • Monitor changes in practice patterns. • Assure timely follow-up on identified issues to ensure actions for improvement have been effective.		
42 CFR §438.330(b)(4) *42 CFR §438.330(d)* *DHCFP Contract Section 3.10.8.6*	13. Assessment of Effectiveness of Plans of Correction (POC) *a) As actions are taken to improve care, the MCO must monitor and evaluate the POC to assure required changes have been made. In addition, changes in practice patterns must be monitored.* *b) The MCO must assure timely follow-up on identified issues to ensure actions for improvement have been effective.*	**Documents Submitted:** • CC.QI.17 Potential Quality of Care Incidents **Description of Process:** *No Corrective Action Plans have been conducted at this time* Pages 5-7 of CC.QI.17 *Potential Quality of Care Incidents* provide details about the identification of QOC issues and the process of referring them to the Medical Director for review, actions taken, and follow-up.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element. However, opportunities for improvement were identified. As the MCO received a *Partially Met* score for these same opportunities for Element 12, the MCO received a *Met* score for this element. Refer to Element 12 for more details.		

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Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	Recommendations: HSAG recommends that the MCO consider a standardized format for documenting all activities conducted to monitor and evaluate the corrective action to assure required changes have been made and changes in practice patterns, assure timely follow-up on identified issues to ensure actions for improvement have been effective, and the modification of corrective action if improvements do not occur.		
	Required Actions: None.		
DHCFP Contract Section 3.10.9.1-4	14. Accountability to the Governing Body *The Governing Body of the MCO is the Board of Directors or, where the Board's participation with quality improvement issues is not direct, a designated committee of the senior management of the MCO that is responsible for the MCO IQAP review. Responsibilities of the Governing Body for monitoring, evaluating and making improvements to care include:* *a) There is documentation that the Governing Body has approved the overall IQAP and the annual IQAP.* *b) The Governing Body has formally designated an entity or entities within the MCO to provide oversight of the IQAP and is accountable to the Governing Body, or has formally decided to provide such oversight as a committee of the whole.* *c) The Governing Body routinely receives written reports from the IQAP describing actions taken, progress in meeting quality assurance objectives, and improvements made.*	**Documents Submitted:** • NV.QI.01 Internal Quality Assurance Program • QIC Q4 2019 Meeting Minutes (annotated) • SSHP Board of Directors 08072019 Meeting Materials • SSHP Board of Directors 08072019 Meeting Minutes **Description of Process:** *Element 14a* *The SSHP Board of Directors 08072019 Meeting Materials* and subsequent *SSHP Board of Directors 08072019 Meeting Minutes* document Board approval of the overall IQAP and the annual IQAP, including the approval of the Program Description; Program Evaluation and Work Plan, *Element 14b* The *NV.QI.01 Internal Quality Assurance Program* (e.g., Program Description) provides	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		for authority of the QI Program (p. 5); SSHP Charters (pp. 7-19). Charters include statement; purpose; objectives; sub-committees as applicable; structure and operations; scheduling; agenda and meeting packets; minutes; attendance requirements; and quorum requirements. *Element 14c* The *SSHP Board of Directors 08072019 Meeting Materials* and the *SSHP Board of Directors 08072019 Meeting Minutes* provide evidence that the Board receives written reports describing IQAP activities.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.10.9.5 (A-D)	15. Annual IQAP Review *The Governing Body formally reviews on a periodic basis, but no less frequently than annually, a written report on the IQAP. This annual quality program evaluation report shall be submitted to the DHCFP in the second calendar quarter and at minimum must include:* *a) Studies undertaken.* *b) Results.* *c) Subsequent actions and aggregate data on utilization and quality of services rendered.* *d) An assessment of the IQAPs continuity, effectiveness and current acceptability.*	**Documents Submitted:** • NV.QI.01 Internal Quality Assurance Program • QIC Q4 2019 Meeting Minutes (annotated) • SSHP Board of Directors 08072019 Meeting Materials • SSHP Board of Directors 08072019 Meeting Minutes **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		The *SSHP Board of Directors 08072019 Meeting Materials* and *SSHP Board of Directors 08072019 Meeting Minutes* demonstrate that the Board receives a written report that includes: Details for Quality Performance Measures and Outcomes concerning the 3 Internal PIPs (description and status) and 2 State Mandated PIPs (description and outcomes) (pp. 16-20); HEDIS Indicators details of measures of focus for 2019 (pp. 20-21); Disease Management Program (pp. 35-38); Clinical Practice Guidelines (pp. 37-50); Appeals (pp. 50-51); Preventive Health Outcomes and areas of opportunity (pp 54-55) and the Quality Work Plan The agenda in the *SSHP Board of Directors 08072019 Meeting Materials* documents the Program Description, Program Evaluation, and the Work Plan and the request for approval *SSHP Board of Directors 08072019 Meeting Minutes* document approval of the Program Description, Program Evaluation, and the Work Plan.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
DHCFP Contract Section 3.10.9.6	16. Program Modification *Upon receipt of regular written reports delineating actions taken and improvements made, the Governing Body must take action when appropriate, and direct that the operational IQAP be modified on an ongoing basis to accommodate review findings and issues of concern with the MCO. This activity is documented in the minutes of the meetings of the Governing Board in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to quality assurance.*	**Documents Submitted:** • NV.QI.01 Internal Quality Assurance Program **Description of Process:** N/A as the Board of Directors has taken no action, nor directed that the operational IQAP be modified on an ongoing basis to accommodate review findings and issues of concern. Pages 3, 5, 8, 23 and 25 of NV.QI.01 *Internal Quality Assurance Program* discuss the Board of Directors' role in the IQAP process, including their authority and how they are kept informed by the QIC of issues.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** While the MCO demonstrated it provided the Board of Directors (BOD) quarterly IQAP updates, little to no discussion items were documented in the meeting minutes. While HSAG acknowledges that there may not be any items that required discussion in some instances, HSAG recommends that the MCO facilitate discussion and dialogue from members of the BOD into IQAP activities.		
	Required Actions: None.		
DHCFP Contract Section 3.10.10	17. Active QA Committee *The IQAP must delineate an identifiable structure responsible for performing quality assurance functions within the MCO. This committee or other structure must have:* *a) The structure/committee must meet on a regular basis with a specified frequency, no less than*	**Documents Submitted:** • NV.QI.01 Internal Quality Assurance Program • QIC Q3 and Q4 2019 Meeting Minutes **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	quarterly to oversee IQAP activities. This frequency must be sufficient to demonstrate that the structure/committee is following up on all findings and required actions. *b) The role, structure and function of the structure/committee must be specified.* *c) There must be records documenting the structure and committee's activities, findings, recommendations and actions.* *d) IQAP subcommittees must be accountable to the Governing Body and must report to it (or its designee) on a scheduled basis on activities, findings, recommendations and actions.* *e) There must be active participation in the IQAP committee from MCO providers, who are representative of the composition of the MCO's providers.*	*Element 17a – Element 17d* *NV.QI.01 Internal Quality Assurance Program* description provides information about Purpose and authority (pages 5-6), Structure (page 7), and the Charter (pages 7-9) The linked *QIC Q3 and Q4 2019 Meeting Minutes* demonstrate that the SSHP Medical Director leads the QIC. *Element 17e* The linked *QIC Q3 and Q4 2019 Meeting Minutes* demonstrate that there is active participation from MCO providers.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.10.11	18. IQAP Supervision *There must be a designated senior executive who is responsible for IQAP implementation. The MCO's Medical Director has involvement in quality assurance activities.*	**Documents Submitted:** • QIC Q3 and Q4 2019 Meeting Minutes **Description of Process:** *Requirement 18* Pages 3, 9, 11, and 18 of the *QIC Q3 and Q4 2019 Meeting Minutes* demonstrate that the SSHP Medical Director leads the QIC.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	Recommendations: The MCO had experienced challenges in filling key leadership positions. While those positions are now filled, HSAG recommends that the MCO encourage Chief Medical Officer (CMO) and Chief Executive Officer (CEO) involvement in its IQAP.		
	Required Actions: None.		
DHCFP Contract Section 3.10.12	19. Adequate Resources *The IQAP must have sufficient material resources and staff with the necessary education, experience, or training to effectively carry out its specified activities.*	**Documents Submitted:** • Annual Quality Program Evaluation (2019) • Executive Job Profile Summaries • Qualifications of Executive Staff (IQAP) **Description of Process:** *Requirement 19* Pages 1 - 3 of the Annual Quality Program Evaluation (2019) describe the QI Department structure and resources. The *Executive Job Profile Summaries* detail the position requirements for the executives who oversee, and help implement and maintain, the IQAP. The *Qualifications of Executive Staff (IQAP)* present individual resumes for executive staff overseeing and maintaining the quality program, including Board members, as well as the Medical Director, Plan CEO, and the Vice President of Quality.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
DHCFP Contract Section 3.10.13	20. Provider Participation in IQAP *a) Participating physicians and other providers must be kept informed about the written IQAP through provider newsletters and updates to the provider manual.* *b) The MCO must include in its provider contracts and employment agreements, for physician and non-physician providers, a requirement securing cooperation with the IQAP.* *c) Contracts must specify that hospitals and other vendors will allow the MCO access to the medical records of its members.*	**Documents Submitted:** • SSHP Provider Website Scorecard • Provider Report Newsletter Issue 3 2019 • SSHP Provider Website QI Program Information • Participating Provider Agreement **Description of Process:** *Element 20a* The *Provider Report Newsletter Issue 3 2019* and the *SSHP Provider Website QI Program Information* provide evidence that SSHP keeps providers informed about the IQAP. *Element 20b* Sections 3.2 and NV-4 of the *Participating Provider Agreement* establish the requirement that the provider cooperates with the IQAC. *Element 20c* Article IV of the *Participating Provider Agreement* (page 7) establishes the provider's contractual duties related to MCO access to medical records.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
DHCFP Contract Section 3.10.22.1	21. Coordination of QA Activities with Other Management Activity *The findings, conclusions, recommendations, actions taken and results of the actions taken as a result of QA activity, are documented and reported within the MCO's organization and through the established QA channels.* *a) Quality assurance information is used in credentialing, recredentialing, and/or annual performance evaluations.* *b) Quality assurance activities are coordinated with other performance monitoring activities, including utilization management, risk management and resolution and monitoring of recipient grievances and appeals.* *c) There is a linkage between quality assurance and the other management functions of the MCO such as:* *i. Network changes.* *ii. Benefits redesign.* *iii. Medical management systems (e.g., pre-certification).* *iv. Practice feedback to practitioners.* *v. Patient education.* *vi. Recipient services.*	**Documents Submitted:** • Complaint and Adverse Event Report • Credentialing Committee Agenda 08132019 • Credentialing Committee Minutes 08132019 • GA Committee Minutes 11262019 • Pharmacy HEDIS Work Plan • PIT Committee Minutes 10302019 • QI Pharmacy Workgroup Notes 09252019 • SSHP Provider Website QI Program Information **Description of Process:** *Element 21a* The *Credentialing Committee Agenda 08132019* and *Credentialing Committee Minutes 08132019* demonstrate that quality assurance information (e.g., adverse events) is used in the credentialing process. The *PIT Committee Minutes 10302019* demonstrate that adverse event information is shared with this committee, including findings, recommendations, actions, and results of actions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		Element 21b and 21c *The SSHP Provider Website QI Program Information* screenshot provides quality program information to providers. *The GA Committee Minutes 11262019* demonstrate coordination for quality assurance. The *Pharmacy HEDIS Work Plan* and the *QI Pharmacy Workgroup Notes 09252019* demonstrate pharmacy and quality assurance collaboration.	
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** While credentialing meeting minutes confirmed sanctions, adverse action reports, complaints, and provider QOC reports are reviewed and considered by the Credentialing Committee, documentation did not support that the MCO had a process to review provider-specific performance at the time of recredentialing. While the MCO demonstrated that quality assurance information was used in credentialing as required by this element, the MCO should be prepared to demonstrate a review of data from grievances and appeals; results of quality reviews; utilization management; and member satisfactions surveys during future reviews of recredentialing files, as required under Contract 3.10.15.6(C).		
	Required Actions: None.		

Results for Standard XI: Internal Quality Assurance Program							
Total Elements	Met	=	19	X	1.00	=	19.00
	Partially Met	=	1	X	.50	=	.50
	Not Met	=	0	X	.00	=	.00
	Not Applicable	=	1	X	.00	=	.00
	Total Applicable	=	20	**Total Rate**		=	19.50
Total Rate ÷ Total Applicable				**= Total Score**			**98%**

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.4.2.15 (A)(1)	1. The Cultural Competency Plan (CCP) *The CCP must be updated annually and submitted to DHCFP in the second quarter of each calendar year.*	**Documents Submitted:** *Requirement 1* • NV.QI.26 Cultural Competency (entire document) • DHCFP File Upload Confirmation • File Load Confirmation (ZIP Extract) **Description of Process:** The *NV.QI.26 Cultural Competency* policy is updated annually and includes, as Attachment A, the Cultural Competency Plan specific to SSHP for the current plan year. The *DHCFP File Upload Confirmation* and the *File Load Confirmation (ZIP Extract)* provide confirmation of DHCFP receipt of the CCP in Q2 2019.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (A)(1)	2. Contents of the CCP *The CCP must describe how care and services are delivered in a culturally competent manner.*	**Documents Submitted:** • NV.QI.26 Cultural Competency (pgs. 1 and 2) **Description of Process:** Pages 1-2 of the *NV.QI.26 Cultural Competency* policy describe the process for	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		delivering care and services in a culturally competent manner.	
	Findings: Attachment A of the Cultural Competency Plan policy and procedure included a statement that the MCO will provide high-quality, culturally sensitive services by the identification, delivery and continual monitoring of members' needs; however, the document did not provide details about how the MCO ensures services delivered to members is culturally competent. During the review session, MCO staff members described various efforts the MCO employed to assure members have access to quality healthcare services that are delivered in a culturally and linguistically competent manner. For example, the MCO conducted an in-depth review of HEDIS measure rates as a tool for identification of health disparities. Further, data analyzed revealed that, for some members, their cultural beliefs impeded members from seeking medical attention unless it was an emergency situation. The MCO implemented strategies that targeted communities with such cultural needs and/or health disparities with the goal of increasing appropriate utilization of needed services that met the cultural and linguistic needs of the members. While MCO staff members could articulate how the MCO delivers care and services in a culturally competent manner, the CCP did not include sufficient detail. **Recommendations:** HSAG recommends that the MCO include additional narrative in the CCP that thoroughly describes and provides specifics on how the MCO ensures care and services are delivered in a culturally competent manner.		
	Required Actions: The contents of the CCP must describe how the MCO ensures care and services are delivered in a culturally competent manner.		
DHCFP Contract Section 3.4.2.15 (A)(2)	3. Staff Involved in the CCP *The MCO CCP must identify a staff person, title or position responsible for the CCP. If there is a change in the staff member responsible for the CCP, the MCO notifies the DHCFP.*	**Documents Submitted:** • NV.QI.26 Cultural Competency (p. 2) **Description of Process:** Page 2 of the *NV.QI.26 Cultural Competency* policy states that the Chief Medical Director is responsible for oversight of the Cultural Competency Plan.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.4.2.15 (A)(3)	4. Staff Recruitment and Retention *The CCP must contain a description of staff recruitment and retention. The MCO must demonstrate how it plans to recruit and retain staff who can meet the cultural needs of the MCO's members. Cultural competence is part of job descriptions.*	**Documents Submitted:** • Cultural Competency Work Plan (2019-2020) (p. 4) • Talent at a Glance (Sept 2019) • Executive Job Profile Summaries • 2019 Goal Setting Workbook (p. 7) • Leadership Feedback Tool (p. 1) **Description of Process:** The *Cultural Competency Work Plan* includes activities and actions to maintain a culturally diverse leadership and staff model and to maintain diverse retention programs. The *Talent at a Glance* report is provided by HR on a monthly basis to the Executive Leadership team and includes workforce statistics such as gender and minority demographics. The *2019 Goal Setting Workbook* and *Leadership Feedback Tool* describes our four leadership pillars. The Talent Multiplier pillar includes "Values diversity of thought and creates an inclusive working environment." SSHP assesses against theses leadership pillars in our annual performance review process,	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		which comprises about 40% of the total performance rating.	
	Findings: The MCO does not include cultural competence in staff job descriptions. The MCO staff members stated during the review session that Centene (parent organization) is responsible for the development of staff job descriptions. The MCO notified Centene of the State contract requirement and this requirement is presently under review.		
	Required Actions: The MCO must include cultural competence in staff job descriptions.		
DHCFP Contract Section 3.4.2.15 (B)(1)	5. Training Program *The training program:* *a) Consists of the methods the MCO uses to ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery to members of all cultures;* *b) Is regularly assessed to determine the training needs of the staff, and the MCO updates the training programs; and* *c) Is customized based on the nature of the contracts the MCO has with providers and/or members.*	**Documents Submitted:** *Element 5a* • NV.QI.26 Cultural Competency (pgs. 2, 8, 12) *Element 5b* • NV.QI.26 Cultural Competency (pgs. 4, 8, 12, 13) • Cultural Competency Training Transcript • Centene U Cultural Competency (screen shot) • Cultural Competency Training PPT (Providers) • Cultural Competency Training (Staff Attendance) *Element 5c* • NV.QI.26 Cultural Competency (pgs. 1, 4, 8, 12, 13) • Cultural Competency Training PPT (Providers)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Description of Process: Pages 2, 8 and 12 of the *NV.QI.26 Cultural Competency* policy describe the requirements and customization of cultural competency training for staff and providers. Pages 4, 12 and 13 describe the process used to determine training needs of the staff and providers and any updates that need to occur. Page 13 describes the customization of the provider requirements for ensuring cultural competency provided to our members. The *Cultural Competency Training Transcript*, the *Centene U Cultural Competency (screen shot)*, and the *Cultural Competency Training PPT (Providers)* provide examples of customized, updated training content for staff, delegates, and providers. The *Cultural Competency Training (Staff Attendance List)* provides evidence of staff and delegate training during the audit period.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (B)(2)	6. Education Program *The education program:*	**Documents Submitted:** *Element 6a* • NV.QI.26 Cultural Competency (p. 3)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	a) Consists of methods the MCO uses for providers and other subcontractors with direct member contact; *b) Is designed to make providers and subcontractors aware of the importance of providing services in a culturally competent manner.*	• Cultural Competency Training (Delegate List) *Element 6b* • NV.QI.26 Cultural Competency (pgs. 1-2; 8-13) • Cultural Competency Training PPT (Providers) **Description of Process:** Pages 1-2 the *NV.QI.26 Cultural Competency* policy describe the process the Plan uses to educate providers and other subcontractors. Page 3 establishes the education requirements for staff and providers. The *Cultural Competency Training (Delegate List)* provides evidence that SSHP subcontractors participated on cultural competency education classes during the audit period. The *Cultural Competency Training PPT (Providers)* provides evidence of SSHP's program to make providers aware of the importance of providing culturally competent care.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.4.2.15 (B)(2)	7. Training Providers and Subcontractors *The MCO must also make additional efforts to train or assist providers and subcontractors in receiving training in how to provide culturally competent services.*	**Documents Submitted:** • Cultural Competency Training PPT (Providers) • Cultural Competency Training Transcript • Cultural Competency Training (Delegate List) **Description of Process:** The *Cultural Competency Training PPT (Providers)* and the *Cultural Competency Training Transcript* provide evidence of SSHP's provision of cultural competency training programs made available to providers and subcontractors. The *Cultural Competency Training (Delegate List)* provides a list of the numerous Envolve delegated entity staff who participated in cultural competency training classes.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (C)(1)	8. Culturally Competent Services and Translation/Interpretation Services *The MCO describes the ongoing evaluation of the cultural diversity of its membership, including*	**Documents Submitted:** • Annual Quality Program Evaluation (2019) (pgs. 6, 12-14, 32-35)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	maintaining an up-to-date demographic and cultural profile of the MCO's members.	**Description of Process:** The assessment of SSHP's Cultural Competency program begins on page 6 of the *Annual Quality Program Evaluation* document. Pages 12-14 include information on membership and demographics, and pages 32-35 detail the member satisfaction results from the results of CAHPS survey, as well as our profile on members for cultural competency.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (C)(1)	9. Regular Assessment of Needs *A regular assessment of needs and/or disparities is performed, which is used to plan for and implement services that respond to the distinct cultural and linguistic characteristics of the MCO's membership.*	**Documents Submitted:** *Requirement 9* • Annual Quality Program Evaluation (2019) (pgs. 6-7 12-14, 32-35) • Cultural Competency Work Plan (2019-2020) (entire document) **Description of Process:** Pages 6-7 of the *Annual Quality Program Evaluation* describe SSHP's process for supporting and providing quality, culturally competent healthcare through adherence to the National Standards on Cultural and Linguistically Appropriate Services (CLAS standards). Pages 12-14 demonstrate our assessment of our member population	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		characteristics, and pages 32-35 provide the results of our member satisfaction surveys. The *Cultural Competency Work Plan (2019-2020)* shows the actions and activities that SSHP performed in response to our evaluations and the results of those activities.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (C)(1)	10. Evaluating the Network *Culturally competent care requires that the MCO regularly evaluate its network, outreach services, and other programs to improve accessibility and quality of care for its membership. It also must describe the provision and coordination needed for linguistic and disability-related services.*	**Documents Submitted:** *Requirement 10* • Annual Quality Program Evaluation (2019) (pgs. 7-10; 23-30; and 32-35) • Cultural Competency Work Plan (2019-2020) (entire document) **Description of Process:** The *Annual Quality Program Evaluation* describe SSHP's process for supporting and providing quality, culturally competent healthcare. Pages 7-10 demonstrate our assessment of practitioner language ability, pages 23-30 show our monitoring of provider PCP appointment accessibility, after-hours access, and call statistics, and pages 32-35 provide the results of our member satisfaction surveys.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		The *Cultural Competency Work Plan (2019-2020)* shows the actions and activities that SSHP performed in response to our evaluations and the results of those activities, including the network portion of cultural competency and the evaluation of gaps noted in 2019 with lack of access to providers who speak Haitian Creole.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.10(d)(5)(i) *DHCFP Contract Section 3.4.2.15 (C)(2)*	11. Translation Services *The MCO must make members aware that translation services are available and will be provided by someone who is proficient and skilled in translation language(s). The availability and accessibility of translation services is not predicated upon the non-availability of a friend or family member who is bilingual. Members may elect to use a friend or relative for translation purposes, but members must not be encouraged to substitute a friend or relative for translation services.* *(Note: Verification of 15 languages as required by Section 1557 of ACA)*	**Documents Submitted:** *Requirement 11* • 1557 Nondiscrimination Notice • 1557 Nondiscrimination Notice (Mailer Insert) • 2019 SSHP Member Handbook (updated) (pgs. 2, 4, 6) • SSHP Member Newsletter (Issue 4 2019) **Description of Process:** SSHP provides a *1557 Nondiscrimination Notice* in or with all significant communications sent to members, which includes all nondiscrimination regulatory and contractual requirements.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Pages 2-4 of the *SSHP Member Handbook* describe other formats and languages available to members, translations and interpreter services, and other translation information, including the 15 ACA required languages. The *SSHP Member Newsletter (Issue 4 2019)* provides an example of a member publication produced in English and Spanish, including our nondiscrimination language.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.10(h)(1)(vii)	12. Providers' Cultural and Linguistic Capabilities *The MCO must make members aware of the provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.*	**Documents Submitted:** *Requirement 12* • Find a Provider ASL (screen shot) • SSHP Provider Directory (screen shots) **Description of Process:** The *SSHP Provider Directory* screen shot pages show a PCP and their alternative language, a specialist and their alternative language (indicating "none"), and a Speech Therapist and their alternative language. The *Find a Provider ASL (screen shot)* demonstrates the search tool available on the SSHP Medicaid website which allows	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		members to search for providers who have capabilities that match their cultural and linguistic needs, including ASL.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (C)(3)	13. Quality Review of Translated Material *The MCO must demonstrate that it uses a quality review mechanism to ensure that translated materials convey intended meaning in a culturally appropriate manner.*	**Documents Submitted:** *Requirement 13* • Member Education (Change Your Body's Age) **Description of Process:** The sample *Change Your Body's Age* member educational materials are available in English and Spanish. Page 5 includes the Spanish translation certification provided by a certified vendor who verified the translation; readability levels for the document are also included.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438/10(d)(1-2) *DHCFP Contract Section 3.4.2.15 (C)(3)(a)*	14. Ten Percent Threshold for Providing Written Translation *All materials shall be translated when the MCO is aware that a language is spoken by 3,000 or 10 percent (whichever is less) of the MCO's members*	**Documents Submitted:** *Requirement 14* • Member Educational Materials (Change Your Body's Age) **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	who also have Limited English proficiency (LEP) in that language.	The sample *Change Your Body's Age* member educational materials are available in English and Spanish and include the Spanish translation certification provided by a certified vendor who verified the translation; readability levels for the document are also included.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438/10(d)(1-3) *DHCFP Contract Section 3.4.2.15 (C)(3)(b)*	15. Five Percent Threshold for Providing Written Translation *All vital materials shall be translated when the MCO is aware that a language is spoken by 1,000 or 5% (whichever is less) of the MCO's members who also have LEP in that language. Vital materials must include, at a minimum, notices for denial, reduction, suspension or termination of services, appeal and grievance notices, provider directories, and vital information from the member handbook.*	**Documents Submitted:** *Requirement 15* • 2019 SSHP Member Handbook (Spanish) • Notice of Initial Adverse Action (A) (pgs. 5, 6, and 7) • SSHP Member Newsletter (Issue 4 2019) (entire document) **Description of Process:** The Statement of Non-Discrimination (page 5 of the *Notice of Initial Adverse Action* letter template) includes information on free translation services, provides the Spanish translation on page 6, and includes the 15 ACA required languages and ACA nondiscrimination notice on page 7.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		The *SSHP Member Newsletter (Issue 4 2019)* provides an example of key member materials that are published in both English and Spanish. SSHP publishes its entire *Member Handbook* in Spanish to address the needs of its LEP members.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (C)(3)(c)	16. Written Notices Informing Members of Interpretation and Translation Services *All written notices informing members of their right to interpretation and translation services shall be translated into the appropriate language when the MCO's caseload consists of 1,000 members that speak that language and have LEP.*	**Documents Submitted:** *Requirement 16* • Notice of Initial Adverse Action (B) (pgs. 1, 3-5) **Description of Process:** The *Notice of Initial Adverse Action* includes information on free translation services, provides the Spanish translation, and includes the 15 ACA required languages and ACA nondiscrimination notice.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.4.2.15 (D)(1)	17. Evaluation and Assessment of CCP *a) The MCO must evaluate the CCP to determine its effectiveness and identify opportunities for improvement.* *b) A summary report of the evaluation must be sent to DHCFP.* *c) The evaluation may, for example, focus on comparative member satisfaction surveys, outcomes for certain cultural groups, member complaints, grievances, provider feedback and/or MCO employee surveys. If issues are identified, they must be tracked and trended, and actions must be taken to resolve the issue(s).*	**Documents Submitted:** *Element 17a* • Cultural Competency Work Plan (2019-2020) *Element 17b* • DHCFP File Upload Confirmation • File Upload Confirmation (ZIP Extract) *Element 17c* • Cultural Competency Work Plan (2019-2020) • NV.QI.01 Internal Quality Assurance Program • PIP Increased Primary Care Access for Homeless **Description of Process:** The *Cultural Competency Work Plan* provides an assessment of all 2019 activities, actions taken, and outcomes. The *NV.QI.01 Internal Quality Assurance Program* policy and IQAP were updated in June 2019 to reflect SSHP's focus for the new plan year.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		The *PIP Increased Primary Care Access for Homeless* document demonstrates the activities and evaluation of a current project. The *DHCFP File Upload Confirmation* and the *File Load Confirmation (ZIP Extract)* provide confirmation of DHCFP receipt of the evaluation in Q2 2019.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Results for Standard XII: Cultural Competency Program						
Total Elements	Met	= 15	X	1.00	=	15.00
	Partially Met	= 2	X	.50	=	1.00
	Not Met	= 0	X	.00	=	.00
	Not Applicable	= 0	X	.00	=	.00
	Total Applicable	= 17	**Total Rate**		=	16.00
Total Rate ÷ Total Applicable = Total Score						**94%**

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.224 *45 CFR parts 160 and subparts A and E of 164* *DHCFP Contract Section 3.10.16.9*	1. Confidentiality of Member Information *The MCO uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and subparts A and E of 164, to the extent that these requirements are applicable.* *a) The MCO acts to ensure that the confidentiality of specified member information and records is protected.* *b) The MCO must establish in writing, and enforce, policies and procedures on confidentiality, including confidentiality of medical records.*	**Documents Submitted:** *Element 1a* • Business Ethics and Code of Conduct (pg. 24) • CC.COMP.04 Confidentiality and Release of PHI (pg. 1) • CC.COMP.15 Administrative Firewalls (pg. 1) • CC.COMP.PRVC.52 Workplace Protection of PHI (pg. 1) • CC.PS.04 Physical Access Control and Validation (pg. 1) • Temp Badge Log • Visitor Log *Element 1b* • Business Ethics and Code of Conduct (pg. 24) • CC.COMP.04 Confidentiality and Release of PHI (pg. 1; entire policy) • CC.COMP.15 Administrative Firewalls (pg. 1; entire policy) • CC.COMP.PRVC.52 Workplace Protection of PHI (pg. 1) • CC.PS.04 Physical Access Control and Validation (pg. 1) • Temp Badge Log • Visitor Log	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		• HIPAA Desktop and Work Area Audit Summary **Description of Process:** The *Business Ethics and Code of Conduct* describes the Plan's commitment to responsibly managing the confidential personal and health information of members, providers, and employees. *CC.COMP.04 Confidentiality and Release of PHI* describes overall Plan responsibilities with respect to the use, disclosure, and maintenance of PHI. *CC.PS.04 Physical Access Control and Validation* describes the process for controlling and validating access to office space by employees, visitors, guests and other individuals. The *Temp Badge Log* and *Visitor Log* provide sample evidence of compliance with this policy. *CC.COMP.15 Administrative Firewalls* describes the Plan's management and protection of confidential information within the company. *CC.COMP.PRVC.52 Workplace Protection of PHI* describes the guidelines for ensuring that PHI and confidential information is secured in	

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		accordance with all applicable regulations and Centene's policies and procedures. The *HIPAA Desktop and Work Area Audit Summary* provides evidence that compliance with *CC.COMP.PRVC.52 Workplace Protection of PHI* is monitored and enforced.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.224 *DHCFP Contract Section 3.10.16.9 (B)*	2. Office Sites Maintaining Confidentiality of Member Information *The MCO must ensure that member care offices/sites have implemented mechanisms to guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the MCO.*	**Documents Submitted:** *Requirement 2* • Provider Agreement (pg. 15-16) • 2019 Provider Manual (pg. 96-97) • Medical Record Audit **Description of Process:** The *Provider Agreement* establishes facility and provider responsibility to maintain the confidentiality of member information and records. The *2019 Provider Manual* reiterates provider contractual and regulatory responsibility to maintain the confidentiality of member records and not release them without appropriate authorization. The *Medical Record Audit* provides sample evidence of periodic provider audits to validate	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		the presence of HIPAA authorization forms and any follow-up steps that were taken.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.224 *DHCFP Contract Section 3.10.16.9 (C)(1-3)*	3. Releasing Confidentiality of Member Information *The MCO holds confidential all information obtained by its personnel about members related to their examination, care and treatment, and does not divulge it without the member's authorization, unless:* *a) It is required by law, or pursuant to a hearing request on the member's behalf;* *b) It is necessary to coordinate the member's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; or* *c) It is necessary in compelling circumstances to protect the health or safety or an individual.*	**Documents Submitted:** *Element 3a* • CC.COMP.04 Confidentiality and Release of PHI (pg. 5) *Element 3b* • CC.COMP.04 Confidentiality and Release of PHI (pg. 4) *Element 3c* • CC.COMP.PRVC.30 Verify Entities Requesting PHI (pg. 3) • CC.COMP.PRVC.43 Disclosing PHI to Avert Threat (pg.1) **Description of Process:** *CC.COMP.04 Confidentiality and Release of PHI* describes the expectation that PHI can only be used and disclosed pursuant to a valid authorization, but notes that certain uses and disclosures are permitted without authorization.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		CC.COMP.PRVC.30 Verify Entities Requesting PHI and *CC.COMP.PRVC.43 Disclosing PHI to Avert Threat* provide for the disclosure of PHI to avert a serious threat to health and safety,	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.224 *45 CFR §164.410*	4. Reporting Inappropriate Use and Disclosure of Protected Health Information (PHI) to DHCFP *The MCO promptly reports to DHCFP any inappropriate use or disclosure of PHI, including a breach of unsecured PHI as required by 45 CFR §164.410 and any security incident the MCO has knowledge of or reasonably should have knowledge of under the circumstances.*	**Documents Submitted:** *Requirement 4* • CC.COMP.PRVC.55 Managing Unauthorized Disclosures (pg. 2) • HIPAA Notification to DHCFP • Privacy Incident Log (July 2019 to Dec 2019) **Description of Process:** *CC.COMP.PRVC.55 Managing Unauthorized Disclosures* describes the process for documenting, remediating, and reporting (to regulators and/or members) any incidents of inappropriate use or disclosure of PHI. The *Privacy Incident Log July 2019 to Dec 2019* is a report of all privacy incidents that occurred during the audit review period. The *HIPAA Notification to DHCFP* document is an example of compliance with the regulator	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		reporting requirements in *CC.COMP.PRVC.55 Managing Unauthorized Disclosures. NOTE: This notification example is from a prior period because SSHP did not send any regulator notifications during the audit period.*	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.224 *DHCFP Contract Section 3.10.16.9 (E)*	5. Requirements for Confidentiality of Patient Information *The MCO may disclose member records whether or not authorized by the member, to qualified personnel, defined as persons or agency representatives who are subject to standards of confidentiality that are comparable to those of the State agency.*	**Documents Submitted:** *Requirement 5* • CC.COMP.04 Confidentiality and Release of PHI (pgs. 5, 8-9) **Description of Process:** *CC.COMP.04 Confidentiality and Release of PHI* describes the expectation that PHI can only be used and disclosed pursuant to a valid authorization, but notes that certain uses and disclosures are permitted without authorization.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
45 CFR §164.404(a)	6. Discovery of a Breach *The MCO, following the discovery of a breach of unsecured PHI, notifies each individual whose unsecured PHI has been, or is reasonably believed by the MCO to have been accessed, acquired, used, or disclosed as a result of such breach.*	**Documents Submitted:** *Requirement 6* • CC.COMP.PRVC.55 Managing Unauthorized Disclosures (pgs. 7-10) • HIPAA Breach Notification Letter Template • Privacy Incident Log (July 2019 to Dec 2019) **Description of Process:** *CC.COMP.PRVC.55 Managing Unauthorized Disclosures* describes the process for documenting, remediating, and reporting any incidents of inappropriate use or disclosure of PHI, with specific guidance concerning notification to members. The *HIPAA Breach Notification Letter Template* provides a format for the development of member notification letters in compliance with Plan policy requirements. The *Privacy Incident Log July 2019 to Dec 2019* tracks whether notifications were sent to affected individual(s).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
45 CFR §164.404(b)	7. Timeliness of Notification *Except as provided in §164.412 (law enforcement delay), the MCO provides notification to the individuals affected by a breach without unreasonable delay and in no case later than sixty (60) calendar days after discovery of a breach.*	**Documents Submitted:** *Requirement 7* • CC.COMP.PRVC.55 Managing Unauthorized Disclosures (pg. 8) • Breach Notification Letter (redacted) **Description of Process:** *CC.COMP.PRVC.55 Managing Unauthorized Disclosures* describes the process for documenting, remediating, and reporting any incidents of inappropriate use or disclosure of PHI, with specific guidance concerning the timeliness of member notification. The *Breach Notification Letter (redacted)* provides an example of an actual member notification.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
45 CFR §164.404(c)(1-2)	8. Content of Notification *The notification required by paragraph (a) of this section shall include, to the extent possible:* *a) A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.*	**Documents Submitted:** *All Elements* • HIPAA Breach Notification Letter Template • Breach Notification Letter (redacted) *Element 8a*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	b) A description of the types of unsecured protected health information that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved). *c) Any steps individuals should take to protect themselves from potential harm resulting from the breach;* *d) A brief description of what the covered entity involved is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches.* *e) Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, Web site, or postal address.* *f) Shall be written in plain language.*	• CC.COMP.PRVC.55 Managing Unauthorized Disclosures (pg. 8) *Element 8b* • CC.COMP.PRVC.55 Managing Unauthorized Disclosures (pg. 9) *Element 8c* • CC.COMP.PRVC.55 Managing Unauthorized Disclosures (pg. 9) *Element 8d* • CC.COMP.PRVC.55 Managing Unauthorized Disclosures (pg. 9) *Element 8e* • CC.COMP.PRVC.55 Managing Unauthorized Disclosures (pg. 9) *Element 8f* • CC.COMP.PRVC.55 Managing Unauthorized Disclosures (pg. 8) **Description of Process:** *CC.COMP.PRVC.55 Managing Unauthorized Disclosures* describes the process for documenting, remediating, and reporting any incidents of inappropriate use or disclosure of PHI, with specific guidance concerning the content of written member notification.	

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		The *HIPAA Breach Notification Letter Template* provides a format for the development of member notification letters in compliance with Plan policy requirements. The *Breach Notification Letter (redacted)* provides an example of an actual member notification.	
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendation:** Although the Breach Notification template was comprehensive and included all required components, the initial redacted Breach Notification letter that was reviewed as evidence of compliance was non-compliant. Additional Breach Notification letters were reviewed and determined to be compliant. HSAG recommends that the MCO develop a quality auditing process of its breach notification letters to ensure they all meet Breach Notification content requirements.		
	Required Actions: None.		
45 CFR §164.404(d)(1)(i-ii)	9. Method of Notification *The notification shall be provided in the following form:* *a) Written notification by first-class mail to the individual at the last known address of the individual or, if the individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. The notification may be provided in one or more mailings as information is available.* *b) If the MCO knows the individual is deceased and has the address of the next of kin or personal representative of the individual (as specified under §164.502(g)(4) of subpart E), written notification by first-class mail to either the next of kin or personal representative of the individual.*	**Documents Submitted:** *Element 9a* • CC.COMP.PRVC.55 Managing Unauthorized Disclosures (pg. 8) *Element 9b* • CC.COMP.PRVC.55 Managing Unauthorized Disclosures (pg. 10) **Description of Process:** *CC.COMP.PRVC.55 Managing Unauthorized Disclosures* describes the process for documenting, remediating, and reporting any incidents of inappropriate use or disclosure of	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	The notification may be provided in one or more mailings as information is available.	PHI, with specific guidance concerning the method of member notification.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
45 CFR §164.404(d)(2)	10. Substitute Notice *In the case in which there is insufficient or out-of-date contact information that precludes written notification to the individual, a substitute form of notice reasonably calculated to reach the individual shall be provided.* a) *Substitute notice need not be provided in the case in which there is insufficient or out-of-date contact information that precludes written notification to the next of kin or personal representative of the individual under paragraph (d)(1)(ii).* b) *In the case in which there is insufficient or out-of-date contact information for fewer than 10 individuals, then such substitute notice may be provided by an alternative form of written notice, telephone, or other means.* c) *In the case in which there is insufficient or out-of-date contact information for 10 or more individuals, then such substitute notice shall:* *i. Be in the form of either a conspicuous posting for a period of 90 days on the home page of the Web site of the covered entity involved, or conspicuous notice in major*	**Documents Submitted:** *Element 10a* • CC.COMP.PRVC.55 Managing Unauthorized Disclosures (pg. 10) *Element 10b* • CC.COMP.PRVC.55 Managing Unauthorized Disclosures (pg. 10) *Element 10c* • CC.COMP.PRVC.55 Managing Unauthorized Disclosures (pg. 10) **Description of Process:** *CC.COMP.PRVC.55 Managing Unauthorized Disclosures* describes the process for documenting, remediating, and reporting any incidents of inappropriate use or disclosure of PHI, with specific guidance concerning substitute notice. There was not an instance in which the plan had to prepare a substitute notice during this audit period.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	print or broadcast media in geographic areas where the individuals affected by the breach likely reside; and ii. *Include a toll-free phone number that remains active for at least 90 days where an individual can learn whether the individual's unsecured protected health information may be included in the breach.*		
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
45 CFR §164.404(d)(3)	11. Additional Notice in Urgent Situations *In any case deemed by the covered entity to require urgency because of possible imminent misuse of unsecured protected health information, the MCO may provide information to individuals by telephone or other means, as appropriate.*	**Documents Submitted:** *Requirement 11* • CC.COMP.PRVC.55 Managing Unauthorized Disclosures (pg. 8) **Description of Process:** *CC.COMP.PRVC.55 Managing Unauthorized Disclosures* describes the process for documenting, remediating, and reporting any incidents of inappropriate use or disclosure of PHI, with specific guidance concerning additional notice in urgent situations. There was not an instance in which the plan had to provide an urgent notice during this audit period.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

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

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.5.1	1. Eligibility and Enrollment Functions *The MCO shall establish and implement enrollment procedures and maintain applicable enrolled member data.*	**Documents Submitted:** *Requirement 1* • NV.ELIG.11 Eligibility Guidelines (p.1) • NV 834 File Processing Procedure **Description of Process:** The *NV.ELIG.11 Eligibility Guidelines* policy defines SSHP's member eligibility and enrollment guidelines, as required by our DHCFP contract. The *NV 834 File Processing Procedure* provides specific instructions for staff who manage the daily 834 data file to ensure consistent, accurate processing of member adds, changes, and disenrollments as provided on the file and for loading into our claims adjudication system.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.5.5, 3.5.7.8	2. Change in Status *The MCO must notify a member that any change in status, including family size and residence, must be immediately reported by the member to their DWSS eligibility worker.* *a) Within seven (7) calendar days of becoming aware of any changes in a member's status, including changes in family size and*	**Documents Submitted:** *Element 2* • NV.ELIG.11 Eligibility Guidelines (p.2) • 2019 SSHP Member Handbook (updated) (p.52) *Element 2a and 2b*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	residence, the MCO must electronically report the change(s) to the DHCFP via the provider supplied data file. *b) The MCO must provide DHCFP with notification of all births and deaths and demographic changes.*	• NV.ELIG.11 Eligibility Guidelines (p.2) • Change In Recipient Status Report DHCFP email **Description of Process:** The *NV.ELIG.11 Eligibility Guidelines* policy establishes the expectation that SSHP will inform members that they must immediately report certain demographic changes to their DWSS Eligibility Worker. The *2019 SSHP Member Handbook* provides actual member notification of this expectation. The *Change In Recipient Status Report DHCFP email* received by SSHP on 07/25/2019 provided notification that the requirement that plans must report within 7 days the change of status of one of their members via the provider supplied data file was being met by the plans transmitting their data to the State data warehouse via the 834 file, and that providing a separate report seemed redundant. As such, the DHCFP discontinued use of the 429/408 report.	
	Findings: HSAG has determined that the MCO has met the requirements for this element. Additionally, HSAG determined that sub-elements (a) and (b) are no longer applicable.		

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Recommendation: The Member Handbook included a section called *Major Life Changes.* This section referred the member to a website to update demographic information. HSAG recommends the MCO review this link to ensure accuracy, as the website could not be accessed by HSAG staff members.		
	Required Actions: None.		
42 CFR §438.56(d)(1)(ii) *DHCFP Contract Section 3.5.7.3 (F)(1)(a-d)*	3. Member Request for Disenrollment *The member must submit an oral or written request to the MCO to process disenrollment requests.* *a) Any member may request to switch MCO's for good cause (as defined in 42 CFR 438.56(d)(2)) at any time.* *b) These members must contact their current MCO orally or in writing for permission to disenroll.*	**Documents Submitted:** *Element 3a* • NV.ELIG.02 Disenrollment(pgs. 2, 4) • 2019 SSHP Member Handbook (updated) (p.52) • Disenrollment Notice of Decision Template *Element 3b* • Disenrollment Form Template • Disenrollment Notice of Decision Template **Description of Process:** The *NV.ELIG.02 Disenrollment* policy describes the process and criteria for Member- and Plan-initiated disenrollment. The *2019 SSHP Member Handbook* informs our members of the reasons for, and timelines when, they can disenroll or change their health plan, as well as the process to do so. The *Disenrollment Form Template* is the State form we use to document a member's request	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		for disenrollment and what SSHP uses to notify the DHCFP if we approve the member's request. The *Disenrollment Notice of Decision Template* is the document SSHP uses to create the member notification of an adverse decision.	
	Findings: The MCO's Member Handbook included a *Disenrollment* section, which contained the reasons a member can disenroll for cause at any time. Although the Member Handbook included an address for disenrollment requests, the address was for Hewlett Packard Enterprise Services instead of the MCO. Further, while members were informed they could also contact the Medicaid District Office, they were not provided with the MCO's contact information for requesting disenrollment for cause. During the interview session, MCO staff members indicated they are forwarded disenrollment requests from the State, which implies members were reaching out to the State due to the information provided in the handbook. Additionally, although the MCO's NV.ELIG.02 Disenrollment policy defined the process and criteria for member-initiated disenrollment, the policy did not clearly describe the step-by-step process members and the MCO must follow to disenroll the member. During the interview session, the MCO indicated revisions have been made to the policy and the policy is currently with the Marketing team. **Recommendations:** HSAG recommends that the Member Handbook be updated to include the address and telephone number members should use when requesting disenrollment for cause. HSAG also recommends that the Disenrollment policy be updated to clearly document the disenrollment process flow.		
	Required Actions: The MCO must ensure members can submit an oral or written request to the MCO to process disenrollment requests, and members must be aware of the contact information, including address and telephone number, to use to make these requests.		

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.56(e)(1-2) *42 CFR §438.56(d)(3)(i)* *42 CFR §438.702(a)(3)* *DHCFP Contract Section 3.5.7.3 (G)*	4. Sufficient Cause to Disenroll *If the MCO determines that there is sufficient cause to disenroll, they will notify the DHCFP by using the form supplied.* *a) The MCO must make a determination as expeditiously as the member's health requires and within a timeline that may not exceed fourteen (14) calendar days following receipt of the request for disenrollment.*	**Documents Submitted:** *Element 4a* • NV.ELIG.02 Disenrollment (p.2) • Disenrollment Form Template **Description of Process:** The *NV.ELIG.02 Disenrollment* policy establishes the expectation that SSHP will notify the DHCFP using the form they supply, and that we will make a determination within the specified timelines. The *Disenrollment Form Template* is the State form we use to document a member's request for disenrollment and what we use to notify the DHCFP if we approve the member's request.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.56(c)(1) *42 CFR §438.56(d)(2)(i-v)* *42 CFR §438.56(d)(3)(i)* *42 CFR §438.702(a)(3)* *DHCFP Contract Section 3.5.7.3 (H)*	5. MCO Denies Request to Disenroll *If the MCO denies the request for disenrollment for lack of good cause the MCO must send a Notice of Decision in writing to the member upon the date of the decision.* *a) Appeal rights must be included with the Notice of Decision.*	**Documents Submitted:** *Element 5a* • Disenrollment Notice of Decision Template *Element 5b* • 2019 SSHP Member Handbook (updated) (p.63)	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	b) The MCO is required to inform the member of their right to first appeal through the MCO and if the appeal is denied to request a State Fair Hearing, how to obtain such a hearing, and representation rules must be explained to the member and provided by the MCO pursuant to 42 CFR §431.200(b); 42 CFR §431.220(5); 42 CFR §438.414; and 42 CFR §438.10(g)(1).	• Disenrollment Notice of Decision Template (p. 2) • NV.ELIG.02 Disenrollment (p. 1) **Description of Process:** The *NV.ELIG.02 Disenrollment* policy describes the process and criteria for Member- and Plan-initiated disenrollment and indicates that if the member's request for disenrollment is denied, the member can appeal through the Fair Hearing process. The *Disenrollment Notice of Decision Template* is the document SSHP uses to create the member notification of an adverse decision. Page 2 of the template provides comprehensive information concerning the member's appeal rights, including the right to ask SSHP for an appeal and, if they do not agree with that decision, the right to ask for a State Fair Hearing. The *2019 SSHP Member Handbook* describes the process for a member to request a State Fair Hearing on page 63.	
	Findings: The MCO's Member Handbook included a *Disenrollment* section that inaccurately informed members that, if they request disenrollment with cause, and the request is denied, they may appeal by using the State fair hearing process.		

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Additionally, the MCO's NV.ELIG.02 Disenrollment policy inaccurately stated that, if the member's request for disenrollment is denied, the member can appeal the decision through the State fair hearing process. The MCO's Notice of Decision template letter supported the MCO had a mechanism for informing the member of the disenrollment request decision; however, it contained confusing language. For example, the letter stated, "we have reviewed your request for a good cause disenrollment, received on {Blank Mandatory User Note} for coverage of {Blank Mandatory User Note}." The template language, "for coverage of…", is not appropriate for a disenrollment request. Additionally, although the letter included most of the correct appeal and State fair hearing rights language, it also informed members of how they could request continuation of services, which would not be appropriate for a disenrollment-related appeal. **Recommendations:** HSAG recommends the MCO update its Member Handbook and Disenrollment policy to clearly indicate the member must appeal to the MCO first before requesting a State fair hearing. HSAG also recommends the MCO review its Notice of Decision letter, and specifically the information pertaining to coverage and continuation of benefits, to determine appropriateness.		
	Required Actions: If the MCO denies the request for disenrollment for lack of good cause, the MCO must send a Notice of Decision in writing to the member upon the date of the decision. Appeals rights must be included with the Notice of Decision, and the MCO must also inform the member of his or her right to first appeal through the MCO and, if the appeal is denied to request a State fair hearing, how to obtain such a hearing, and representation rules must be explained to the member and provided by the MCO pursuant to federal requirements.		
42 CFR §438.56(d)(5)(i-ii) *42 CFR §438.56(e)(1)* *DHCFP Contract Section 3.5.7.3 (I)*	6. Use of the MCO's Grievance System *DHCFP requires that the member seek redress through the MCO's grievance system before making a determination on the member's request.* a) *The grievance process must be completed in time to permit the disenrollment (if approved) to be effective no later than the first day of the second month following the month in which the member files the request.*	**Documents Submitted:** *Element 6a* • NV.ELIG.02 Disenrollment (p.1) • Disenrollment Form Template **Description of Process:** The *NV.ELIG.02 Disenrollment* policy describes the process and criteria for managing a member's request for disenrollment, including completion of initial documentation	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		at the time of the call receipt of written correspondence. The policy also establishes the expectation that SSHP will render a decision and notify the member within 14 calendar days or sooner if the member's health requires an expedited decision. The *Disenrollment Form Template* is the State form we use to document a member's request for disenrollment and provides for both the date that the member submitted the disenrollment request and the date that SSHP approved the request.	
	Findings: The NV.Elig.02 Disenrollment policy described the process and criteria for member requested disenrollments; however, the policy did not describe how the grievance process was used in the disenrollment process. During the interview session, MCO staff members indicated they reach out to members after they receive the disenrollment request and attempt to keep the member in their plan by resolving the members' concerns. For example, staff members indicated they may obtain a single case agreement with a non-participating provider if necessary to address the member's concerns about a provider not being in network. Staff members indicated they log these situations as issues, but they would not necessarily go through the formal grievance process.		
	Required Actions: The MCO must ensure that members seek redress through the MCO's grievance system before making a determination on the member's disenrollment request. The grievance process must be completed in time to permit the disenrollment (if approved) to be effective no later than the first day of the second month following the month in which the member files the request.		

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.56(b)(2) *DHCFP Contract Section 3.5.7.4 (A)*	7. Disenrollment at the Request of the MCO *The MCO may request disenrollment of a member if the continued enrollment of the member seriously impairs the MCO's ability to furnish service to either the particular member or other members.* *a) The MCO must confirm that the member has been referred to the MCO's Member Services Department and has either refused to comply with this referral or refused to act in good faith to attempt to resolve the problem.*	**Documents Submitted:** *Element 7a* • NV.ELIG.02 Disenrollment (p.2) • 2019 SSHP Member Handbook (updated) (p.55) **Description of Process:** The *NV.ELIG.02 Disenrollment* policy describes the reasons that SSHP may or may not request disenrollment of a member and the requirement that the Plan confirm that the member was referred to our member services department and has either refused to comply with the referral or refused to act in good faith to attempt to resolve the problem. The *2019 SSHP Member Handbook* informs our members of the reasons we may ask for involuntary disenrollment of a member for cause.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.56(b)(2) *DHCFP Contract Section 3.5.7.4 (C)(1-7)*	8. Reasons an MCO May Not Request Disenrollment The MCO may not request disenrollment of a member for any of the following reasons:	**Documents Submitted:** *Requirement 8* • NV.ELIG.02 Disenrollment (p.2)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	a) An adverse change in the member's health status; b) A pre-existing medical condition; c) The member's utilization of medical services; d) Diminished mental capacity; e) Uncooperative or disruptive behavior resulting from his or her special needs (except when continued enrollment of such a member seriously impairs the MCO's ability to furnish services to either this particular member or other members); f) A member's attempt to exercise his or her grievance or appeal rights; or g) Based on the member's national origin creed, color, sex, religion, or age.	• 2019 SSHP Member Handbook (updated) (p.55) **Description of Process:** The *NV.ELIG.02 Disenrollment* policy describes the reasons that SSHP may or may not request disenrollment of a member and the requirement that the Plan confirm that the member was referred to our member services department and has either refused to comply with the referral or refused to act in good faith to attempt to resolve the problem. The *2019 SSHP Member Handbook* informs our members of the reasons we may ask for involuntary disenrollment of a member for cause.	
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendation:** HSAG recommends the MCO update the *Disenrollment* section of its Member Handbook to include all reasons listed under sub-elements (a)–(g) of this element.		
	Required Actions: None.		

Results for Standard XIV: Enrollment and Disenrollment							
Total Elements	Met	=	5	X	1.00	=	5.00
	Partially Met	=	2	X	.50	=	1.00
	Not Met	=	1	X	.00	=	.00
	Not Applicable	=	0	X	.00	=	.00
	Total Applicable	=	8	**Total Rate**		=	6.00
Total Rate ÷ Total Applicable				**= Total Score**			**75%**

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

Instructions: For each element that required corrective action, provide evidence to support that the plans of action were completed and implemented.

State Fiscal Year (SFY) 2017–18 CAP Compliance Review

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
DHCFP Contract Section 3.7.5.1–3.7.5.5	13. Access and Availability The MCO shall: a) Ensure adequate physical and geographic access to covered services for enrolled recipients; b) On a quarterly basis, use geo-access mapping and data-driven analyses to ensure compliance with access standards, and take appropriate corrective action, if necessary, to comply with such access standards; c) Partner actively with DHCFP, community providers and stakeholders to identify and address issues and opportunities to improve health care access and availability for Medicaid and CHIP recipients. d) Assure access to health screenings, reproductive services and immunizations through county and state public health clinics.	**Documents Submitted:** Geo Access Report EPSDT Log-Available On-Site EPSDT SOP PAC NV Agenda 4.23 CC.CM.01.04 New Member Welcome Calls 0417-NV New Member Welcome Call Scrip_v4 0617_New Member Orientation Script 2017 Welcome Call Report HRS Form **Description of Process:**	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
	e) Promote care management and early intervention services by completing welcome calls and/or visits to new recipients to ensure orientation with emphasis on access to care, choice of PCP, and availability of an initial health risk screening occurs proactively with each recipient who becomes enrolled. If a screening risk level determines need for further care management, a care management referral will be completed.		
	Findings: The Geo Access Report provided evidence that SilverSummit monitored geographic access standards for primary care and specialty providers contracted with the MCO. In addition to reviewing the Geo Access Reports, SilverSummit staff members stated that they reviewed the provider network every two weeks in conjunction with prior authorization requests to determine the additional providers and provider types necessary to assure access for members. The policy, NV.CONT.01 Network Adequacy Selection Maintenance and Retention, included the organizations and provider types SilverSummit would partner with to assure health screenings, reproductive services, and immunizations were accessible through county and public health clinics, in addition to contracted providers. The document, 0417 NV New Member Welcome Call Script_v4, included the script that member services representatives referenced when working with Medicaid members. The script included step-by-step instructions for helping members select a PCP if they did not already have one and obtaining health services. The welcome call report showed how many calls were made to members as well as how many of those calls were answered by a member for the months of September, October, November, and December 2017. The Geo Access Report highlighted several deficiencies wherein members were without access to the following specialties and locations: behavior technicians in Reno, gastroenterology in Reno, and vascular surgery in Reno as well as in Clark County. SilverSummit staff members stated that they were aware of the deficiencies and made efforts to secure contracts with additional providers to fill the gaps in the network. SilverSummit staff members stated that the MCO signed contracts with five additional vascular surgeons, a behavioral health clinic with behavior technicians, and one additional gastroenterology provider to address the deficiencies. Four of the vascular surgery provider contracts were signed prior to July 1, 2017. One		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
	contract was signed February 23, 2018. The gastroenterology provider contract was signed April 20, 2018. During the on-site review, HSAG reviewers asked for an updated Geo Access Report to verify that the additional providers filled the gaps noted in the previous reports. The revised report showed that there was no longer a gap for behavior technicians, but gaps in the network still existed for gastroenterology and vascular surgery. SilverSummit staff members stated that the information for the gastroenterologist was not loaded into the system yet and that there was a mapping issue related to the provider crosswalk that fed the Geo Access Report, causing the additional vascular surgery providers to show as general surgery instead of vascular surgery providers. Since the mapping issue was not discovered until the date of the on-site review (April 24, 2018), and the quarterly Geo Access Reports generated for quarters 3 and 4 of 2017 showed deficiencies, it appeared that SilverSummit staff members were not following internal policies to use the Geo Access Reports to identify gaps in the network and take action to address the gaps in the network for the two specialties: gastroenterology and vascular surgery.		
	Recommendations: The MCO should monitor its network on a regular basis, including the use of 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.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Based on this analysis, the following steps will be taken immediately to ensure the accuracy of the geo access report, along with true identified gaps: 1. Monthly geo access report will be run by the business analyst to ensure ongoing monitoring of gaps and ensure potential gaps are identified within a timely manner. Identification and monitoring of the gaps will be conducted by the Director of Contracting, and VP of Network Development. 2. Any true gaps identified will be addressed immediately, and targeted to be resolved within 30 days 3. Any erroneous information identified, will also be addressed immediately. The Networking Team will collaborate with the Corporate Provider Data Management team to ensure accurate information is loaded for all areas, counties, specialties, etc. that are identified 4. Any network adequacy issues identified by a member will be addressed within 24-48 hours of becoming aware of the issue. 5. Director of Contracting and/or VP of Network Development will also work to identify and address any gaps that may be identified by the state of Nevada and other carriers, as an ongoing statewide issue.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
	Please note that members were never without access to services. SilverSummit ensures that members had continued access to services via Single Case Agreements when necessary. And, SilverSummit was fully aware of geo mapping issues, prior to the April 24th visit. And, were working to ensure data accuracy of the report.		
DHCFP Response (To be completed by DHCFP/HSAG.)	Although the SilverSummit's Corrective Action Plan (CAP) described the process for identifying future gaps in the network, it is unclear if the steps outlined in the CAP will be part of a policy or plan that is communicated to staff members and departments listed in the CAP. Further, the CAP did not include target dates for implementation and completion and the person responsible for implementing the CAP. **DHCFP Comment**: Please resubmit a CAP that describes the method for communicating the new process to staff members (e.g., policy update, training, plan, etc.), monitoring the completeness of actions taken and timeframes for implementing and completing the CAP, and detailing the person(s) responsible for implementing the CAP.		
Corrective Action Plan, Second Submission	a. A monthly Geo Access gap analysis report is provided to staff in member services, medical management, provider relations, and executive staff detailing the gaps identified and plan of action to address and close gap is possible. b. A weekly Provider Data Management meeting is held in which all identified action items are tracked and discussed as indicated, as well as, a provider loading issue log is maintained and any identified issues will be added to this log c. Time frame for implementing the CAP process was July 1, 2018 and completion of CAP process was done on July 1, 2018, but note all the action items from the CAP are ongoing monthly activities and will continue. d. Responsible person for CAP implementation is Angela Stewart, Director of Contracting		
DHCFP Response (To be completed by DHCFP/HSAG.)	SilverSummit's revised CAP describes the method for communicating the new process for Geo Access reports to staff members, monitoring the completeness of actions taken, implementation timeframes and the person responsible for implementing the CAP. Based on the information provided, SilverSummit has addressed the deficiencies. **DHCFP Comment**: The revised CAP is approved.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
2020 CAP Compliance Review			

MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.*

Documents Submitted:

- Monthly Summary by Specialty
- Network Adequacy Report Inquiry
- NV Weekly Status Update (Call List and Agenda)
- Provider GEO and Practitioner GEO Distribution
- Provider GEO and Practitioner GEO Network Extract
- Quarterly 402A 402B Network Adequacy Reports

Description of Process:

CAP Item A. Monthly GeoAccess Gap Analysis report (Reports)

Each week, the *Provider GEO and Practitioner GEO Network Extract* reports are distributed to health plan leadership to review, identify, and address provider network gaps. These are detailed reports that show individual provider demographic information by specialty. These reports, along with the *Provider GEO and Practitioner GEO Distribution* document, show the frequency of report distribution and the leadership staff who receive and review them. Upon receipt, the reports are examined to evaluate specific provider groups within each specialty. As needed, comparisons are created between two reports to review any material changes to the network.

Each month, the *Monthly Summary by Specialty* report is distributed to the Provider Network leadership team. This is a summary report that displays the count of groups, locations, and practitioners by specialty within each county. Similar to the weekly reports, but at a specialty level, this report allows the network team to monitor and evaluate the number of practitioners, groups, and locations within each specialty. The *Network Adequacy Report Inquiry* provides additional insight.

Each quarter, the *Quarterly 402A and 402B Network Adequacy Reports* are generated using Quest Analytics and submitted to DHCFP. The 402a report shows the PCP-to-Recipient ratios as well as Physician Specialist-to-Recipient ratios; the 402b report evaluates member access to specialty

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
providers based on miles and minutes. The Quest Analytics application evaluates member access to care based on time and distance. Any gaps in access are drilled down by specific zip code and specialty for review of available providers. *CAP Item B. Weekly Provider Data Management meeting (Meetings and Reviews)* Weekly meetings with Provider Data Management (PDM) team and the Network team are held to address all provider enrollment requests, including provider data corrections. These meetings focus on ensuring the accuracy of provider enrollment data. The *NV Weekly Status Update (Call List and Agenda)* provides the distribution list of health plan and corporate attendees, as well as the standard agenda of topics for discussion and resolution. *CAP Item C. Timeframe for Implementing the CAP process* The established timeframe for implementing the CAP process was July 1, 2018 and implementation of was achieved on that date. Since process implementation, the established activities continue on a weekly, monthly, and quarterly basis as outlined above. *CAP Item D. Responsible Person for CAP Implementation* The previous Director of Contracting, Angela Stewart, left SSHP in October 2018. The current Director of Contracting, Christine Hall, has managed these activities since January 2019.			
HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was complete and successfully implemented.			
Required Actions: None.			☒ Met ☐ Not Met

SFY 2018–19 CAP Compliance Review

Standard VI: Member Rights and Responsibilities			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.10(f)(5) *DHCFP Contract Section 3.6.3.4(B)*	5. Provider Terminations In cases where a PCP has been terminated, the MCO must notify enrolled recipients in writing and allow recipients to select another PCP or make a reassignment within 15 business days of the termination effective date, and must provide for urgent care for enrolled recipients until re-assignment.	**Documents Submitted:** Member Handbook - page 35 **Description of Process:** To inform members of our policy to notify them of PCP terminations within 15 days of receiving notification and to reassign them to another PCP.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The CC.PRVR.23 Provider Termination policy provided while on-site stipulated that when a PCP has been terminated, SilverSummit must provide written notification within 15 business days of the termination effective date to enrolled members that they may select a new PCP or that SilverSummit reassigned a PCP to them. The member handbook informed recipients that SilverSummit will provide members with written notification within 15 business days after receipt or issuance of their provider's termination from the network. Neither the policy nor member handbook included that if a provider was terminated from the network, SilverSummit would provide urgent care for enrolled recipients until PCP reassignment.		
	Recommendations: SilverSummit must ensure that enrolled members understand that when their PCP is terminated, the MCO provides for urgent care until PCP reassignment.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	SilverSummit will add additional language to policy CC.PRVR.23 (provider termination policy) as well as the member handbook. We will mail an addendum to the member handbook with additional language to all members as well as place an update on the on line member handbook. The additional language will include the following "You may continue to see any in-network doctor or visit any of our in-network urgent care facilities until you select a new PCP". Responsible parties: Update policy-Provider Relations Director; Member handbook updates: Director of Member Services; mail addendum and update on-line member handbook: Manager of Marketing. Completion Date: 8/31/19		

Standard VI: Member Rights and Responsibilities			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Response (To be completed by DHCFP/HSAG.)	The SilverSummit CAP described updates to the member handbook and policy CC.PRVR.23 to be completed by August 31, 2019. The CAP did not include copies of the revised policy or member handbook. The DHCFP rejects this CAP and requires the MCO to resubmit this CAP with the revised documents described in the CAP, including evidence that members received an updated member handbook.		
Revised Corrective Action Plan (Include required action, responsible individual, and completion date.)	SSHP response:		
DHCFP Response (To be completed by DHCFP/HSAG.)	The updated member handbook in English and Spanish contained information that informed members that when their assigned PCP is terminated, that the MCO provides urgent care until PCP reassignment. A sample of the post card mailed to enrolled members and a copy of the mailing receipt demonstrated that members were informed of the changes to the member handbook. The updated policy CC.PRVR.23 Provider Termination was not included with the MCO's CAP submission. The DHCFP rejects this CAP and requires the MCO to resubmit this CAP with the updated policy CC.PRVR.23 Provider Termination.		
Revised Corrective Action Plan (Include required action, responsible individual, and completion date.)	Updated policy is attached and was approved by DHCFP		
DHCFP Response (To be completed by DHCFP/HSAG.)	The updated NV.PRVR.23 Provider Terminations policy was submitted with the CAP submission. The DHCFP approves this CAP.		

Standard VI: Member Rights and Responsibilities			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
2020 CAP Compliance Review			
MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.* **Documents Submitted:** • 2019 SSHP Member Handbook (updated) (p. 37) • Member Notification Postcard • NV.PRVR.23 Provider Terminations (p. 3) **Description of Process:** The 8/19 revision to the *NV.PRVR.23 Provider Terminations* policy and page 37 of the *2019 SSHP Member Handbook* include language that provides for member notification that, if a provider is terminated from the network, the member may continue to see any in-network doctor or visit and in-network urgent care facility until they select a new PCP. SSHP mailed a *Member Notification Postcard* to make members aware of this and other updates.			
HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was complete and successfully implemented.			
Required Actions: None.			☒ Met ☐ Not Met

Standard VI: Member Rights and Responsibilities			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.10.16.10	10. Treatment of Minors The MCO must have written policies regarding the treatment of minors.	**Documents Submitted:** Policy CC.QI.20 EPSDT –Page 1 **Description of Process:** Policy detailing coverage for all members under age 21 years of age for all EPSDT services	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
	Findings: The CC.QI.20 Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) policy specified that the member's PCP is responsible for providing or arranging the provision of EPSDT services, including screening, diagnosis, and treatment. The policy described the procedures for educating staff, providers, and members regarding EPSDT services and the monitoring activities to ensure members under the age of 21 receive EPSDT services as required. However, this policy did not include the specific State laws regarding treatment of minors. SilverSummit staff members confirmed during the on-site interview that the MCO does not specify in policy the processes for the treatment of minors in accordance with State laws.		
	Recommendations: SilverSummit must ensure that it has written policies regarding the treatment of minors in accordance with the DHCFP contract and applicable State laws.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	We believe this one to be partially met as we do have a policy around providing care to minors. In addition, SilverSummit has developed a Nevada specific policy, NV.QI.27 Treatment of Minors (included in the email response) effective 8/1/19. Responsible party: VP Quality and Risk Adjustment. Completion date: 8/1/19. In addition, policy will be sent to the State for approval.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The newly developed policy, NV.QI.27 Treatment of Minors, included procedures for practitioners and providers to abide by when treating or providing services to minors, in accordance with state laws. The CAP did not include the date that policy, NV.QI.27 Treatment of Minors, will be sent to the DHCFP for review and approval. Since the policy was not produced at the time of the onsite audit or submitted within the allotted timeframe for document resubmission after the onsite visit, the original score of *Not Met* will remain. The DHCFP approves this CAP once the MCO receives DHCFP approval of policy NV.QI.27 Treatment of Minors.		

Standard VI: Member Rights and Responsibilities			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Revised Corrective Action Plan (Include required action, responsible individual, and completion date.)	SSHP: waiting on DHCFP approval		
DHCFP Response (To be completed by DHCFP/HSAG.)	Please review the DHCFP's edits to the NV.QI.27 Treatment of Minors policy. The DHCFP requires the MCO to revise policy NV.QI.27 Treatment of Minors to include DHCFP's edits and resubmit the revised policy as part of this CAP.		
Revised Corrective Action Plan (Include required action, responsible individual, and completion date.)	Edits reviewed and corrections made. Updated policy with corrections is provided		
DHCFP Response (To be completed by DHCFP/HSAG.)	The DHCFP reviewed and approved the edits made to the NV.QI.27 Treatment of Minors policy. The DHCFP approves this CAP.		

2020 CAP Compliance Review

MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.*

Documents Submitted:

- NV.QI.27 Treatment of Minors (page 1, Purpose)

Standard VI: Member Rights and Responsibilities			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Description of Process: The *NV.QI.27 Treatment of Minors* policy is active and current; it was most recently updated in August 2019 (attached) and is due to renew again in 2020 as part of the annual review process. The DHCFP "reviewed and approved the edits made to the NV.QI.27 Treatment of Minors policy" when they approved this CAP. The policy Purpose states that practitioners and providers who treat or provide services to SSHP members must comply with federal and state laws requiring consent for treatment of minors, and makes reference to applicable Nevada laws.			
HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was completed. While not specifically noted as an action for this CAP, the MCO should have documentation to support that staff and providers were trained or received proper notification on the NV.QI.27 Treatment of Minors policy. **Recommendations:** The MCO should develop internal mechanisms that assure staff and providers (as appropriate) are trained on new and updated policies that impact service delivery to members.			
Required Actions: None.			☒ Met ☐ Not Met

Standard VI: Member Rights and Responsibilities			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.10.16.11 (C-D)	12. Survey Results As a result of the survey(s), the MCO must: a. Identify and investigate sources of dissatisfaction; b. Outline action steps to follow up on the findings; c. Inform practitioners and providers of assessment results; and d. Re-evaluate the effects of the above activities.	**Documents Submitted:** N/A First Survey results will not be available until August 2019 **Description of Process:**	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: At the time of the on-site review, SilverSummit staff explained that the inaugural CAHPS satisfaction survey was in process and that results would not be available until August 2019. The staff members explained that the MCO completed a satisfaction survey of new members in July 2018 and provided the written survey report while on-site. The December 19, 2018, Quality Improvement Committee (QIC) meeting minutes demonstrated that SilverSummit reviewed the new member survey results and identified sources of dissatisfaction but did not include any action steps to follow up on the findings, the plan to reevaluate the effectiveness of actions taken, or if the survey results would be shared with practitioners and providers.		
	Recommendations: SilverSummit must ensure that survey results outline action steps to follow up on the findings, inform practitioners and providers of assessment results, and reevaluate the effects of the above activities.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	An action plan was developed when survey was received in 2018 and we failed to provide this as we were only thinking of above elements for the CAHPS survey which is not available until this month. During on-site you asked for a copy of our survey and I did not think to send you the action plan. The action plan is attached. In addition, the action plan was discussed during the QIC, however, we failed to document in the minutes. We are currently re-evaluating our action plans from 2018, as we just received the 2019 results. We dispute that we partially met this requirement. Responsible party: VP Quality and Risk Adjustment. No completion until receive response from HSAG. Action plan attached to CAP email		
DHCFP Response (To be completed by DHCFP/HSAG.)	The member survey action plan detailed the activities the MCO implemented as well as the monitoring schedule the MCO used to monitor each activity. The action plan did not address how practitioners and providers are informed of survey results or how the MCO re-evaluates the effectiveness of the actions taken to address member dissatisfaction. Since the documents		

Standard VI: Member Rights and Responsibilities			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	referenced in this CAP were not produced at the time of the onsite audit or submitted within the allotted timeframe for document resubmission after the onsite visit, the original score of *Partially Met* will remain. The DHCFP rejects this CAP and requires the MCO to resubmit a CAP in response to this element.		
Corrective Action Plan, Second Submission (Include required action, responsible individual, and completion date.)	SSHP response: QIC minutes informing providers Member Satisfaction Committee initiated in September to look at survey results. Evaluating recent 2019 New Member Survey and CAHPS survey to determine if action plans were effective.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The topics discussed and documented in the QIC minutes from June 27, 2018 did not pertain to the new member satisfaction survey that was conducted in July 2018, as the QIC meeting occurred before the survey was conducted. The MCO has not demonstrated that the action plan addressed how practitioners and providers are informed of survey results or how the MCO re-evaluates the effectiveness of the actions taken to address member dissatisfaction. The DHCFP rejects this CAP and requires the MCO to resubmit a CAP in response to this element.		
Revised Corrective Action Plan (Include required action, responsible individual, and completion date.)	Apologize for the error, submitted the wrong QIC minutes. Please see attached minutes from Q3 2018 QIC meeting.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The Q3 2018 QIC meeting minutes dated September 18, 2018 included discussion on the results of the NCQA New Member Understanding IVR Study completed in May 2019. The CC.QI.06 Member Experience Analysis policy described the procedures for annually assessing member experiences with the MCO's services, identifying potential areas for improvement, and communicating the results and subsequent improvement outcomes to internal and external stakeholders, providers, and		

Standard VI: Member Rights and Responsibilities			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	members. The CAHPS Action Plan demonstrated the MCO's monitoring of quality improvement activities identified from the results of the CAHPS survey. The CC.QI.06 policy and CAHPS Action Plan provided evidence that the MCO informs practitioners and providers of assessment results; and re-evaluates the effects of improvement activities. The DHCFP approves this CAP.		

2020 CAP Compliance Review

MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.*

Documents Submitted:

- CAHPS Action Plan Master List
- Member Satisfaction Meeting 11 2019 CM GA UM
- Member Satisfaction Meeting 11 2019 Cust Service
- Member Satisfaction Meeting 11 2019 Provider Relations
- Member Satisfaction Meeting 12 2019 All Dept
- Member Satisfaction Meeting 12 2019 CM GA UM
- QIC Minutes Ad Hoc Sept 2019 (p. 6)
- SSHP Provider Website Scorecard (pgs. 2-3)

Description of Process:
SSHP continues to ensure that survey results outline action steps to follow up on the findings, to inform our providers of assessment results, and to reevaluate the effects of the activities we implement in response to survey results. *Member Satisfaction Meetings* are convened on an established and ad hoc basis, with updates to the interventions for each department included in the *CAHPS Action Plan Master List*.

Minutes from the *QIC Minutes Ad Hoc Sept 2019* meeting demonstrate that the Accessibility Survey was discussed with QIC. The *SSHP Provider Website Scorecard* screenshot demonstrates that we inform our provider of survey results.

HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was complete and successfully implemented.

Standard VI: Member Rights and Responsibilities			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Required Actions: None.			☒ Met ☐ Not Met

Standard VII: Member Information			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.10(g)(1) *42 CFR §438.10(g)(3)(i-iv)* *DHCFP Contract Section 3.6.1.1*	6. Member Handbook The MCO must provide all recipients with a Member Handbook. The MCO can meet this requirement by sending the Member Handbook to the head of the household. *Cross-reference Member Handbook Checklist*	**Documents Submitted:** Member Handbook-see checklist and excel spreadsheets indicating mailing and time frame **Description of Process:** Member handbooks are sent to all new members as part of a new welcome packet within 5 days of receiving their enrollment.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The CC.MBRS.04 – Distribution of New Member Materials policy addressed the process for providing all enrollees with a member handbook. Staff members stated that a single member handbook would be mailed to the head of the household within five days of enrollment. The SilverSummit member handbook included 31 of the 33 elements reviewed in the Member Handbook checklist. While the member handbook identified that the MCO covered emergency transportation, an explanation of procedures for using nonemergency transportation was not included in the member handbook. An explanation of how transportation is provided was also not included in the member handbook.		
	Recommendations: SilverSummit must ensure that members are informed of the procedures for using nonemergency transportation and an explanation of how transportation is provided.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	SilverSummit will add language to member handbook informing members of procedures for using non-emergency transportation and an explanation of how transportation is provided. This language will be added to same page of handbook that explains emergency transportation but as a separate section. We will also send an addendum including same information to all members via mail and update on line member handbook. Language will read: Non-Emergency Transportation "If you need a ride to and from your medical appointments for routine visits, call member services at 1-844-366-2880. Press number 2 for transportation. You will be connected to MTM. You can call to schedule a ride Monday through Friday from 8 a.m. to 5 p.m. Please call us as soon as possible and at least five business days before your scheduled appointment. MTM will work with you to find the right transportation for you and may consult your health care provider." "Non-emergency transportation service is only available to Medicaid recipients. Nevada Check Up members are not eligible for this service."		

Standard VII: Member Information			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Responsible party: Director of Member Services to update handbook; Manager of Marketing to mail addendum and update on line member handbook page 32. Completion date -8/31/19		
DHCFP Response (To be completed by DHCFP/HSAG.)	The SilverSummit CAP described updates to the member handbook to be completed by August 31, 2019. The CAP did not include a copy of the revised member handbook. The DHCFP rejects this CAP and requires the MCO to resubmit a CAP with the revised member handbook and evidence that all members, including existing members, have been informed of the nonemergency transportation benefit and how the benefit is provided.		
Revised Corrective Action Plan (Include required action, responsible individual, and completion date.)	SSHP response:		
DHCFP Response (To be completed by DHCFP/HSAG.)	The updated member handbook in English and Spanish contained information that informed members of the procedures for using nonemergency transportation and an explanation of how transportation is provided. A sample of the post card mailed to members and a copy of the mailing receipt demonstrated that members were informed of the changes to the member handbook. The DHCFP approves this CAP.		
2020 CAP Compliance Review			
MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.*			

Standard VII: Member Information			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Documents Submitted: • 2019 SSHP Member Handbook (updated) (p. 32) • Member Notification Postcard **Description of Process:** The *2019 SSHP Member Handbook* includes language that ensure that members are informed of the procedures for using nonemergency transportation and an explanation of how transportation is provided. SSHP mailed a *Member Notification Postcard* to make members aware of this and other updates.			
HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was complete and successfully implemented.			
Required Actions: None.			☒ Met ☐ Not Met

Standard VIII: Continuity and Coordination of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.208(c)(2) *DHCFP Contract Section 3.10.20.2(C)*	5. Components of CM Programs: Comprehensive Assessment <u>For recipients identified through the Health Needs Assessment Screening to potentially need CM services:</u> a. A comprehensive assessment must be completed to evaluate the recipient's physical health, behavioral health, co-morbid conditions, and psycho-social, environmental, and community support needs. b. The assessment must be completed by a physician, physician assistant, registered nurse (RN), licensed practical nurse (LPN), licensed social worker, or a graduate of a two-or four-year allied health program. c. If the assessment is completed by another medical professional, there should be oversight and monitoring by either an RN or physician.	**Documents Submitted:** Policy NV.CM.02 (Reference document Care Coordination, Care Management Services Policy File) Member Files **Description of Process:** See Policy NV.CM.02 (Reference document Care Coordination, Care Management Services Policy File) and Member Files with annotated bookmarks.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The NV.CM.02 – Care Coordination/Case Management Services policy described the process for completing the comprehensive assessment to evaluate the member's health status. SilverSummit staff members confirmed that only RNs and licensed social workers conduct the assessment and reassessment for members identified for care management. Ten case files of members receiving complex care management services were reviewed. Nine of 10 case files included a comprehensive assessment that evaluated the member's physical health, behavioral health, comorbid conditions, psychosocial, environmental, cultural, linguistic, and community support needs. One case file contained an assessment which did not include documentation that the cultural and linguistic needs of the member were assessed. All 10 case files reviewed contained assessments completed by an RN or licensed social worker.		
	Recommendations: SilverSummit must ensure that all assessments completed for members enrolled in care management are comprehensive and assess the member's cultural and linguistic needs.		

Standard VIII: Continuity and Coordination of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Please note that the licensed social workers mentioned in the findings above should actually state licensed clinical social workers. All licensed clinical case managers were instructed to always address cultural and linguistic needs and to ensure the clinical documentation includes this as part of the comprehensive assessment. Responsible party: CM, Manager (PH and BH). Education to CM's completed on 5/27/19 based on discussion during on-site audit.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The CAP did not define the monitoring activities the MCO will use to ensure that all assessments for members enrolled in care management are comprehensive and assess the member's cultural and linguistic needs. Also, the CAP did not include a copy of the staff training document or other materials that verify staff were trained. The DHCFP rejects this CAP and requires the MCO to resubmit a CAP in response to this element that includes the documents or materials used to train staff.		
Revised Corrective Action Plan (Include required action, responsible individual, and completion date.)	SSHP response: Education to CMs was completed on 04/04/19 pro-actively prior to the actual survey on 05/22/19. These deficiencies were noted as a result of compiling the files for HSAG. See attached Staff Meeting Training Power Point. A new audit tool is attached which includes the elements to monitor.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The MCO's initial CAP indicated that staff education was provided on May 27, 2019. The CM/MC/PS team meeting slides from April 4, 2019 and provided in the 2nd CAP submission identified that member assessments were discussed. Please provide clarification on whether or not staff received additional education on May 27, 2019. The training slides specified that assessments need to be comprehensive and assess the members cultural and linguistic needs. The CAP included a copy of the weekly case detail report that case managers will use to track assigned tasks and due dates. The CAP also included a quarterly case management audit tool that management will use to audit case management files to monitor compliance with the elements listed in Standard VIII, element 5.		

Standard VIII: Continuity and Coordination of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	The DHCFP rejects this CAP and requires the MCO to provide clarification on the dates staff received training/education to address the deficiencies noted.		
Revised Corrective Action Plan (Include required action, responsible individual, and completion date.)	There was additional training opportunity that was identified for the Case Management team in regards to care gap closures and assisting our members in closing these gaps. This training was on April 17, 2019 A refresher course was completed on 5/27/19 including how to complete assessments and cultural competency.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The MCO provided clarification on the dates staff received training/education to address the deficiencies noted for this element. The DHCFP approves this CAP.		

2020 CAP Compliance Review

MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.*

Documents Submitted:

- NV.CM.02 Care Coord Case Mgmt Services (pages 3, 12 and 20)
- Case Management Team Meeting 03272019 (slides 3-5)
- Case Management Team Meeting 04042919 (slides 2-3)
- Case Management Audit Tool (indicator 7j)

Description of Process:

NOTE: The original CAP submission indicated that education to Case Management staff occurred on April 4, 2019, with another on May 27, 2019. This second date of May 27, 2019 was a transcription error, as this this date was Memorial Day. The correct dates are March 27, 2019 for the initial training and April 4, 2019 for the follow-up training.

Standard VIII: Continuity and Coordination of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
During 2018-2019 file review preparation, Management found that certain elements were missing from the files that were to be reviewed by HSAG. In an effort to be pro-active, a *Case Management Team Meeting* was held on March 27, 2019 and these missing elements were discussed with the staff. Another *Case Management Team Meeting* was held with the team on April 4, 2019. The documents included with this review referenced which elements were deficient and included a re-education of those elements. To help ensure that all assessments completed for members enrolled in care management are comprehensive and assess the member's cultural and linguistic needs, SSHP conducts random audits of case management files. The attached *Case Management Audit Tool* is an actual audit of a case management file that was open during the audit period. Cases to audit are selected from Case Detail reports that SSHP generates on a regular basis.			
HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was complete and successfully implemented.			
Required Actions: None.			☒ Met ☐ Not Met

Standard VIII: Continuity and Coordination of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.208(b) *DHCFP Contract Section 3.10.20.2(E)(1-4)*	7. Components of CM Programs: Person Centered Care Treatment Plan The following components are incorporated into the MCO's CM program: a. Based on the assessment, the MCO must assure and coordinate the placement of the recipient into CM and development of a person centered care treatment plan within ninety (90) calendar days of membership. b. The recipient, designated formal and informal supports, and the recipient's PCP are actively involved in the development of the care treatment plan. c. Ongoing communication regarding the status of the care treatment plan may be accomplished between the MCO and the PCP's designee (i.e. qualified health professional). Revisions to the clinical portion of the care treatment plan should be completed in consultation with the PCP, d. The MCO must arrange or provide for professional care management services performed collaboratively by the recipient, designated formal and informal supports, and a team of professionals appropriate for the recipient's condition and health care needs. e. The person centered care treatment plan should reflect the recipient's primary medical diagnosis and health condition, any co-morbidity, and the	**Documents Submitted:** Policy NV.CM.02 (Reference document Care Coordination, Care Management Services Policy File) Member Files **Description of Process:** See Policy NV.CM.02 (Reference document Care Coordination, Care Management Services Policy File) and Member Files with annotated bookmarks.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VIII: Continuity and Coordination of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	recipient's psychological and community support needs. f. At a minimum, the MCO case manager must attempt to coordinate care with the recipient's case manager from other health systems, including behavioral health. g. The person centered care treatment plan must also include specific provisions for periodic reviews of the recipient's condition and appropriate updates to the plan. h. The MCO must honor ongoing person centered care treatment plans, as medically necessary, for recipients transferred into the MCO from another Medicaid vendor, a State-designated HIX plan or any other existing care treatment plans.		
	Findings: The NV.CM.02 – Care Coordination/Case Management Services policy described the process for development of the person-centered care plan in collaboration with the recipient, the member's family, PCP, and others providing care. Eight of the 10 complex case management files reviewed had person-centered treatment plans developed within 90 days of enrollment into case management. Two case files did not have person-centered treatment plans developed within 90 days. In all 10 case files, the member's designated formal and informal supports were identified and involved in the member's treatment as indicated in the assessment and person-centered treatment plan. Evidence that the PCP was sent the person-centered treatment plan for review and comment was not found in any of the 10 case files reviewed. Ongoing communication with the member and the member's provider when applicable was documented in all 10 case files. There was evidence in all 10 case files reviewed that SilverSummit coordinated with the appropriate team of professionals based on the member's healthcare needs. The person-centered treatment plans included the member's primary medical diagnosis and health condition, any comorbidities, and the member's psychological and community support needs. In all 10 case files, the initial person-centered treatment plan specified a date by which periodic review of the member's condition would be		

Standard VIII: Continuity and Coordination of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	completed and the plan updated. Revisions to the person-centered treatment plan were made in seven of the 10 case files reviewed. The time period established for reevaluation of the person-centered treatment plan was in the future and outside of the look back period for the file review for three of the cases reviewed. There was no indication of the member's involvement with another health plan in any of the case files reviewed. Two of the case files contained documentation of involvement with the behavioral health system. In two of the 10 case files, the member had been in an acute care setting at the time of referral with documented coordination of care and discharge planning assistance among involved care providers.		
	Recommendations: SilverSummit must ensure that person-centered treatment plans are developed within the time frame required by the DHCFP contract.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	SilverSummit leadership has reviewed and re-trained case management staff on the expectations of creating a person-centered treatment plan within 30 days for all members enrolled into the case management program. Re-training also included the requirement of sending the member's PCP the Welcome Letter to Case Management, upon enrollment. Re-training also focused on setting tasks to ensure the timeliness of addressing care plan, follow-up, revisions and re-evaluations, and to review the set tasks in the system on a daily basis to avoid any becoming overdue. Weekly Case Detail Reports are generated and sent to each case manager, which helps to monitor tasks, assessments and care plan statuses along with the set frequency of contact. Case managers can also use this as a reference to insure nothing becomes overdue or missed. Responsible party: CM Manager (PH and BH). Completed 5/27 after on-site visit.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The CAP did not include a copy of the staff training document or other materials that verify staff were trained. The DHCFP rejects this CAP and requires the MCO to submit evidence of the documents or materials used to train staff, and the weekly case detail reports used to monitor timeliness and status of assessments and person-centered treatment plans.		
Revised Corrective Action Plan (Include required action, responsible individual, and completion date.)	SSHP response: Education to CMs was completed on 04/04/19 pro-actively prior to the actual survey on 05/22/19. These deficiencies were noted as a result of compiling the files for HSAG. See attached Staff Meeting Training Power Point. A new audit tool is attached which includes the elements to monitor. A blank copy of the Weekly Case Detail Report is also attached.		

Standard VIII: Continuity and Coordination of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Response (To be completed by DHCFP/HSAG.)	The MCO's initial CAP indicated that staff education was provided on May 27, 2019. The CM/MC/PS team meeting slides from April 4, 2019 and provided in the 2nd CAP submission included the topic of comprehensive assessments and care coordination. Please provide clarification on whether or not staff received additional education on May 27, 2019. The CAP included a copy of the weekly case detail report that case managers will use to track assigned tasks, including assessment and care plan due dates. The CAP also included a quarterly case management audit tool that management will use to audit case management files to monitor compliance with the elements listed in Standard VIII, element 7. The DHCFP rejects this CAP and requires the MCO to provide clarification on the dates staff received training/education to address the deficiencies noted.		
Revised Corrective Action Plan (Include required action, responsible individual, and completion date.)	A refresher course was completed on 5/27/19 including how to complete assessments and cultural competency.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The MCO provided clarification on the dates staff received training/education to address the deficiencies noted for this element. The DHCFP approves this CAP.		

2020 CAP Compliance Review

MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.*

Documents Submitted:

- NV.CM.02 Care Coord Case Mgmt Services (page 10-11)

Standard VIII: Continuity and Coordination of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
• Case Management Team Meeting 03272019 (slides 3-5) • Case Management Team Meeting 04042919 (slides 2 and 4) • Case Management Audit Tool (indicator 8b, column H) **Description of Process:** NOTE: The original CAP submission indicated that education to Case Management staff occurred on April 4, 2019, with another on May 27, 2019. This second date of May 27, 2019 was a transcription error, as this this date was Memorial Day. The correct dates are March 27, 2019 for the initial training and April 4, 2019 for the follow-up training. During 2018-2019 file review preparation, Management found that certain elements were missing from the files that were to be reviewed by HSAG. In an effort to be pro-active, a *Case Management Team Meeting* was held on March 27, 2019 and these missing elements were discussed with the staff. Another *Case Management Team Meeting* was held with the team on April 4, 2019. The documents included with this review referenced which elements were deficient and included a re-education of those elements. SSHP's *NV.CM.02 Care Coord Case Mgmt Services* policy describes the process for development of the person-centered care plan in collaboration with the recipient, the member's family, PCP, and others providing care. To help ensure that person-centered treatment plans are developed within the time frame required by the DHCFP contract, SSHP conducts random audits of case management files. The attached Case Management Audit Tool is an actual audit of a case management file that was open during the audit period. Cases to audit are selected from Case Detail reports that SSHP generates on a regular basis.			
HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was complete and successfully implemented.			
Required Actions: None.			☒ Met ☐ Not Met

Standard VIII: Continuity and Coordination of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.10.20.2(C)	8. Recipient and PCP Notification and Participation The MCO must provide information to the recipients and their PCPs that they have been identified as meeting criteria for CM, including their enrollment into CM services.	**Documents Submitted:** Policy NV.CM.02 (Reference document Care Coordination, Care Management Services Policy File) Member Files **Description of Process:** See Policy NV.CM.02 (Reference document Care Coordination, Care Management Services Policy File) and Member Files with annotated bookmarks.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The NV.CM.02 – Care Coordination/Case Management Services policy maintained that members and their PCPs are informed when a member is identified as meeting criteria for care management services. Staff members explained the process used for notifying members and PCPs of meeting care management criteria, including member enrollment into care management services. All 10 case files contained evidence that the member was informed and agreed to participate in the care management program. However, evidence that the PCP was informed that the member met the criteria for care management and was enrollment in care management was not found in any of the files reviewed. Evidence of PCP involvement in the development of the member's person-centered care plan also was not found in any of the case files reviewed.		
	Recommendations: SilverSummit must ensure that a member's case file contains documentation indicating that the PCP is informed when the member is identified as meeting criteria for care management, when the member is enrolled in care management services, and that the PCP is involved in care plan development.		

Standard VIII: Continuity and Coordination of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Corrective Action Plan (Include required action, responsible individual, and completion date.)	SilverSummit reviewed and re-trained case management staff to the documentation standards for noting PCP involvement. Current case management process is to send the member's PCP a letter notifying the PCP that the member is enrolled in case management along with a letter of notification to the PCP that outlines the completed care plan. Responsible party: CM, Manager (PH and BH). Completed on 5/27 after on-site audit.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The CAP specified the MCO's current process for notifying a member's PCP of the member's enrollment in case management and notification to the PCP regarding the completion of the person-centered treatment plan. The CAP did not include the process for informing the member's PCP that the member met the criteria for care management. Also, the CAP did not include a process for monitoring the effectiveness of actions taken to address the deficiencies noted in Standard VIII, element 8. The DHCFP rejects this CAP and requires the MCO to resubmit a CAP in response to this element.		
Revised Corrective Action Plan (Include required action, responsible individual, and completion date.)	SSHP response: Education to CMs was completed on 04/04/19 pro-actively prior to the actual survey on 05/22/19. These deficiencies were noted as a result of compiling the files for HSAG. See attached Staff Meeting Training Power Point. A new audit tool is attached which includes the elements to monitor. A blank copy of the Weekly Case Detail Report is also attached.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The MCO's initial CAP indicated that staff education was provided on May 27, 2019. The CM/MC/PS April 4, 2019 team meeting slides provided in the revised CAP submission included the process for notifying a member's PCP: that the member has met the criteria for case management, of the member's enrollment in case management, and notification to the PCP regarding the completion of the person-centered treatment plan. Please provide clarification on whether or not staff received additional education on May 27, 2019. The CAP included a copy of the weekly case detail report that case managers will use to track assigned tasks and due dates, including PCP notifications and coordination of care activities. Monitoring compliance with the elements listed in Standard VIII, element 8 will be conducted through quarterly case management file audits utilizing the newly developed case management audit tool.		

Standard VIII: Continuity and Coordination of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	The DHCFP rejects this CAP and requires the MCO to provide clarification on the dates staff received training/education to address the deficiencies noted.		
Revised Corrective Action Plan (Include required action, responsible individual, and completion date.)	A refresher course was completed on 5/27/19 including how to complete assessments, notifying PCP and cultural competency.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The MCO provided clarification on the dates staff received training/education to address the deficiencies noted for this element. The DHCFP approves this CAP.		

2020 CAP Compliance Review

MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.*

Documents Submitted:

- Care Plan Correspondence Letter to the PCP
- Case Management Audit Tool (indicator 5, column H)
- Case Management Team Meeting 03272019 (slides 3-5)
- Case Management Team Meeting 04042919 (slides 2 and 5)
- New Member Welcome Letter
- NV.CM.02 Care Coord Case Mgmt Services (page 13)

Standard VIII: Continuity and Coordination of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Description of Process: NOTE: The original CAP submission indicated that education to Case Management staff occurred on April 4, 2019, with another on May 27, 2019. This second date of May 27, 2019 was a transcription error, as this this date was Memorial Day. The correct dates are March 27, 2019 for the initial training and April 4, 2019 for the follow-up training. During 2018-2019 file review preparation, Management found that certain elements were missing from the files that were to be reviewed by HSAG. In an effort to be pro-active, a *Case Management Team Meeting* was held on March 27, 2019 and these missing elements were discussed with the staff. Another *Case Management Team Meeting* was held with the team on April 4, 2019. The documents included with this review referenced which elements were deficient and included a re-education of those elements. SSHP's *NV.CM.02 Care Coord Case Mgmt Services* policy establishes the expectation that members and their PCPs are informed when a member is identified as meeting criteria for care management services. To help ensure that a member's case file contains documentation indicating that the necessary notifications take place in a timely manner, SSHP conducts random audits of case management files. The attached *Case Management Audit Tool* is an actual audit of a case management file that was open during the audit period. Also included are copies of the associated *New Member Welcome Letter* and the *Care Plan Correspondence Letter to the PCP*.			
HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was complete and successfully implemented.			
Required Actions: None.			☒ Met ☐ Not Met

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.408(b)(1-3) *42 CFR §438.408(d)(1)* *42 CFR §438.408(d)(2)(i)* *DHCFP Contract Section 3.13.5–3.13.5.3*	20. Handling of Grievances and Appeals The MCO is required to dispose of each grievance and resolve each appeal and to provide notice as expeditiously as the recipient's health condition requires within the State's established time frames specified as follows: a. Standard disposition of grievances: The MCO is allowed no more than 90 calendar days from the date of receipt of the grievance. b. Standard resolution of appeals: The MCO is allowed no more than 30 calendar days from the date of receipt of the appeal. c. Expedited resolution of appeals: The MCO must resolve each expedited appeal and provide notice, as expeditiously as the recipient's health condition requires, not to exceed 72 hours after the MCO receives the expedited appeal request.	**Documents Submitted:** 20a. NV.QI.11-Grievance System Description-Page 5 20a. Member Handbook-Page 53 20b. Member Handbook-Page 55 20c. Member Handbook-Page 56 20c. NV.QI.11-Grievance System Description-Page 7 **Description of Process:**	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The policy, Grievance System Description, detailed the provisions for disposing each grievance, resolving each appeal, and providing notice to members and providers, as applicable, as outlined in this element. The appeal file review showed that three of the four standard appeals reviewed were resolved in the 30-day time frame, and no notice of extension was sent for the one standard appeal that was resolved outside the 30-day time frame.		
	Recommendations: SilverSummit must ensure that all standard appeals are resolved and notice given within 30 days of the date the appeal was received by the MCO.		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Corrective Action Plan (Include required action, responsible individual, and completion date.)	SilverSummit has educated all staff and vendors regarding the requirements of ensuring resolutions are provided in a timely manner and in accordance with the relevant regulations. However, please send correspondence in email requesting further clarification. Responsible party: G&A Manager. Completion Date: 6/3/19		
DHCFP Response (To be completed by DHCFP/HSAG.)	The DHCFP rejects this CAP and requires the MCO to specify how staff and vendors were trained and submit evidence of the documents or materials used to train them.		
Revised Corrective Action Plan (Include required action, responsible individual, and completion date.)	SilverSummit provided the documents mentioned below.		
DHCFP Response (To be completed by DHCFP/HSAG.)	SilverSummit provided additional documents that included an appeal work flow, a policy that described the grievance and appeals timeliness process, as well as a TruCare Appeal Manual. SilverSummit did not provide a description as to how these documents were used for training or communicating to staff members the process for processing standard appeals within 30 calendar days. DHCFP rejects this CAP and requires the MCO to resubmit a CAP that specifies how staff and vendors were trained on the information contained in the documents (appeal work flow, member grievance and appeal process policy, and the TruCare appeal manual and submit evidence of the documents or materials used to train them.		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Revised Corrective Action Plan (Include required action, responsible individual, and completion date.)	The A&G department has two employees, Grievance and Appeals Coordinators, who were trained in two team weekly sessions on the appeal work flow, reviewed the policy and timelines and the TruCare Appeal Manual related to documentation of appeals and submission of appeals review. The vendors have monthly calls, the first work day of the month, in which the G&A Manager, conducted training on the same documents. The vendor staff included the appeals coordinator, appeals manager and the vendor manager.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The MCO provided clarification on how staff and vendors were trained on the information in the appeal work flow, grievance and appeal process policy, and the TruCare appeal manual. The DHCFP approves this CAP.		
2020 CAP Compliance Review			
MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.* The DHCFP Response to the CAP indicates that, "the MCO provided clarification on how staff and vendors were trained on the information in the appeal work flow, grievance and appeal process policy, and the TruCare appeal manual," and accepted the CAP. However, SSHP has initiated additional steps since that approval. **Documents Submitted:** • Appeals File Review Audit Worksheet • Appeal Notice of Resolution Member Letter **Description of Process:** To ensure that "all standard appeals are resolved and notice given within 30 days of the date the appeal was received by the MCO", the G&A Manager began conducting appeals and grievances audits in 2020. Included are an *Appeals File Review Audit Worksheet* and the associated *Appeal Notice of Resolution Member Letter* with the mailing date.		
HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was complete and successfully implemented.			
Required Actions: None.			☒ Met ☐ Not Met

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.424(a-b) *DHCFP Contract Section 3.13.7.4*	33. Reversing an Action to Deny, Limit, or Delay Services If the MCO or Fair Hearing Officer reverses an action to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO authorizes or provides the disputed services promptly and as expeditiously as the recipient's health condition requires (but no later than 72 hours from the date it receives notice reversing the determination.) If the MCO or State Fair Hearing Officer reverses a decision to deny authorization of services, and the recipient received the disputed services while the appeal was pending, the MCO or the State pays for those services in accordance with State policy and regulations.	**Documents Submitted:** NV.QI.11-Grievance System Description-Page 8 **Description of Process:**	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The policy, Grievance System Description, detailed the processes and procedures to authorize or provide the disputed services promptly and as expeditiously as the recipient's health condition requires when the MCO or fair hearing officer reverses an action. The policy did not contain the provision, however, that the services must continue no later than 72 hours from the date the MCO receives notice reversing the determination.		
	Recommendations: SilverSummit must ensure that if the MCO or fair hearing officer reverses an action to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO authorizes or provides the disputed services promptly and as expeditiously as the recipient's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Upon review of the finds, we have updated the relevant pages of NV.QI.11. Specifically we have updated Section E. Continuations of Benefits #4: Add (but no later than 72 hours from the date it receives notice reversing the determination). Responsible party: G&A Manager and VP Quality. Completion Date: 8/7/19. Policy included for review		
DHCFP Response (To be completed by DHCFP/HSAG.)	The policy, Member Grievance System Description NV QI.11, revised August 2019, included the provision that if the MCO or fair hearing officer reverses an action to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO authorizes or provides the disputed services promptly and as expeditiously as the recipient's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. The DHCFP approves this CAP.		

2020 CAP Compliance Review

MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.*

The DHCFP Response to the CAP indicates that all requested documentation had been provided and that they accepted the CAP. However, SSHP has initiated additional steps since that approval.

Documents Submitted:

- Appeals File Review Audit Worksheet

Description of Process:
To ensure that, "SSHP authorizes or provides the disputed services promptly and as expeditiously as the recipient's health condition requires (but no later than 72 hours from the date it receives notice reversing the determination)", the G&A Manager began conducting appeals and grievances audits in 2020. To date, we have received 47 appeals with 10 overturned. Included are an *Appeals File Review Audit Worksheet* for an appeal with findings.

HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was complete and successfully implemented.

Required Actions: None.

☒ Met
☐ Not Met

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.210(b)(1) *DHCFP Contract Section 3.4.2.5*	3. Written Policies and Procedures The MCO must, for itself and its subcontractors, have in place and follow, written policies and procedures for the processing of requests for initial and continuing authorizations of services.	**Documents Submitted:** NV.UM.01—UM Program Description **Description of Process:**	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The UM Program Description and the following policies provided evidence of SilverSummit's written policies and procedures for processing initial and continuing authorizations of services: Clinical Decision Criteria and Application, and Timeliness of UM Decisions and Notifications, as well as the Quality Improvement (QI) Program Description. All 10 denial files reviewed included the reasons for the denial in the notice of decision, and the decision made by a qualified clinician. Of the 10 denial files reviewed, a decision was made within the required time frame in seven of the files; in three files, a decision was made outside the required time frame.		
	Recommendations: SilverSummit must ensure that a decision is made within the required time frame for all service authorization requests.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	SSHP is conducting 100% denial letter review and daily assignment of urgent cases to ensure timely turnaround times. Weekly projected turnaround time reports are run and analyzed and feedback provided to front-line staff to ensure we are meeting all requirement. 1. 100 Denial letter review 2. Projected turnaround time reporting Responsible party: UM, Manager. Completion Date: will do reviews through December 2019.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The DHCFP requires the MCO to submit the weekly projected turnaround time reports as evidence that monitoring is occurring according to the CAP.		

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Revised Corrective Action Plan (Include required action, responsible individual, and completion date.)	Excel workbook		
DHCFP Response (To be completed by DHCFP/HSAG.)	The Excel workbook provided evidence that SilverSummit maintained a process to monitor the turnaround times for providing authorizations to members. The DHCFP approves this CAP.		

2020 CAP Compliance Review

MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.*

Documents Submitted:

- 2019 Overall TAT Excel Spreadsheet (July 2019 – Dec 2019)
- Denial Letter Review Task (sample)
- NV.UM.05 Timeliness of UM Decisions and Notifications (entire policy establishes required time frames)
- Weekly TAT Projections 07012019 to 08032019 (sample)
- Weekly TAT Projections 10012019 to 11032019 (sample)
- Weekly TAT Projections 10012019 to 11102019 (sample)
- NV.UM.01.01 Covered Benefits and Services (policy for general reference only)
- NV.UM.02 Clinical Criteria and Application (policy for general reference only)

SSHP is providing evidence that we continue to maintain a process to monitor the turnaround times for providing authorizations to members and ensure that a decision is made within the required time frame for all service authorization requests. The *NV.UM.05 Timeliness of UM Decisions and*

Standard X: Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Notifications policy establishes required time frames. *Weekly TAT Projections* reports are run and analyzed and feedback provided to front-line staff to ensure we are meeting all requirements. TAT information is consolidated in the *2019 Overall TAT Excel Spreadsheet*.			
HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was complete and successfully implemented.			
Required Actions: None.			☒ Met ☐ Not Met

SFY 2019–20 Compliance With Standards Review Tool CAP Template

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[C-1]**	**Score**
DHCFP Contract Section 3.10.8.4, 3.10.8.5 (A-F)	12. Implementation of Corrective Actions *The IQAP must include written procedures for taking corrective action, as determined under the IQAP, whenever inappropriate or substandard services are furnished, or services that should have been furnished were not. These written corrective action procedures must include:* *a) Specification of the types of problems requiring corrective action.* *b) Specification of the person(s) or body responsible for making the final determinations regarding quality problems.* *c) Specific actions to be taken; provision of feedback to appropriate health professionals, providers and staff.* *d) The schedule and accountability for implementing corrective actions.* *e) The approach to modifying the corrective action if improvements do not occur.* *f) Procedures for terminating the affiliation with the physician, or other health professional or provider.*	**Documents Submitted:** • NV.QI.01 Internal Quality Assurance Program • CC.QI.17 Potential Quality of Care Incidents **Description of Process:** *No Corrective Action Plans have been conducted at this time* Page 9 of NV.QI.01 *Internal Quality Assurance Program* details the Peer Review Committee responsibilities for Corrective Action Plans; page 10 details the Credentialing Committee responsibilities. Page 25 describes Quality of Care issues and Adverse Events that are subject to the CAP process. Details about performance improvement activities are provided on pages 31-32. Policy CC.QI.17 *Potential Quality of Care Incidents* describes the process followed when inappropriate or substandard care is furnished.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[C-1]**	**Score**
		Page 1 describes the types of QOC incidents; pages 2-3 and 6 describe the individuals responsible for reviewing the incident; page 7 descries the follow-up activities.	
	Findings: The 2019 Quality Program Description identified the Peer Review Committee (PRC) as the responsible entity for reviewing potential inappropriate services rendered by providers such as quality of care (QOC) incidents, and adverse and sentinel events. The 2019 Quality Program Description also required the PRC to make recommendations for corrective actions. The Potential Quality of Care Incidents policy identified types of incidents that may be reviewed, the responsibilities of the Medical Director and PRC, and the process for recording recommendations and notifying the provider of the resolution. The MCO's expectations related to specific processes for monitoring and evaluating corrective actions to assure required changes have been made, monitoring changes in practice patterns, assuring timely follow-up on identified issues to ensure actions for improvement have been effective, and the approach to modifying the corrective action if improvements do not occur were not well defined in policy. Policy indicated that once an IAP is successfully completed, no further action is necessary, suggesting that ongoing monitoring after the completion of the IAP may not be completed. **Recommendations:** After the review, the MCO submitted a draft Peer Review Committee and Process policy, which addressed the requirements of this element and provided specificity regarding provisions for monitoring corrective action implementation, follow-up activities, expectations for satisfactory behavioral changes by a provider, and continued monitoring. HSAG recommends that the MCO proceed with finalizing this draft policy and submit it as part of the MCO's corrective action plan for this element. Additionally, HSAG recommends that the MCO consider a standardized format for documenting all activities conducted to monitor and evaluate the corrective action to assure required changes have been made, monitor changes in practice patterns, assure timely follow-up on identified issues to ensure actions for improvement have been effective, and modify the corrective action if improvements do not occur.		
	Required Actions: The IQAP must include written procedures for taking corrective action, as determined under the IQAP, whenever inappropriate or substandard services are furnished, or services that should have been furnished were not. These written corrective action procedures must include: • The approach to modifying the corrective action if improvements do not occur.		

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[C-1]**	**Score**
	The MCO must also: • Monitor and evaluate the plans of correction (POC) to assure required changes have been made. • Monitor changes in practice patterns. • Assure timely follow-up on identified issues to ensure actions for improvement have been effective.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	No later than 12/31/20, SSHP's VP of Quality will review and, as necessary, revise the existing relevant policy (CC.QI.19 *Peer Review Committee and Process*) to ensure it addresses the required procedures for taking corrective actions whenever inappropriate or substandard services are furnished, or services that should have been furnished were not. Corrective actions that will be addressed in the policy include SSHP's approach to modifying the corrective action if improvements do not occur. Effective immediately, when plans of correction (POC) are required, the VP Quality will monitor and evaluate each POC to ensure required changes have been made, monitor changes in practice patterns, and assure timely follow-up on identified issues to ensure actions for improvement have been effective, utilizing a standardized *Quality of Care Peer Review Tracking* spreadsheet for documenting these activities.		
HSAG Response	HSAG has determined that the MCO's CAP is sufficient to ensure compliance with this element. The MCO must submit the updated policy to DHCFP to be reviewed and approved by the DHCFP prior to the policy being finalized. Implementation of the CAP will be reviewed during future compliance reviews.		
DHCFP Approval	DHCFP approves this CAP.		

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.4.2.15 (A)(1)	2. Contents of the CCP *The CCP must describe how care and services are delivered in a culturally competent manner.*	**Documents Submitted:** • NV.QI.26 Cultural Competency (pgs. 1 and 2) **Description of Process:** Pages 1-2 of the *NV.QI.26 Cultural Competency* policy describe the process for delivering care and services in a culturally competent manner.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: Attachment A of the Cultural Competency Plan policy and procedure included a statement that the MCO will provide high-quality, culturally sensitive services by the identification, delivery and continual monitoring of members' needs; however, the document did not provide details about how the MCO ensures services delivered to members is culturally competent. During the review session, MCO staff members described various efforts the MCO employed to assure members have access to quality healthcare services that are delivered in a culturally and linguistically competent manner. For example, the MCO conducted an in-depth review of HEDIS measure rates as a tool for identification of health disparities. Further, data analyzed revealed that, for some members, their cultural beliefs impeded members from seeking medical attention unless it was an emergency situation. The MCO implemented strategies that targeted communities with such cultural needs and/or health disparities with the goal of increasing appropriate utilization of needed services that met the cultural and linguistic needs of the members. While MCO staff members could articulate how the MCO delivers care and services in a culturally competent manner, the CCP did not include sufficient detail. **Recommendations:** HSAG recommends that the MCO include additional narrative in the CCP that thoroughly describes and provides specifics on how the MCO ensures care and services are delivered in a culturally competent manner.		
	Required Actions: The contents of the CCP must describe how the MCO ensures care and services are delivered in a culturally competent manner.		

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Corrective Action Plan (Include required action, responsible individual, and completion date.)	No later than 11/30/20, SSHP's VP of Quality will review and, as necessary, revise SSHP's Cultural Competency Plan (NV.QI.26 *Cultural Competency*) to ensure it describes how SSHP ensures care and services are delivered in a culturally competent manner.		
HSAG Response	HSAG has determined that the MCO's CAP is sufficient to ensure compliance with this element. Implementation of the CAP will be reviewed during future compliance reviews to ensure that specificity has been added to the cultural competency plan.		
DHCFP Approval	DHCFP approves this CAP.		
DHCFP Contract Section 3.4.2.15 (A)(3)	4. Staff Recruitment and Retention *The CCP must contain a description of staff recruitment and retention. The MCO must demonstrate how it plans to recruit and retain staff who can meet the cultural needs of the MCO's members. Cultural competence is part of job descriptions.*	**Documents Submitted:** • Cultural Competency Work Plan (2019-2020) (p. 4) • Talent at a Glance (Sept 2019) • Executive Job Profile Summaries • 2019 Goal Setting Workbook (p. 7) • Leadership Feedback Tool (p. 1) **Description of Process:** The *Cultural Competency Work Plan* includes activities and actions to maintain a culturally diverse leadership and staff model and to maintain diverse retention programs. The *Talent at a Glance* report is provided by HR on a monthly basis to the Executive Leadership team and includes workforce	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		statistics such as gender and minority demographics. The *2019 Goal Setting Workbook* and *Leadership Feedback Tool* describes our four leadership pillars. The Talent Multiplier pillar includes "Values diversity of thought and creates an inclusive working environment." SSHP assesses against theses leadership pillars in our annual performance review process, which comprises about 40% of the total performance rating.	
	Findings: The MCO does not include cultural competence in staff job descriptions. The MCO staff members stated during the review session that Centene (parent organization) is responsible for the development of staff job descriptions. The MCO notified Centene of the State contract requirement and this requirement is presently under review.		
	Required Actions: The MCO must include cultural competence in staff job descriptions.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	No later than 01/01/2021, SSHP's VP of Quality, in collaboration with SSHP's Director of Human Resources and Centene's Director of Diversity and Inclusion, will develop a Nevada job description addendum that includes cultural competence for staff with responsibilities and job duties related to cultural competency.		
HSAG Response	HSAG has determined that the MCO's CAP is sufficient to ensure compliance with this element. Implementation of the CAP will be reviewed during future compliance reviews.		
DHCFP Approval	DHCFP approves this CAP.		

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.56(d)(1)(ii) *DHCFP Contract Section 3.5.7.3 (F)(1)(a-d)*	3. Member Request for Disenrollment *The member must submit an oral or written request to the MCO to process disenrollment requests.* *a) Any member may request to switch MCO's for good cause (as defined in 42 CFR 438.56(d)(2)) at any time.* *b) These members must contact their current MCO orally or in writing for permission to disenroll.*	**Documents Submitted:** *Element 3a* • NV.ELIG.02 Disenrollment(pgs. 2, 4) • 2019 SSHP Member Handbook (updated) (p.52) • Disenrollment Notice of Decision Template *Element 3b* • Disenrollment Form Template • Disenrollment Notice of Decision Template **Description of Process:** The *NV.ELIG.02 Disenrollment* policy describes the process and criteria for Member- and Plan-initiated disenrollment. The *2019 SSHP Member Handbook* informs our members of the reasons for, and timelines when, they can disenroll or change their health plan, as well as the process to do so. The *Disenrollment Form Template* is the State form we use to document a member's request for disenrollment and what SSHP uses to notify the DHCFP if we approve the member's request.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		The *Disenrollment Notice of Decision Template* is the document SSHP uses to create the member notification of an adverse decision.	
	Findings: The MCO's Member Handbook included a *Disenrollment* section, which contained the reasons a member can disenroll for cause at any time. Although the Member Handbook included an address for disenrollment requests, the address was for Hewlett Packard Enterprise Services instead of the MCO. Further, while members were informed they could also contact the Medicaid District Office, they were not provided with the MCO's contact information for requesting disenrollment for cause. During the interview session, MCO staff members indicated they are forwarded disenrollment requests from the State, which implies members were reaching out to the State due to the information provided in the handbook. Additionally, although the MCO's NV.ELIG.02 Disenrollment policy defined the process and criteria for member-initiated disenrollment, the policy did not clearly describe the step-by-step process members and the MCO must follow to disenroll the member. During the interview session, the MCO indicated revisions have been made to the policy and the policy is currently with the Marketing team. **Recommendations:** HSAG recommends that the Member Handbook be updated to include the address and telephone number members should use when requesting disenrollment for cause. HSAG also recommends that the Disenrollment policy be updated to clearly document the disenrollment process flow.		
	Required Actions: The MCO must ensure members can submit an oral or written request to the MCO to process disenrollment requests, and members must be aware of the contact information, including address and telephone number, to use to make these requests.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	No later than 12/31/20, SSHP's Director of Customer Service, in collaboration with the Compliance and Grievance & Appeals departments, will update the NV.ELIG.02 *Disenrollment* policy to clearly document the disenrollment process flow. The updated policy will include the process for member disenrollment requests within 90 days of becoming a SilverSummit member, disenrollment during open enrollment, and good cause disenrollment, all in accordance with the requirements in contract Section 3.5.7 *Disenrollment Requirements and Limitations.*		

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	No later than 01/15/2021, SSHP's Director of Customer Service, in collaboration with the Marketing department, will update the *Disenrollment* section of the SSHP Member Handbook to specifically outline the steps members can take to request a disenrollment. The update will specify that members can contact SSHP orally or in writing to request disenrollment and will include the address and telephone number members should use when making these requests. No later than 01/15/2021, SSHP's Director of Customer Service, in collaboration with the Marketing department, will facilitate the mailing of postcards to our existing Medicaid membership to make them aware of the updated disenrollment process in our online Member Handbook.		
HSAG Response	HSAG has determined that the MCO's CAP is sufficient to ensure compliance with this element. The MCO must submit the updated policy and member handbook to DHCFP to be reviewed and approved by the DHCFP prior to the policy being finalized. Implementation of the CAP will be reviewed during future compliance reviews.		
DHCFP Approval	DHCFP approves this CAP.		
42 CFR §438.56(c)(1) *42 CFR §438.56(d)(2)(i-v)* *42 CFR §438.56(d)(3)(i)* *42 CFR §438.702(a)(3)* *DHCFP Contract Section 3.5.7.3 (H)*	5. MCO Denies Request to Disenroll *If the MCO denies the request for disenrollment for lack of good cause the MCO must send a Notice of Decision in writing to the member upon the date of the decision.* *a) Appeal rights must be included with the Notice of Decision.* *b) The MCO is required to inform the member of their right to first appeal through the MCO and if the appeal is denied to request a State Fair Hearing, how to obtain such a hearing, and representation rules must be explained to the member and provided by the MCO pursuant to 42 CFR §431.200(b); 42 CFR*	**Documents Submitted:** *Element 5a* • Disenrollment Notice of Decision Template *Element 5b* • 2019 SSHP Member Handbook (updated) (p.63) • Disenrollment Notice of Decision Template (p. 2) • NV.ELIG.02 Disenrollment (p. 1) **Description of Process:**	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	§431.220(5); 42 CFR §438.414; and 42 CFR §438.10(g)(1).	The *NV.ELIG.02 Disenrollment* policy describes the process and criteria for Member- and Plan-initiated disenrollment and indicates that if the member's request for disenrollment is denied, the member can appeal through the Fair Hearing process. The *Disenrollment Notice of Decision Template* is the document SSHP uses to create the member notification of an adverse decision. Page 2 of the template provides comprehensive information concerning the member's appeal rights, including the right to ask SSHP for an appeal and, if they do not agree with that decision, the right to ask for a State Fair Hearing. The *2019 SSHP Member Handbook* describes the process for a member to request a State Fair Hearing on page 63.	
	Findings: The MCO's Member Handbook included a *Disenrollment* section that inaccurately informed members that, if they request disenrollment with cause, and the request is denied, they may appeal by using the State fair hearing process. Additionally, the MCO's NV.ELIG.02 Disenrollment policy inaccurately stated that, if the member's request for disenrollment is denied, the member can appeal the decision through the State fair hearing process. The MCO's Notice of Decision template letter supported the MCO had a mechanism for informing the member of the disenrollment request decision; however, it contained confusing language. For example, the letter stated, "we have reviewed your request for a good cause disenrollment, received on {Blank Mandatory User Note} for coverage of {Blank Mandatory User Note}." The		

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	template language, "for coverage of…", is not appropriate for a disenrollment request. Additionally, although the letter included most of the correct appeal and State fair hearing rights language, it also informed members of how they could request continuation of services, which would not be appropriate for a disenrollment-related appeal. **Recommendations:** HSAG recommends the MCO update its Member Handbook and Disenrollment policy to clearly indicate the member must appeal to the MCO first before requesting a State fair hearing. HSAG also recommends the MCO review its Notice of Decision letter, and specifically the information pertaining to coverage and continuation of benefits, to determine appropriateness.		
	Required Actions: If the MCO denies the request for disenrollment for lack of good cause, the MCO must send a Notice of Decision in writing to the member upon the date of the decision. Appeals rights must be included with the Notice of Decision, and the MCO must also inform the member of his or her right to first appeal through the MCO and, if the appeal is denied to request a State fair hearing, how to obtain such a hearing, and representation rules must be explained to the member and provided by the MCO pursuant to federal requirements.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	As of the time of this submission, SSHP's Director of Customer Service, in collaboration with the Utilization Review department, has completed the revision of SSHP's Notice of Decision letter template to remove the inappropriate language pertaining to coverage and continuation of benefits. No later than 12/18/20, SSHP's Director of Customer Service, in collaboration with the Grievance & Appeals and Compliance departments, will review and update the SSHP Notice of Decision letter template used with disenrollment requests. The revised template will accurately reflect the member's appeals rights, including the fact that the member must first appeal to the MCO and, if the appeal is denied, to request a State fair hearing and how to obtain such a hearing. The Notice of Decision letter will also include an explanation of representation rules pursuant to federal requirements. SSHP will send a Notice of Decision in writing to the member upon the date of the decision. No later than 12/31/20, SSHP's Director of Customer Service, in collaboration with the Grievance & Appeals and Compliance departments, will update the NV.ELIG.02 *Disenrollment* policy to clearly indicate that the member must appeal to the MCO first before requesting a State fair hearing.		

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	No later than 01/15/2021, SSHP's Director of Customer Service, in collaboration with the Marketing department, will update the *Disenrollment* section of the SSHP Member Handbook to clearly indicate that the member must appeal to the MCO first before requesting a State fair hearing. No later than 01/15/2021, SSHP's Director of Customer Service, in collaboration with the Marketing department, will facilitate the mailing of postcards to our existing Medicaid membership to make them aware of the updated disenrollment process in our online member handbook.		
HSAG Response	HSAG has determined that the MCO's CAP is sufficient to ensure compliance with this element. The MCO must submit the updated policy and member handbook to DHCFP to be reviewed and approved by the DHCFP prior to the policy being finalized. Implementation of the CAP will be reviewed during future compliance reviews.		
DHCFP Approval	DHCFP approves this CAP.		
42 CFR §438.56(d)(5)(i-ii) *42 CFR §438.56(e)(1)* *DHCFP Contract Section 3.5.7.3 (I)*	6. Use of the MCO's Grievance System *DHCFP requires that the member seek redress through the MCO's grievance system before making a determination on the member's request.* *a) The grievance process must be completed in time to permit the disenrollment (if approved) to be effective no later than the first day of the second month following the month in which the member files the request.*	**Documents Submitted:** *Element 6a* • NV.ELIG.02 Disenrollment (p.1) • Disenrollment Form Template **Description of Process:** The *NV.ELIG.02 Disenrollment* policy describes the process and criteria for managing a member's request for disenrollment, including completion of initial documentation at the time of the call receipt of written correspondence. The policy also establishes the expectation that SSHP will render a decision and notify the member within 14 calendar days	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		or sooner if the member's health requires an expedited decision. The *Disenrollment Form Template* is the State form we use to document a member's request for disenrollment and provides for both the date that the member submitted the disenrollment request and the date that SSHP approved the request.	
	Findings: The NV.Elig.02 Disenrollment policy described the process and criteria for member requested disenrollments; however, the policy did not describe how the grievance process was used in the disenrollment process. During the interview session, MCO staff members indicated they reach out to members after they receive the disenrollment request and attempt to keep the member in their plan by resolving the members' concerns. For example, staff members indicated they may obtain a single case agreement with a non-participating provider if necessary to address the member's concerns about a provider not being in network. Staff members indicated they log these situations as issues, but they would not necessarily go through the formal grievance process.		
	Required Actions: The MCO must ensure that members seek redress through the MCO's grievance system before making a determination on the member's disenrollment request. The grievance process must be completed in time to permit the disenrollment (if approved) to be effective no later than the first day of the second month following the month in which the member files the request.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	No later than 12/31/20, SSHP's Director of Customer Service, in collaboration with the Grievance & Appeals and Compliance departments, will update the NV.ELIG.02 *Disenrollment* policy to ensure that members seek redress through SSHP's grievance system before the health plan makes a determination concerning the member's disenrollment request, and that the grievance process is completed in time to permit timely disenrollment in compliance with DHCFP Contract Section 3.5.7.3 (I).		

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	No later than 01/15/2021, SSHP's Director of Customer Service, in collaboration with the Marketing department, will update the *Disenrollment* section of the SSHP Member Handbook to clearly indicate SSHP will facilitate member redress through SSHP's grievance system before making a determination on the member's disenrollment request. No later than 01/15/2021, SSHP's Director of Customer Service, in collaboration with the Marketing department, will facilitate the mailing of postcards to our existing Medicaid membership to make them aware of the updated disenrollment process in our online Member Handbook.		
HSAG Response	HSAG has determined that the MCO's CAP is sufficient to ensure compliance with this element. The MCO must submit the updated policy and member handbook to DHCFP to be reviewed and approved by the DHCFP prior to the policy being finalized. Implementation of the CAP will be reviewed during future compliance reviews.		
DHCFP Approval	DHCFP approves this CAP.		