State of Nevada

Division of Health Care Financing and Policy

FY 2014-2015 Internal Quality Assurance Program (IQAP) On-Site Review of Compliance

for

Health Plan of Nevada

March 2015

HSAG Health Services Advisory Group

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1. Executive Summary
for Health Plan of Nevada

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

The purpose of the fiscal year (FY) 2014–2015 Internal Quality Assurance Program (IQAP) On-Site Review of Compliance was to determine **Health Plan of Nevada** (**HPN**'s) compliance with federal and the State's managed care standards. For the FY 2014–2015 IQAP On-Site Review of Compliance, HSAG reviewed **HPN**'s managed care and quality program activities that occurred during FY 2013–2014. HSAG reviewed **HPN**'s compliance with the following:

- State and federal managed care requirements, which were categorized into 14 contract standards, referred to as ***IQAP Standards***
- Outreach and educational materials associated with member rights and responsibilities, member handbook, medical record standards, and the provider manual, referred to as ***Checklists***
- Operational compliance for credentialing, recredentialing, service denial, grievances, and appeal processing activities, referred to as ***File Reviews***

HPN had a composite score of 98.6 percent for all elements evaluated in the FY 2014-2015 IQAP Compliance Review. With a couple of exceptions noted in this report, **HPN** demonstrated strong compliance with the federal and State requirements contained in its managed care contract. Figure 1 summarizes the overall ratings for **HPN**'s IQAP Standards, Checklists, and File Reviews for the FY 2014-2015 IQAP Compliance Review.

Figure 1 presents the combined overall rating for **HPN**.

Figure 1 Overall Rating for HPN	
IQAP Standards Score	For the IQAP Standards, **HPN** received a total score of **97.3%**.
Checklist Score	For the Checklist review, **HPN** received a total score of **98.7%**.
File Review Score	For the File Review, **HPN** received a total score of **99.1%**.
Overall Score	**HPN** received an overall rating of **98.6%** for all elements reviewed in the FY 2014–2015 IQAP Compliance Review.

2. Background
for Health Plan of Nevada

Overview

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

According to the 42nd Code of Federal Regulations (CFR) 438.358, which describes the activities related to external quality reviews, 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. In accordance with 42 CFR 438.204(g), these standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR 438. To meet this requirement, DHCFP contracted with HSAG to perform a comprehensive review of compliance with State and federal standards for **Health Plan of Nevada (HPN**). According to the federal requirements, the quality of health care delivered to Medicaid recipients enrolled in MCOs must be tracked, analyzed, and reported annually. Oversight activities of the EQRO focus on evaluating quality outcomes and the timeliness of, and access to, care and services provided to Medicaid and Nevada Check Up beneficiaries.

Purpose of the Review

The purpose of the fiscal year (FY) 2014–2015 Internal Quality Assurance Program (IQAP)[1-1] On-Site Review of Compliance was to determine **HPN**'s compliance with federal and the State's managed care standards. In addition, HSAG conducted a review of individual files for the areas of credentialing, recredentialing, grievances, appeals, denials, and case management services to evaluate **HPN**'s implementation of the standards. Checklist reviews validated that the managed care organization (MCO) informed members of their rights and responsibilities and other required information in the member handbook. Checklists also confirmed that **HPN** apprised providers of the medical records standards and additional required information in the provider manual. For the FY 2014–2015 IQAP On-Site Review of Compliance, HSAG reviewed **HPN**'s quality program activities that occurred during the review period, which was July 1, 2013–June 30, 2014 (i.e., FY 2013–2014).

[1-1] The internal quality assurance program (IQAP) is a strategy consisting of systematic quality improvement activities to ensure an ongoing quality assessment and performance improvement (QAPI) program for services furnished to recipients.

3. Methodology
for Health Plan of Nevada

Compliance Review Process

The IQAP standards were derived from the requirements as set forth in the Department of Human Services, Division of Health Care Financing and Policy Request for Proposal No. 1988 for Managed Care, and all attachments and amendments in effect during FY 2013–2014. HSAG followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012[1-2] to create the process, tools, and interview questions used for the FY 2014–2015 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 laws and on the requirements set forth in the contract between DHCFP and the MCOs, as they related to the scope of the review. HSAG conducted pre-on-site, on-site, and post-on-site review activities.

Pre-on-site review activities included:

- Developing the compliance review tools.
- Preparing and forwarding to 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.
- Scheduling the on-site reviews.
- Developing the agenda for the 2-day on-site review.
- Providing the detailed agenda and the data collection (compliance review) tool to each MCO to facilitate its preparation for HSAG's review.
- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents and other information obtained from DHCFP, and of documents 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 on-site review.
- Generating a list of 10 sample cases plus an oversample of 5 cases for each of the following file reviews: grievances, appeals, denials, credentialing, recredentialing, and case management.

On-site review activities included**:**

[1-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By- Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

- An opening conference, with introductions and a review of the agenda and logistics for HSAG's on-site review activities.
- A review of the documents HSAG requested that each MCO have available on-site.
- A review of the member cases HSAG requested from each MCO.
- A review of the data systems each MCO used in its operations, which includes but is not limited to care management, grievance and appeal tracking, quality improvement tracking, and quality measure reporting.
- Interviews conducted with 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 (compliance review) tool shown in Appendix A, which now serves as a comprehensive record of HSAG's findings, performance scores assigned to each requirement, and the actions required to bring the MCOs' performance into compliance for those requirements that HSAG assessed as less than fully compliant. The results for the IQAP standards are noted in Table 2 of this report. The results for checklists and file reviews are summarized in Table 3 and Table 4, respectively, in the pages that follow.

Post-on-site review activities: HSAG reviewers aggregated findings to produce this comprehensive compliance review report. In addition, HSAG created the Corrective Action Plan (CAP) template, shown in Appendix B, which contains the findings and recommendations for each element scored *Partially Met* or *Not Met*. When submitting its CAP to DHCFP, **HPN** 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). **HPN** must submit its CAP to DHCFP **within 21 days of receiving this report.**

Description of Data Obtained

To assess the MCOs' 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, the following:

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

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

IQAP Standards, Checklists, and Files Reviewed

Table 1 lists the standards reviewed and associated checklists or files reviewed as evidence of compliance with internal policies.

Table 1: IQAP Standards, Checklists, and File Reviews		
IQAP Standard Number	IQAP Standard Name	Number of Elements
I	Internal Quality Assurance Program	54
II	Credentialing and Recredentialing	16
III	Member Rights and Responsibilities	14
IV	Member Information	14
V	Availability and Accessibility of Services	28
VI	Continuity and Coordination of Care	16
VII	Grievances and Appeals	35
VIII	Subcontracts and Delegation	13
IX	Cultural Competency Program	16
X	Coverage and Authorization of Services	23
XI	Provider Dispute and Complaint Resolution	9
XII	Confidentiality and Record Keeping	9
XIII	Provider Information	3
XIV	Enrollment/Disenrollment	11
	Total Number of IQAP Elements	261
Associated IQAP Standard #	Checklist Name	Number of Elements
III	Member Rights and Responsibilities	9
IV	Member Handbook	34
XII	Medical Record Standards	26
XIII	Provider Manual	10
	Total Number of Checklist Elements	79
Associated IQAP Standard #	File Review Name	Number of Elements
II	Initial Credentialing	162
II	Recredentialing	207
VII	Grievances	30
VII	Appeals	39
VII	Denials	30
VI	Case Management	177
	Total Number of File Review Elements	645

Data Aggregation and Analysis

IQAP Standards

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which the 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 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. The protocol describes the scoring as follows:

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

From the scores it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each of the 14 IQAP standards and an overall percentage-of-compliance score across the 14 IQAP standards. HSAG calculated the total score for each of the standards by adding the weighted score for each requirement in the standard receiving a score of *Met* (value: 1 point), *Partially Met* (value: 0.5 point), and *Not Met* (0 points) and 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 areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores and dividing the result by the total number of applicable requirements).

Checklists

For the Checklists reviewed, HSAG surveyors scored each applicable element within the checklists as either *Yes*, the element was contained within the associated document, or *No*, the element was not contained within the document. Elements that were not applicable to the MCO were scored as *Not Applicable* and were not included in the denominator of the total score. To obtain a percentage

score, HSAG added the total number of elements that received a *Yes* score and divided it by the total number of applicable elements.

File Reviews

HSAG conducted file reviews of the MCO's records for credentialing, recredentialing, grievances, appeals, denials, and case management to verify that the MCO has put into practice what the MCO documented in its policy. HSAG randomly selected 10 files of each type of record from the full universe of records provided by the MCO. The file reviews were not intended to be a statistically significant representation of all of the MCO's files. Rather, the file review highlighted when practices described in policy were not followed by MCO staff. Based on the results of the file reviews, the MCO must determine if any areas found to be out of compliance are the result of an anomaly or if a more serious breach in policy occurred.

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

Aggregating the Scores

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

- Documented findings describing the MCOs' performance in complying with each of the IQAP standard requirements.
- Scores assigned to the MCOs' performance for each requirement.
- The total percentage-of-compliance score calculated for each of the 14 IQAP standards.
- The overall percentage-of-compliance score calculated across the 14 IQAP standards.
- The overall percentage-of-compliance score calculated for each of the file reviews.
- The overall percentage-of-compliance score calculated for each of the checklists.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Partially Met* or *Not Met*.

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

4. IQAP Findings
for Health Plan of Nevada

Evaluation Ratings for HPN

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

Table 2 presents **HPN**'s scores for the IQAP standards. Details regarding **HPN**'s compliance with the 14 IQAP standards, including the score **HPN** received for each of the elements in each standard, can be found in Appendix A, IQAP FY 2014–2015 Compliance Review Tool for **HPN.**

Table 2 Summary of Scores for the IQAP Standards

IQAP Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				M	*PM*	*NM*	*NA*	
I	Internal Quality Assurance Program	**54**	54	53	1	0	0	**99.1%**
II	Credentialing and Recredentialing	**16**	15	15	0	0	1	**100.0%**
III	Member Rights and Responsibilities	**14**	14	13	1	0	0	**96.4%**
IV	Member Information	**14**	14	14	0	0	0	**100.0%**
V	Availability and Accessibility of Services	**28**	28	27	1	0	0	**98.2%**
VI	Continuity and Coordination of Care	**16**	16	16	0	0	0	**100.0%**
VII	Grievances and Appeals	**35**	35	31	3	1	0	**92.9%**
VIII	Subcontracts and Delegation	**13**	12	10	2	0	1	**91.7%**
IX	Cultural Competency Program	**16**	16	14	2	0	0	**93.8%**
X	Coverage and Authorization of Services	**23**	23	23	0	0	0	**100.0%**
XI	Provider Dispute and Complaint Resolution	**9**	9	9	0	0	0	**100.0%**
XII	Confidentiality and Record Keeping	**9**	9	8	1	0	0	**94.4%**
XIII	Provider Information	**3**	3	3	0	0	0	**100.0%**
XIV	Enrollment/Disenrollment	**11**	11	10	1	0	0	**95.5%**
	Total Compliance Score	**261**	**259**	**246**	**12**	**1**	**2**	**97.3%**

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

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

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

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

A review of the IQAP standards show how well an MCO has interpreted the required elements of the managed care contract and developed the necessary policies, procedures, and plans to carry out the required functions of the MCO. Of the 259 applicable elements, **HPN** received a *Met* for 246 elements, a *Partially Met* for 12 elements, and a *Not Met* for 1 element. The findings suggest that,

with a few exceptions, **HPN** developed the necessary policies, procedures, and plans to operationalize the required elements of its contract and demonstrate its compliance with the contract. Further, interviews with **HPN** staff showed that staff were knowledgeable about contract requirements and the procedures the MCO employed to meet its contractual requirements.

Table 3 presents the scores for the checklists. HSAG reviewed all requirements related to Member Rights and Responsibilities, Member Handbook, Medical Record Standards, and Provider Manual to verify that each was in compliance with State and federal requirements. HSAG scored the elements required for each of these areas via checklists. Each checklist review area was scored based on the total number of **HPN**'s compliant elements divided by the total number of applicable elements for each of the four areas reviewed.

Table 3 Summary of Scores for the Checklists

Associated IQAP Standard #	Description of File Review	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
III	Member Rights and Responsibilities	**9**	9	100%
IV	Member Handbook	**34**	33	97.1%
XII	Medical Record Standards	**26**	26	100%
XIII	Provider Manual	**10**	10	100%
	Checklist Totals	**79**	**78**	**98.7%**

The results generated by the checklists serve as another indicator of the MCO's development of outreach information and ensure that the information contains all contractually required elements. Of the 79 elements reviewed for the checklists, **HPN** received a score of *Met* for all 78 elements. The findings suggest that **HPN** had strong compliance with each of the areas evaluated by the checklists and **HPN** developed the necessary manuals, standards, and policies according to contract requirements. **HPN**'s member handbook did not contain the provision that if a member loses Medicaid or Check Up eligibility, the member will be auto-assigned once eligibility is restored.

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

Table 4 Summary of Scores for the File Reviews

Associated IQAP Standard #	Description of File Review	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
II	Initial Credentialing	**10**	162	162	100%
II	Recredentialing	**10**	207	207	100%
VII	Grievances	**10**	30	29	96.7%
VII	Appeals	**10**	39	35	89.7%
VII	Denials	**10**	30	30	100%
VI	Case Management	**10**	177	176	99.4%
	File Review Totals	**60**	**645**	**639**	**99.1%**

File reviews are important to the overall findings of the IQAP review because the results show how well an MCO operationalized and followed the policies it developed for the required elements of the contract. Of the 645 applicable elements reviewed for the file reviews, **HPN** received a score of *Met* for 639 of the elements for a total of 99.1 percent. **HPN** scored 100 percent compliant for three of the areas reviewed, Initial Credentialing, Recredentialing, and Denials. **HPN** scored 99.4 percent for Case Management and 96.7 percent for the Grievance record reviews. These results suggest that **HPN** followed the policies it developed to operationalize the required elements of its contract.

The greatest opportunity for improvement was with the Appeals record review wherein **HPN** scored 89.7 percent. The Appeals record review showed that 8 of 10 appeals were acknowledged within the required timeframe; 6 of 6 standard appeals were resolved within the required timeframe; 3 of 4 expedited appeals were resolved with the proper notice sent; and there was 1 expedited appeal that was not resolved within the required timeframe and no extension notice was sent to the member.

5. Conclusions and Recommendations
for **Health Plan of Nevada**

Conclusions and Recommendations

Figure 2 presents overall ratings for **HPN** for IQAP Standards, Checklists, and File Reviews, as well as the overall composite score.

Figure 2 Overall Rating for HPN	
IQAP Standards Score	For the IQAP Standards, **HPN** received a total score of **97.3%**.
Checklist Score	For the Checklist review, **HPN** received a total score of **98.7%**.
File Review Score	For the File Review, **HPN** received a total score of **99.1%**.
Overall Score	**HPN** received an overall rating of **98.6%** for all elements reviewed in the FY 2014–2015 IQAP Compliance Review.

HPN's overall results for the review of the IQAP standards in the FY 2014–2015 on-site review was 97.3 percent. In addition, **HPN** received a score of 99.1 percent for the file review, a score of 98.7 percent for the checklist review, and an overall composite score of 98.6 percent. The overall results demonstrated that, with a few exceptions, **HPN** had strong adherence to State and federal standards required by its contract with DHCFP. **HPN** developed the necessary policies, procedures, and plans to carry out the required functions of the contract and the checklists and file review results demonstrated that **HPN** staff appropriately operationalized the elements described in its policies, procedures, and plans, with a few exceptions described below.

Compliance with IQAP Standards

Of the 14 standard areas reviewed, **HPN** achieved 100 percent compliance on 6 standards, demonstrating performance strengths and adherence to all requirements measured in the areas of Credentialing and Recredentialing, Member Information, Continuity and Coordination of Care, Coverage and Authorization of Services, Provider Dispute and Complaint Resolution, and Provider Information.

The following standards achieved at least 91 percent or higher for all elements contained in the standards: Internal Quality Assurance Program, Member Rights and Responsibilities, Availability and Accessibility of Services, Grievances and Appeals, Subcontracts and Delegation, Cultural Competency Program, Confidentiality and Record Keeping, and Enrollment/Disenrollment.

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

Compliance with File Review

HPN achieved 100 percent compliance on the Initial Credentialing and Recredentialing file reviews, which demonstrated the MCO's strong compliance with the credentialing and recredentialing standards. **HPN** also received 100 percent compliance for all required elements related to the file review for service Denials. All files reviewed demonstrated **HPN**'s compliance with the standards related to notices of decision when the MCO denied a service.

HPN received a 89.7 percent score for the Appeal file review. The Appeal file review showed that 8 of 10 appeals were acknowledged within the required timeframe; 6 of 6 standard appeals were resolved within the required timeframe; 3 of 4 expedited appeals were resolved with the proper notice sent; and for the 1 expedited appeal which was not resolved within the required timeframe, no extension notice was sent to the member. The Appeal file review did show that all appeal decisions were made by staff with the appropriate clinical expertise and who were not involved in the original decision to deny services.

- HSAG recommends that **HPN** determine if areas found to be out of compliance are the result of an anomaly or if a more serious breach in policy occurred. Further, **HPN** must acknowledge appeals within the timeframes specified by its policy. For expedited appeals, the MCO must ensure that a notice of extension is sent to members when the MCO requires more time to resolve the expedited appeal and that the expedited appeal is resolved within the required timeframes specified by the MCO's policy.

HPN received a 96.7 percent score for Grievance file review. The Grievance file review showed that 9 of 10 grievances were acknowledged within the required timeframe; all grievances were resolved within the required timeframe; and all grievances were reviewed and decisions were made by staff with appropriate clinical expertise.

- HSAG recommends that **HPN** determine if areas found to be out of compliance are the result of an anomaly or if a more serious breach in policy occurred. Further, **HPN** must ensure that grievances are acknowledged within the timeframes specified by its policy.

HPN achieved 99.4 percent compliance on the case management file review. **HPN** had strong adherence to the contractual requirements for identification and performing and documenting a comprehensive health risk assessment. In one file, the assessment was performed outside of the timeframe. All of the files reviewed showed that **HPN** had developed and documented a comprehensive case management plan, which included evidence that disease-specific health education materials were sent to the member. **HPN** met all of the requirements evaluated for reassessment of the care management plan. Further, the **HPN** case management files showed that **HPN** case managers evaluated members' barriers to achieve members' goals and worked with members to overcome those barriers.

- HSAG recommends that **HPN** complete comprehensive assessments of members within 90 days of enrollment.

Compliance with Checklists

HPN achieved 98.7 percent compliance for the checklist review, wherein **HPN** received a *Not Met* for one element related to the member handbook. Overall, **HPN**'s results for checklists

demonstrated strong compliance with the requirements for information included in the member rights and responsibilities, the member handbook, medical record standards, and the provider manual.

6. Corrective Action Plan
for **Health Plan of Nevada**

Corrective Action Plan

Appendix B contains the Corrective Action Plan (CAP) template HSAG prepared for **HPN** to use in preparing its CAP to be submitted to DHCFP. The template lists each of the elements for which HSAG assigned a score of *Partially Met* or *Not Met*, and the associated findings and recommendations made to bring the organization's performance into full compliance with the requirement. **HPN** must use this template to submit its corrective action plan to bring any elements scored *Partially Met* or *Not Met* into compliance with the applicable standard(s). **HPN**'s CAP must be submitted to DHCFP **no later than 21 calendar days after receipt of this report**.

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

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

Any corrective action plans that do not meet the above criteria will require resubmission by the organization until approved by 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 **HPN** in its submitted CAP.

Standard I. Internal Quality Assurance Program

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.2.6.3	1. Dental Director Oversight of Internal Quality Assurance Plan (IQAP) The Dental Director is responsible for the oversight of development, implementation and review of the MCO's internal quality assurance program for the dental program, including adherence to any plan of correction (POC).	**Documents Submitted:** • 2013 Dental Program Description • 2013 UM Program Description FINAL pg.45 • 2014 UM Program Description Final pg.45 • HPN Dental Director job description **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2013 Dental Program Description, 2013 UM Program Description, 2014 UM Program Description, and the HPN Dental Director job description provided evidence of the Dental Director's responsibility for the oversight of the MCO IQAP dental program.		
	Recommendations: None.		
DHCFP Contract Section 4.2.6.3 (A-H)	2. Responsibilities of the Dental Director The responsibilities of the Dental Director include the following: a) Serves on the MCO's applicable utilization review/quality assurance committee(s); b) Directs the development and implementation of the MCO's IQAP and utilization management activities, and monitors the quality of the dental care that MCO recipients receive regarding dental services. c) Oversight of the development and revision of the	**Documents Submitted:** • 2013 Dental Program Description • HPN Dental Director job description **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I. Internal Quality Assurance Program

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	MCO's dental care standards, practice guidelines and protocols; d) Reviews all potential quality-of-care problems regarding dental services, and oversees development and implementation of plans of correction; e) Oversight of the MCO's referral process for specialty and out-of-network services. All services prescribed by a dentist or requested by an enrolled recipient which are denied by the MCO are reviewed by a dentist; the reason for the denial must be documented and logged; all denials identify the appeal rights of the recipient; f) Oversight of the MCO's dental provider recruiting and credentialing activities; g) Serves as a liaison between the MCO and its dental providers, communicating regularly with the MCO's dental providers, including oversight of provider education, in-service training and orientation; and, h) Available to the MCO's medical staff for consultation on referrals, denials, grievances, and appeals, and problems regarding dental services.		
	Findings: The 2013 Dental Program Description, 2013 UM Program Description, 2014 UM Program Description, and the HPN Dental Director job description provided evidence of the Dental Director's responsibilities required by this element.		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None.		
DHCFP Contract Section 4.7.2.2 (B)	3. EPSDT Program The MCO's internal quality assurance of the EPSDT programs includes monitoring and evaluation of the referrals that are the result of an EPSDT screening.	**Documents Submitted:** • EPSDT report 2013-2014 • WRHCO 133 EPSDT (Healthy Children Screening) **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2013 and 2014 HPN SHL QI Work Plans included the performance goal to improve EPSDT screening and referral rates for Medicaid members and also included the persons and committees responsible for the performance goal. The EPSDT Report 2013-2014 showed results of indicators for Medicaid children under the age of 21, which included well child visits, screening tests, and immunizations.		
	Recommendations: None.		
42 CFR 438.240 *42 CFR 438.240(a)* *42 CFR 438.20(b)(1)* *42 CFR 438.240(d)(1)(i-iv)* *42 CFR 438.240(d)(2)* *DHCFP Contract Section 4.8*	4. Ongoing QA and PIP Programs The MCO's IQAPs consists of systematic activities, undertaken by the MCO, to monitor and evaluate the care delivered to enrolled recipients according to predetermined, objective standards, and effect improvements as needed.	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc FINAL pg.27-32 • 2013 QI Program Eval FINAL entire doc • 2014 HPN SHL QI Program Desc pg.26-31 • AMB_PIP Summary Form FINAL • CAP_PIP Summary Form_FINAL **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2013 HPN and SHL QI Program Description, 2013 QI Program Evaluation, and 2014 HPN SHL QI Program Description provided evidence of HPN's ongoing quality assurance and performance improvement programs that monitor and evaluate the care delivered to enrolled recipients according to predetermined, objective standards. During the on-site interview, HPN staff described that the quality improvement department was responsible for tracking and reporting the quality of care the health plan		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	delivers, such as HEDIS measurement and reporting, member surveys, disease management, and all performance measures and performance improvement projects that were tracked for Medicaid and Check Up. The QI department was also responsible for developing the annual QI Program Evaluation.		
	Recommendations: None.		
DHCFP Contract Section 4.8.1.4	5. Evaluation of the IQAP The MCO has its own evaluation of the impact and effectiveness of its quality assessment and IQAP.	**Documents Submitted:** • 2013 QI Program Eval-entire doc **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2013 QI Program Evaluation provided evidence of HPN's ongoing monitoring and evaluation of its quality assurance and performance improvement programs.		
	Recommendations: None.		
42 CFR 438.242(b)(2) *42 CFR 438.242(a)* *42 CFR 438.242(b)(1)* *42 CFR 438.242(b)(2)(i-iii)* *42 CFR 438.242(b)(3)* *DHCFP Contract Section 4.8.4*	6. Health Information The MCO maintains a health information system that collects, analyzes, integrates, and reports data in accordance with 42 CFR 438.242 and can achieve the objectives of the ongoing IQAP. The systems provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than the loss of program eligibility. The basic elements of a health information system with which an MCO complies include the following: a) Collect data on member and provider characteristics as specified by the DHCFP, and on services	**Documents Submitted:** • WRHCO 277 Medicaid Encounter Reporting **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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	furnished to the members through an encounter data system or other methods as may be specified by the DHCFP; b) Verify the data received from providers is accurate, complete, and timely; and in accordance with 42 CFR 438.242(b)(2); and c) Make all collected data available to the DHCFP and upon request to CMS as required.		
	Findings: HPN's policy, WRHCO 277 Encounter Reporting, provided evidence of HPN's policy to require the submission of encounter data from sub-capitated providers, for all covered services provided to an HPN Medicaid or Nevada Check Up member. HPN staff stated that all other providers received a fee-for-service payment from HPN for health care rendered to Medicaid and Check Up members. HPN's encounter reporting policy described HPN's requirements for receiving encounter data as well as its process for validating the encounter data received from providers. Further, HPN's policy included the provision for making collected data available to DHCFP as required.		
	Recommendations: None.		
DHCFP Contract Section 4.8.5	7. Written IQAP Description The MCO has a written description of its IQAP. The written description contains a detailed set of quality assurance (QA) objectives, which are developed annually and include a timetable for implementation and accomplishment.	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc- entire doc • 2013 HPN and SHL QI Workplan FINAL • 2014 HPN SHL QI Program Desc- entire doc • 2014 HPN SHL QI Workplan **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: Both the 2013 and 2014 HPN and SHL QI Program Descriptions and the 2013 and 2014 QI Work Plans provided evidence of HPN's written IQAP description and included the objectives identified for the program. It also included the objectives identified by DHCFP in its State Quality Strategy.		
	Recommendations: None.		
DHCFP Contract Section 4.8.5.3 (A)	8. Scope of the IQAP The scope of the IQAP is comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service, such as and including: availability, accessibility, coordination, and continuity of care.	**Documents Submitted:** • 2013 HPN Access and Availability Policy pg. 10-14, 17-19 • 2013 HPN and SHL QI Program Desc- pg.6-8 • 2013 HPN and SHL QI Workplan-entire doc • 2013 QI Program Eval-entire doc • 2014 HPN SHL QI Program Desc- pg.6-8 • 2014 HPN SHL QI Workplan-entire doc • Continuity and Coordination of Care Policy 2013 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2013 and 2014 HPN and SHL QI Program Descriptions a described the quality of clinical and nonclinical care and the scope of the quality improvement program in place. The policy, Continuity and Coordination of Care, addressed coordination of care program in place at HPN. The 2013 HPN Access and Availability Policy described HPN's activities to promote access to information from the health plan at the times member need it. The 2013 and 2014 QI Work Plans provided evidence of HPN's monitoring of both clinical and nonclinical aspects of services.		
	Recommendations: None.		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.240(b)(4) *DHCFP Contract Section 4.8.5.3 (B)*	9. Range of Care The IQAP methodology provides for review of the entire range of care provided by the MCO, including services provided to 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.	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc-pg.5 • 2013 QI Program Eval-pg. 22-25 • 2013 UM Program Eval FINAL • 2014 HPN SHL QI Program Desc-pg.5 • Continuity and Coordination of Care Policy 2013 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HPN's 2013 and 2014 QI Program Descriptions included the entire range of services required by this element, which are provided by the MCO. The 2013 QI Program Evaluation and 2013 UM Program Evaluation provided evidence of HPN's monitoring and evaluation of the entire range of services managed by the MCO. The two documents also provided evidence that the review of the entire range of care was carried out over multiple review periods. During the on-site review, HPN staff stated that the care provided to children with special health care needs was tracked as part of the complex case management program.		
	Recommendations: None.		
DHCFP Contract Section 4.8.5.4	10. Specific Activities in the IQAP The written description specifies 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 are clearly identified and qualified to develop the studies and analyze outcomes.	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc-entire doc • 2013 HPN and SHL QI Workplan--entire doc • 2014 HPN SHL QI Program Desc- entire doc • 2014 HPN SHL QI Workplan-entire doc	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		• LT resume 2013 (Updated 12-13) **Description of Process:** N/A	
	Findings: The 2013 HPN and SHL QI Program Description and the 2013 HPN and SHL QI Work Plan provided evidence of the quality of care studies and other quality improvement activities undertaken by HPN for 2013. Likewise, the 2014 HPN and SHL QI Program Description and the 2014 HPN and SHL QI Work Plan provided evidence of the quality of care studies and other quality improvement activities undertaken by HPN for the year. The QI work plans for both years listed the individuals responsible for the QI activities and the plan for monitoring each of the activities.		
	Recommendations: None.		
DHCFP Contract Section 4.8.5.6	11. Continuous Performance Activities The written description provides for continuous performance of the activities, including tracking of issues over time.	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc-entire doc • 2013 HPN and SHL QI Workplan-entire doc • 2014 HPN SHL QI Program Desc-entire doc • 2014 HPN SHL QI Workplan-entire doc **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2013 HPN and SHL QI Program Description and the 2014 HPN and SHL QI Program Description provided evidence of the quality of care studies and other quality improvement activities undertaken by HPN for each year. The QI work plans for each year provided evidence of HPN's tracking of the activities and issues over time. The QI evaluations for each year described the interventions and activities that occurred over the year, results of quality measurement and studies performed accomplishments for the year, and challenges and opportunities for action for the following year.		
	Recommendations: None.		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.8.5.7	12. Provider Review Physicians and other health professionals review the process followed in the provision of health services and provide feedback to health professionals and the MCO's staff regarding performance and patient health care outcomes.	**Documents Submitted:** • 2013 HPN and SHL QI Eval Highlights Part 2 • 2013 HPN and SHL QI Program Desc-entire doc • 2013 HPN SHL QI Eval Highlights part I • 2013 Provider Summary Guide pg. 66, 420 • 2014 HPN SHL QI Program Desc--entire doc • 2014 Provider Summary Guide pg. 65, 205 • Practitioner Meeting Participation Grid • Provider-Survey 2013_Summary • QIC Meeting Minutes **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Provider-Survey 2013 Summary provided evidence of the aggregation of provider feedback from a provider survey administered by HPN. The document, 2013 HPN and SHL QI Evaluation Highlights, provided evidence of HPN's QI highlights and performance that were presented to its Customer Centric Task Force. According to the 2013 HPN and SHL QI Program Description, the Customer Centric Task force was created to focus on areas that impact health plan members and providers as related to NCQA accreditation and other regulatory requirements. The task force included providers, who were also participants of the Quality Improvement Committee (QIC). The document, Practitioner Meeting Participation Grid, listed the names of providers and their respective specialties, and all of the committees in which they participate, which included the Quality Improvement Committee, Customer Centric Task Force, Medicaid Quality Improvement Subcommittee, Quality Review Committee, and Utilization Management Committee, among other committees. The Quality Improvement Committee Meeting Minutes from July 25, 2013 and January 9, 2014 provided evidence that Medicaid performance measure results and health care outcome information was presented to the committee. The January 9, 2014 meeting minutes also provided evidence of subcommittee report presentations that were made to		

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	the QIC. During the on-site review, HPN staff provided a copy of the Gaps in Care report, which is a type of provider profile that shows all of the HEDIS measures assigned to a given provider or group practice based on the provider's membership. The Gaps in Care report showed where there were noted gaps in care, based on HEDIS measure specifications, for the population served by the provider. HPN staff stated that the report aids in discussions with providers about HEDIS measures and the performance of the provider relative to those measures.		
	Recommendations: None.		
DHCFP Contract Section 4.8.5.8	13. Focus on Health Outcomes The IQAP methodology addresses health outcomes to the extent consistent with existing technology.	**Documents Submitted:** • Mcaid QIC Presentation_FINAL • Medicaid Process Improvement - September 2013 (3) • QIC Meeting Minutes **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The document, Mcaid QIC Presentation Final, provided evidence of the health outcomes reviewed and monitored for the Medicaid population. The QI program descriptions also described the methodology used to collect information that performance measure rates related to health outcomes. The QI work plans each described the performance goals that would be measured to assess performance for Medicaid services provided. The Quality Improvement Committee Meeting Minutes from July 25, 2013 and January 9, 2014 provided evidence that Medicaid performance measure results and health care outcome information was presented to the committee. The January 9, 2014 meeting minutes also provided evidence of subcommittee report presentations that were made to the QIC. The presentation, Medicaid Process Improvement September 2013, provided evidence of the specific Medicaid and Check Up quality initiatives and interventions that were planned to address opportunities for improvement.		
	Recommendations: None.		
42 CFR 438.204(b)(1) *DHCFP Contract Section 4.8.6*	14. Systematic Process of QA and QI The IQAP objectively and systematically monitors and	**Documents Submitted:** • 2013 HPN and SHL QI Program -entire doc	☒ Met ☐ Partially Met ☐ Not Met

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	evaluates the quality and appropriateness of care and service provided to enrolled recipients through quality of care studies and related activities, and pursues opportunities for improvement on an ongoing basis.	• 2013 HPN and SHL QI Workplan-entire doc • 2013 QI Program Eval- pg. 117-131 • 2014 HPN SHL QI Program Desc-entire doc • 2014 HPN SHL QI Workplan-entire doc • AMB_PIP Summary Form FINAL • CAP_PIP Summary Form_FINAL **Description of Process:** N/A	☐ N/A
	Findings: The 2013 HPN and SHL QI Program Description and the 2014 HPN and SHL QI Program Description provided evidence of the quality of care studies and other quality improvement activities undertaken by HPN for each year. The QI program descriptions also described the methodology used to collect information that performance measure rates related to health outcomes. The QI work plans for each year provided evidence of HPN's tracking of the activities and issues over time. The document, Mcaid QIC Presentation Final, provided evidence of the health outcomes reviewed and monitored for the Medicaid population. The QI work plans each described the performance goals that would be measured to assess performance for Medicaid services provided. The Quality Improvement Committee Meeting Minutes from July 25, 2013 and January 9, 2014 provided evidence that Medicaid performance measure results and health care outcome information was presented to the committee. The January 9, 2014 meeting minutes also provided evidence of subcommittee report presentations that were made to the QIC. The presentation, Medicaid Process Improvement September 2013, provided evidence of the specific Medicaid and Check Up quality initiatives and interventions that were planned to address opportunities for improvement.		
	Recommendations: None.		
42 CFR 438.240(b)(1) *DHCFP Contract Section 4.8.6*	15. Written Guidelines for the IQAP The IQAP has written guidelines for its Performance Improvement Projects (PIPs) and related activities.	**Documents Submitted:** • 2013 HPN and SHL QI Program-entire doc • 2013 HPN and SHL QI Workplan-entire	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		doc • 2014 HPN SHL QI Program Desc-entire doc • 2014 HPN SHL QI Workplan-entire doc **Description of Process:** N/A	
	Findings: The 2013 HPN and SHL QI Program Description and the 2014 HPN and SHL QI Program Description provided evidence of the quality of care studies and other quality improvement activities undertaken by HPN for each year. The QI work plans for each year provided evidence of HPN's tracking of the activities and issues over time. Each year, HPN was required to submit its PIPs to HSAG for validation. HPN submitted its PIPs, in accordance with its contract, and HSAG validated the PIPs as required by the MCO contract. The QI work plans provided evidence that the MCO tracked and monitored the required PIPs as part of its ongoing QI activities.		
	Recommendations: None.		
DHCFP Contract Section 4.8.6.2	16. IQAP Monitoring and Evaluation For the FMC/TANF/CHAP as well as the Adult Medicaid Expansion Group and Nevada Check Up recipients, the IQAP monitors and evaluates, at a minimum, care and services in certain priority areas of concern selected by the DHCFP.	**Documents Submitted:** • AMB_PIP Summary Form FINAL • CAP_PIP Summary Form_FINAL **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2013 HPN and SHL QI Program Description and the 2014 HPN and SHL QI Program Description provided evidence of the quality of care studies and other quality improvement activities undertaken by HPN for each year. The QI work plans for each year provided evidence of HPN's tracking of the activities and issues over time. The QI evaluations provided evidence of HPN's evaluation of all of the quality activities that occurred for the Medicaid and Nevada Check Up population, which included the goals and objectives outlined in the DHCFP State Quality Strategy.		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None.		
DHCFP Contract Section 4.8.6.2 (A)	17. Clinical Areas The following are recommended clinical areas of concern to be included in the evaluation: a) Childhood Immunizations (monitoring will be required by DHCFP for recipients); b) Pregnancy (monitoring will be required by DHCFP for recipients); c) Cervical Cancer/Pap Smears (monitoring will be required by the State of Nevada Health Division); d) Comprehensive Well-Child Periodic Health Assessment (will be required by DHCFP for recipients); e) Lead Toxicity (screening required under EPSDT guidelines); f) Pregnancy Prevention and/or Family Planning (monitoring will be required by DHCFP for recipients); g) Hearing and Vision Screening and Services for Medicaid members less than twenty-one (21) years of age (will be required by DHCFP for recipients).	**Documents Submitted:** • 01NVUHC1414 Prenatal Class Mailer • 1278 Jun 2014 NV Check Up Revision (2) PG 15 • 1858 Well Child Self Mailer • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH PG 16 • 2011 Birth Control Options • 2013 QI Program Eval-pg. 80; 83-88; 91-113 • 21NVHP13484 Look Out For Lead Card • 21NVHPN14170 REVISED Well Child Incentive Mailer • 21NVMDCD11732 Healthy Expectations Brochure • 21NVMDCD13483 Prenatal Care Brochure • EPSDT report 2013-2014 **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2013 HPN and SHL QI Program Description and the 2014 HPN and SHL QI Program Description provided evidence of the quality of care studies and other clinical quality improvement activities undertaken by HPN for each year. The QI work plans for each year provided evidence of HPN's tracking of the activities and issues over time. The QI evaluations provided evidence of		

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	HPN's evaluation of all of the quality activities that occurred for the Medicaid and Nevada Check Up population, which included the goals and objectives outlined in the DHCFP State Quality Strategy and the HEDIS and PIP performance measures that are required as part of the external quality review activities. Items a-e in this element were contained in the QI evaluations for both 2013 and 2014. For item f, HPN staff reported that family planning visits were monitored through the HEDIS measure, *Postpartum Care*. The 2014 HEDIS administrative and hybrid measure specifications for *Postpartum Care* did not specifically require contraceptive counseling to be included in the numerator specifications for the measure, *Postpartum Care*. Further, the *Postpartum Care* HEDIS measure only tracked those women who had a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year. The measure did not include women who did not have a live birth within the same period of time. For item g, HPN staff stated that hearing and vision screening services were part of the EPSDT program; however, the QI evaluations for 2013 and 2014 did not include an evaluation of EPSDT services that were provided for the year. HPN staff stated that the EPSDT service evaluations were included in prior years' QI evaluations and the information will be included in the 2015 evaluation.		
	Recommendations: The MCO must ensure that the following are included in its annual quality evaluations: pregnancy prevention and/or family planning and hearing and vision screening and services for Medicaid members less than twenty-one (21) years of age.		
DHCFP Contract Section 4.8.6.2 (B)	18. Health Services Delivery The following are recommended health services delivery areas of concern that should be evaluated: a) Access to Care; b) Utilization of Services; c) Coordination of Care; d) Continuity of Care; e) Health Education; and f) Emergency Services.	**Documents Submitted:** • 2013 HPN Access and Availability Policy-pg. 15-16; 20-22 • 2013 HPN and SHL QI Program Desc-pg. 9 and 24 • 2013 QI Program Eval- pg. 132-1138; 160-161; 168-169 • 2013 UM Program Description-entire doc • 2013 UM Program Eval- pg. 8-11 • 2014 HPN SHL QI Program Desc-pg. 9 and 23 • 2014 UM Program Description- entire doc • AMB_PIP Summary Form FINAL • CAP_PIP Summary Form_FINAL	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		• Continuity and Coordination of Care Policy 2013 • Medicaid ER Presentation **Description of Process:** N/A	
	Findings: The documents, 2013 HPN Access and Availability Policy and Continuity and Coordination of Care Policy 2013, provided evidence of HPN's provisions for tracking and evaluating access to services and coordination and continuity of care of the health care services delivered to Medicaid and Check Up populations. The 2013 HPN and SHL QI Program Description and the 2014 HPN and SHL QI Program Description provided evidence of the health service delivery areas required by this element for tracking and evaluation. The QI work plans for each year provided evidence of HPN's tracking of the activities and issues over time. The QI evaluations provided evidence of HPN's evaluation of all of access to care, coordination of care, service utilization review, continuity of care, health education, and emergency service utilization review.		
	Recommendations: None.		
DHCFP Contract Section 4.8.6.3 (A-D)	19. Use of Quality Indicators 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 Center Medicaid and CHIP Services, with respect to the priority areas selected by the State; c) Ensure methods and frequency of data collection are effective and sufficient to detect the need for	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc-pg. 6-8 • 2013 HPN and SHL QI Workplan-entire doc • 2013 QI Program Eval-pg. 43-116 • 2014 HPN SHL QI Program Desc-pg. 7-8 • 2014 HPN SHL QI Workplan-entire doc • AMB_PIP Summary Form FINAL • CAP_PIP Summary Form_FINAL • Over and Under Utilization Analysis **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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	program change; and d) Have mechanisms to detect under and over utilization.	N/A	
	Findings: The quality indicators used in the PIPs and for the HEDIS measures were objective, measurable, and based on current knowledge and clinical experience. Annually, DHCFP determined the indicators for the PIPs and HEDIS studies, and the rigorous specifications developed for those two activities ensured methods and frequency of data collection were effective and sufficient to detect the need for program change. The QI and UM program evaluations noted in the accomplishments for previous year, which included an annual analysis of potential over- and underutilization of service. The document, Over and Under Utilization Analysis, also provided evidence of the MCO's tracking of over- and underutilization of services. The QI evaluations provided evidence of HPN's evaluation of all of the quality activities that occurred for the Medicaid and Nevada Check Up population, which included the goals and objectives outlined in the DHCFP State Quality Strategy and the HEDIS and PIP performance measures that are required as part of the external quality review activities.		
	Recommendations: None.		
DHCFP Contract Section 4.8.6.5 (A)	20. Analysis of Clinical Care and Related Services For issues identified in the IQAPs targeted clinical areas, the analysis includes the identified quality indicators and uses clinical care standards or practice guidelines.	**Documents Submitted:** • 2013 QI Program Eval- pg.22-25; 43-116 • AMB_PIP Summary Form FINAL • CAP_PIP Summary Form_FINAL **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The quality indicators used in the PIPs and for the HEDIS measures were objective, measurable, and based on current knowledge and clinical standards of practice. Annually, DHCFP determined the indicators for the PIPs and HEDIS studies, and the rigorous specifications developed for those two activities ensured methods and frequency of data collection were effective and sufficient to detect the need for program change. The QI and UM program evaluations noted in the accomplishments for previous year.		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None.		
42 CFR 438.240(b)(4) *DHCFP Contract Section 4.8.6.5 (B)*	21. Multi-disciplinary Teams Multi-disciplinary teams are required, when available and appropriate, to analyze and address systems issues. The MCO has in effect mechanisms to assess quality and appropriateness of care furnished to enrollees with special health care needs.	**Documents Submitted:** • 2013 QI Program Eval-pg.142-144 • 2013 UM Program Description-pg. 31-35 • 2013 UM Program Eval- pg.13-16 • 2014 UM Program Description-pg.31-35 • Practitioner Meeting Participation Grid • QIC Meeting Minutes **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The documents, 2013 UM Program Description and 2013 and 2014 UM Program Descriptions, included descriptions of the use of multi-disciplinary teams and committees to analyze and address systems issues. The Practitioner Meeting Participation Grid listed all of the providers who participated on each of the committees noted in the QI program descriptions. The QIC Meeting Minutes provided evidence that the committee assessed the quality of services furnished to enrollees. The 2013 QI Program Evaluation and 2013 UM Program Evaluation provided evidence that services to members with chronic conditions were evaluated. The information provided for Standard X provided evidence that enrollees with special health care needs were part of the chronic conditions care management program.		
	Recommendations: None.		
DHCFP Contract Section 4.8.6.6	22. Corrective Actions The IQAP includes written procedures for taking corrective action whenever, as determined under the IQAP, inappropriate or substandard services are furnished, or services that should have been furnished were not.	**Documents Submitted:** • 2013 Cred-Recred_Policy pg.60-64 • 2013 HPN and SHL QI Program Desc-pg.19; 21; 26-30; 35-36 • 2014 HPN SHL QI Program Desc-pg. 8-9; 14; 20; 22; 27-32; 37-38	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		Description of Process: N/A	
	Findings: The 2013 QI Program Description and the 2014 QI Program Description each specified the implementation of corrective action when areas for improvement are identified through quality monitoring activities. This included issuance of a corrective action to a provider if inappropriate or substandard services were furnished. The QI Description assigned monitoring and oversight of any corrective actions to the Quality Management Department. The 2013 QI Program Evaluation provided evidence of the types of improvements and activities that would be implemented as a result of barrier analyses for any opportunities for improvement identified.		
	Recommendations: None.		
DHCFP Contract Section 4.8.6.6 (A-F)	23. Implementation of Corrective Actions These written corrective action procedures 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; and f) Procedures for terminating the affiliation with the	**Documents Submitted:** • 2013 Cred-Recred_Policy pg.60-64 • 2013 HPN and SHL QI Program Desc-pg.19; 21; 26-30; 35-36 • 2014 HPN SHL QI Program Desc-pg. 8-9; 14; 20; 22; 27-32; 37-38 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	physician, or other health professional or provider.		
	Findings: The HPN 2013 QI Program Description included a section that delineated the corrective action procedures. To identify issues that may involve quality concerns, the plan reviewed adverse medical and dental outcomes, monitored for trends, reviewed high-volume/high-risk diagnoses and procedures, and used peer review to evaluate clinical processes of care and member complaints. HPN used peer review, the dental director, and the medical director to conduct investigations into potential quality issues. The corrective action section of the QI Description detailed the need to identify a person responsible for ensuring the corrective action is completed within the required timeframe. The description also contained the process for monthly monitoring and the process for assessing the effectiveness of the corrective action. The Quality Management Department evaluated the effectiveness of the action. The medical director or the Peer Review Committee made the final decisions concerning the appropriateness of corrective actions for medical quality of care. The medical director or dental director presented the case to the Peer Review Committee if the corrective action did not appear to be effective. The Peer Review Committee decided if the corrective action should be modified or terminated. Adverse actions taken against a provider could be appealed as defined in the Provider Appeal Process policy. Actions that could occur included suspending, limiting, or terminating the practitioner's participation in the HPN network.		
	Recommendations: None.		
DHCFP Contract Section 4.8.6.7 (A-B)	24. Assessment of Effectiveness of POC As actions are taken to improve care, there is monitoring and evaluation including a Plan of Correction (POC) to assure required changes have been made. In addition, changes in practice patterns are monitored. The MCO assures follow-up on identified issues to ensure actions for improvement have been effective.	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc-pg. 14; 20; 22; 27; 29-32; 37-38 • 2014 HPN SHL QI Program Desc-pg. 14; 19; 21; 26-30; 35-36 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The corrective action section of the QI Description detailed the need to identify a person responsible for ensuring the corrective action is completed within the required timeframe. The description also contained the process for monthly monitoring and the process for assessing the effectiveness of the corrective action. The Quality Management Department evaluated the effectiveness of the action. The medical director or the Peer Review Committee made the final decisions concerning the appropriateness of corrective actions for medical quality of care. The medical director or dental director presented the case to the Peer Review		

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	Committee if the corrective action did not appear to be effective. The Peer Review Committee decided if the corrective action should be modified or terminated. Adverse actions taken against a provider could be appealed as defined in the Provider Appeal Process policy. Actions that could occur included suspending, limiting, or terminating the practitioner's participation in the HPN network.		
	Recommendations: None.		
DHCFP Contract Section 4.8.6.8 (A)	25. Evaluation of Continuity and Effectiveness of the IQAP The MCO conducts a regular and periodic examination of the scope and content of the IQAP to ensure that it covers all types of services in all settings, as specified in RFP Section 4.8.5	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc-pg. 32 • 2013 QI Program Eval- entire doc • 2014 HPN SHL QI Program Desc-pg. 33-34 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2013 QI Program Description described the MCO's process for conducting annual evaluation of the quality improvement program and the performance metrics contained therein as well as within the QI work plan. The 2013 QI Program Evaluation provided evidence of HPN's evaluation of the scope and content of its quality improvement program and covered the types of services and all settings noted in Section 4.8.5.		
	Recommendations: None.		
42 CFR 438.240(c)(1-3) *DHCFP Contract Section 4.8.6.8 (B)*	26. Annual Written IQAP Report At the end of each year, a written report on the IQAP is prepared which addresses: a) Quality assurance studies and other activities completed; b) Trending of clinical and service indicators and other performance data;	**Documents Submitted:** • 2013 QI Program Eval- entire doc **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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	c) Demonstrated improvements in quality; d) Areas of deficiency and recommendations for corrective action; and e) An evaluation of the overall effectiveness of the IQAP.		
	Findings: The 2013 HPN and SHL QI Program Description and the 2014 HPN and SHL QI Program Description provided evidence of the quality of care studies and other quality improvement activities undertaken by HPN for each year. The QI work plans for each year provided evidence of HPN's tracking of the activities and issues over time. The QI evaluations for each year described the interventions and activities that occurred over the year, results of quality measurement and studies performed, accomplishments and demonstrated improvements in quality for the year, challenges and opportunities for action for the following year, and an evaluation of the overall effectiveness of the quality improvement program.		
	Recommendations: None.		
DHCFP Contract Section 4.8.6.8 (C)	27. Significant Improvements There is evidence that quality assurance activities have contributed to significant improvements in the care delivered to recipients.	**Documents Submitted:** • HPN_NV2012-13_MCO_PIP-Val_ERVisits_D1_0713 • HPN_NV2012-13_MCO_PIP-Val_Immunizations_D1_0713 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The validated PIP documentation for the Avoidable Emergency Room Visit PIP and the Increase Rate of Immunizations PIP provided evidence that quality activities have contributed to significant improvement in care delivered to members. The 2013 QI Evaluation described the interventions and activities that occurred over the year, results of quality measurement and studies performed, and any notable improvements in the care delivered to members.		
	Recommendations: None.		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.8.7	28. Governing Body The Governing Body 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 is responsible for the MCO's IQAP review.	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc-pg. 11-12 • 2014 HPN SHL QI Program Desc-pg. 11-12 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2013 and 2014 HPN Quality Program Descriptions defined the responsibilities of the governing board to remain accountable for the HPN Quality Program; review, evaluate, and approve the HPN Quality Program Description, Annual Quality Program Evaluation, and Quality Program Work Plan; and review and evaluate summary key indicator reports, study updates, results of member surveys, and HEDIS reports to include an analysis of significant trends, variations, and action plans. The QI Program Descriptions noted that the governing board delegated responsibility of the oversight and review of the QI program to the Quality Improvement Committee (QIC). A review of the QIC meeting minutes validated that the QI Committee prepared a packet including an overview of the Quality Improvement Report for the prior quarter for the committee members to review. The meeting minutes contained evidence of discussion of the information contained in the report, and, at every meeting, the Board of Directors unanimously accepted the information submitted by the QI Committee.		
	Recommendations: None.		
DHCFP Contract Section 4.8.7	29. Responsibilities of the Governing Body The Governing Body is responsible for monitoring, evaluating, and making improvements to care.	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc-pg. 11-12 • 2014 HPN SHL QI Program Desc-pg. 11-12 • BOD Meeting Summary	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		Description of Process: N/A	
	Findings: The 2013 and 2014 HPN Quality Program Descriptions defined the responsibilities of the governing board to remain accountable for the HPN Quality Program; review, evaluate, and approve the HPN Quality Program Description, Annual Quality Program Evaluation, and Quality Program Work Plan; and review and evaluate summary key indicator reports, study updates, results of member surveys, and HEDIS reports to include an analysis of significant trends, variations, and action plans. The QI Program Descriptions noted that the governing board delegated responsibility of the oversight and review of the QI program to the Quality Improvement Committee (QIC).		
	Recommendations: None.		
DHCFP Contract Section 4.8.7.1	30. Oversight of IQAP There is documentation that the Governing Body has approved the overall IQAP and an annual IQAP**.**	**Documents Submitted:** • 2012 QI Program Eval sigpage • 2013 Program Description sgdpage • BOD Meeting Summary pg. 3-4 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2012 QI Program Evaluation signature page and the 2013 Program Description signature page provided evidence of the governing body's approval of the overall quality improvement program and annual review and evaluation of the quality improvement program. The Board of Director Meeting Minutes of September 10, 2013, December 10, 2013, and June 10, 2013, provided evidence of the quality improvement reports that were presented to the Board of Directors at each meeting.		
	Recommendations: None.		
DHCFP Contract Section 4.8.7.2	31. Oversight Entity 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	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc-pg. 11-25 • 2014 HPN SHL QI Program Desc-pg. 11-24	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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	decided to provide such oversight as a committee of the whole.	**Description of Process:** N/A	
	Findings: The 2013 and 2014 HPN Quality Program Descriptions defined the responsibilities of the governing board to remain accountable for the HPN Quality Program. The QI Program Descriptions noted that the governing board delegated responsibility of the oversight and review of the QI program to the QIC, which was formally decided to provide oversight and communicate the activities and outcomes of the quality program to the governing board of directors.		
	Recommendations: None.		
DHCFP Contract Section 4.8.7.3	32. IQAP Progress Reports The Governing Body routinely receives written reports from the IQAP describing actions taken, progress in meeting quality assurance objectives, and improvements made.	**Documents Submitted:** • 2013 HPN and SHL QI Eval Highlights Part 2 • 2013 HPN SHL QI Eval Highlights part I • BOD Meeting Summary **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: A review of the QIC meeting minutes validated that the QI Committee prepared a packet including an overview of the Quality Improvement Report for the prior quarter for the committee members to review. The meeting minutes contained evidence of discussion of the information contained in the report. The Board of Director Meeting Minutes of September 10, 2013, December 10, 2013, and June 10, 2013, provided evidence of the quality improvement reports that were presented to the Board of Directors at each meeting.		
	Recommendations: None.		
42 CFR 438.240(c)(1-3) *42 CFR 438.240(e)(1)(i and ii)* *42 CFR 438.240(e)(2)*	33. Annual IQAP Review The Governing Body formally reviews on a periodic basis,	**Documents Submitted:** • 2013 QI Program Eval-entire doc • BOD Meeting Summary	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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DHCFP Contract Section 4.8.7.4	but no less frequently than annually, a written report on the IQAP. This annual quality program evaluation report is submitted to DHCFP annually in the second calendar quarter and at minimum includes: a) Studies undertaken; b) Results; c) Subsequent actions and aggregate data on utilization and quality of services rendered; and d) An assessment of the IQAPs continuity, effectiveness, and current acceptability.	**Description of Process:** N/A	
	Findings: The 2013 Quality Program Evaluation included sections that assessed the effectiveness of clinical activities, members' satisfaction, service activity, credentialing, patient safety, and delegation. The plan used charts and graphs to show year-to-year trends in the results and identified improvements in quality. HPN noted areas of deficiency and prepared recommendations to correct the areas needing improvement. The plan also addressed the overall effectiveness of the IQAP in the program evaluation. The Board of Director Meeting Minutes of September 10, 2013, December 10, 2013, and June 10, 2013, provided evidence of the quality improvement reports that were presented to the Board of Directors at each meeting and the Board of Director's approval of the quality reports presented.		
	Recommendations: None.		
DHCFP Contract Section 4.8.8	34. QA Committee The IQAP delineates an identifiable structure responsible for performing quality assurance functions within the MCO.	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc-pg. 11-12 • 2014 HPN SHL QI Program Desc-pg. 11-12 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: The 2013 and 2014 QI Program Descriptions delineated the roles and responsibilities of the HPN persons responsible for quality improvement activities as well as the programmatic structure of the QI program. The QI descriptions also detailed the roles and responsibilities of the committees that were part of the HPN QI program, which were responsible for performing various quality assurance functions for the MCO.		
	Recommendations: None.		
DHCFP Contract Section 4.8.8.1	35. QA Committee: Regular Meetings The QA committee or other structure has regular meetings. The structure/committee meets on a regular basis with specified frequency to oversee IQAP activities. This frequency is sufficient to demonstrate that the structure/committee is following up on all findings and required actions, but in no case are such meetings less frequent than quarterly.	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc- pg. 11-12 • 2014 HPN SHL QI Program Desc- pg. 11-12 • QIC Meeting Minutes **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2013 and 2014 Quality Program Descriptions listed the frequency of meeting for the QI Committee as a minimum of four times per year. A review of QIC meeting minutes for July 25, 2013, September 12, 2013, November 14, 2013, January 9, 2014, and May 29, 2014, validated that the committee met on a regular basis, and the minutes contained evidence that the committee discussed quality activities at every meeting.		
	Recommendations: None.		
DHCFP Contract Section 4.8.8.2	36. QA Committee: Established Parameters The QA committee or other structure has established parameters for operating. The role, structure, and function of the structure/committee are specified.	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc FINAL pgs. 11-12 • 2014 HPN SHL QI Program Desc pgs. 11-12	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		Description of Process: N/A	
	Findings: The 2013 and 2014 QI Program Descriptions defined the QIC structure and operational functions and responsibilities of the committee. A review of QIC meeting minutes or July 25, 2013, September 12, 2013, November 14, 2013, January 9, 2014, and May 29, 2014, validated that the QIC operated according to the functions, roles, and responsibilities defined in the QI Program Descriptions.		
	Recommendations: None.		
DHCFP Contract Section 4.8.8.3	37. QA Committee: Documentation The QA committee or other structure has documentation. There are records documenting the structures/committee's activities, findings, recommendations, and actions.	**Documents Submitted:** • QIC Meeting Minutes **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2013 and 2014 QI Program Descriptions defined the QIC structure and operational functions and responsibilities of the committee. A review of QIC meeting minutes of July 25, 2013, September 12, 2013, November 14, 2013, January 9, 2014, and May 29, 2014, validated that the committee met on a regular basis, and the minutes contained evidence that the committee discussed quality activities at every meeting and provided findings and recommended actions as a results of the quality report provided.		
	Recommendations: None.		
DHCFP Contract Section 4.8.8.4	38. QA Committee: Accountability The QA committee or other structure has accountability. IQAP subcommittees are accountable to the Governing Body and they report to it (or its designee) on a scheduled basis on activities, findings, recommendations, and actions.	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc- pg. 11-12 • 2014 HPN SHL QI Program Desc- pg. 11-12 • BOD Meeting Summary **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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	Findings: The 2013 and 2014 QI Program Descriptions contained information concerning the delegation of quality improvement activities from the Board of Directors to the HPN QI Committee. The Board of Directors retained the responsibility of directing the operational quality program and taking action as appropriate based on the review of reports and updates. The HPN Board of Directors delegated the implementation and oversight of the HPN Quality Program to the QI Committee. The responsibilities of the QI Committee included establishing quality improvement goals, monitoring quality indicators, monitoring and promoting access and availability, monitoring over- and underutilization of services, monitoring and reporting of quality improvement studies and activities, analyzing results of quality improvement studies, approving quality improvement policies and procedures, and ensuring appropriate oversight of delegated functions. A review of the QI Committee minutes validated that the meeting included discussions concerning quality activities. The minutes also contained evidence that the committee discussed results of studies and initiatives to improve results for the coming year.		
	Recommendations: None.		
DHCFP Contract Section 4.8.8.5	39. QA Committee: Membership The QA committee or other structure has membership. There is active participation in the IQAP committee from MCO providers, who are representative of the composition of the MCO's providers.	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc-pg. 11-12 • 2014 HPN SHL QI Program Desc-pg. 11-12 • Practitioner Meeting Participation Grid • QIC Meeting Minutes **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The membership of the QI Committee included the chief nursing officer; vice president of health care quality and education, the medical director of primary care at Southwest Medical Associates; the associate medical director of quality assurance and quality improvement at Southwest Medical Associates; the associate director of health care informatics; the executive director of Behavioral Healthcare Options; assistance vice president; Medicaid operational and health education and wellness; director pharmacy services; director member services; director customer response and resolution; the director of QI; the director of UM compliance; the director of UM access center and case management; the vice president of provider services; and medical directors		

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	and/or practitioners from participating provider groups.		
	Recommendations: None.		
DHCFP Contract Section 4.8.9	40. IQAP Supervision There is a designated senior executive who is responsible for IQAP implementation. The MCO's Medical Director has involvement in quality assurance activities.	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc- pg. 21 • 2014 HPN SHL QI Program Desc- pg. 20 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The membership of the QI Committee is described in the 2013 and 2014 QI Program Descriptions and listed the chair as the vice president of healthcare quality and education. The QI Committee also included representation from the chief nursing officer and the medical director of primary care at Southwest Medical Associates. Further, the meeting minutes from Board of Director meetings provided evidence of the MCO's medical director's involvement in quality improvement activities.		
	Recommendations: None.		
DHCFP Contract Section 4.8.10	41. Adequate Resources The IQAP has sufficient material resources and staff with the necessary education, experience, or training to effectively carry out its specified activities. (Refer to Section 4.7.2)	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc- pg. 21-24 • 2013 UM Program Description- pg. 31-35; 45-48 • 2014 HPN SHL QI Program Desc- pg. 22-25 • 2014 UM Program Description--pg. 31-35; 45-48 • LT resume 2013 (Updated 12-13)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		Description of Process: N/A	
	Findings: A review of the HPN Nevada organizational chart, the staff members responsible for implementing the Nevada Quality Management Work Plan, and interviews with staff members confirmed that the MCO had sufficient material resources and staff members with the education and experience to effectively implement and monitor the IQAP.		
	Recommendations: None.		
DHCFP Contract Section 4.8.11.1	42. Provider Participation IQAP There is evidence that providers participate in the IQAP. Participating physicians and other providers are kept informed about the written IQAP through provider newsletters and updates to the provider manual.	**Documents Submitted:** • 2013 Provider Summary Guide- pg. 419-423 • 2014 Provider Summary Guide-pg. 204-208 • 21NVMDCD13670 Provider Newsletter Winter 2013 • 21NVMDCD143014 Provider Newsletter Summer 2014 • Screenshot_QI Info **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The2013 and 2014 Provider Summary Guides provided evidence of information disseminated regarding HPN's quality improvement program. The provider summary guides described the Quality Program structure, the current QI initiatives, member and practitioner satisfaction surveys, HEDIS measures, quality and patient safety, disease management programs, and outpatient case management programs. A review of the provider newsletters for winter 2013 and summer 2014 validated that the plan informed providers about subjects like, EPSDT and well child exams, flu shots, medical record documentation, asthma education awareness, immunization reimbursements, cultural competency, annual wellness exams, open enrollment, pediatric health, online provider center, diabetes information.		

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	Recommendations: None.		
DHCFP Contract Section 4.8.11.2	43. Provider Cooperation with the IQAP The MCO includes in its provider contracts and employment agreements, for physician and non-physician providers, a requirement securing cooperation with the IQAP.	**Documents Submitted:** • Consulting Provider Template Article III Section K • Primary Care Physician FFS Template Article III, section M **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The contract template documents, Consulting Provider Template and the Primary Care Physician FFS Template, provided evidence of HPN's requirement for physician and non-physician providers to cooperate with the quality management program. Review of the signed Human Behavior Institute (HBI) contract validated that the consulting provider agreement contained the required elements in Article III, Section I of the contract.		
	Recommendations: None.		
DHCFP Contract Section 4.8.11.3	44. Access to Medical Records Contracts specify that hospitals and other vendors allow the MCO access to the medical records of its recipients.	**Documents Submitted:** • Consulting Provider Template Article III, Section I • Primary Care Physician FFS Template Article III, Section K **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The contract template documents, Consulting Provider Template and the Primary Care Physician FFS Template, provided evidence of HPN's requirement for the provider to allow HPN access to medical records for HPN's members. Review of the signed Human Behavior Institute contract validated that the consulting provider agreement contained the required elements in Article III, Section G of the contract.		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None.		
DHCFP Contract Section 4.8.12	45. Delegation of IQAP Activities The MCO remains accountable for all IQAP functions, even if certain functions are delegated to other entities.	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc-pg. 32-33; 40 • 2014 HPN SHL QI Program Desc-pg. 31-32; 38 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2013 and 2014 QI Program Descriptions detailed HPN's responsibility for remaining accountable for all quality improvement and management functions, regardless if any other functions are delegated to the entity.		
	Recommendations: None.		
DHCFP Contract Section 4.8.12.1–3	46. Requirements for Delegation of IQAP Activities If the MCO delegates any quality assurance activities, it must: a) Have a written description of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the MCO; b) Have written procedures for monitoring and evaluating the implementation of the delegated functions, and for verifying the actual quality of care being provided; and, c) Provide evidence of continuous and ongoing	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc-pg. 32-33; 40 • 2014 HPN SHL QI Program Desc-pg. 31-32; 38 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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	evaluation of delegated activities, including approval of quality improvement plans and regular specified reports.		
	Findings: The 2013 and 2014 QI Program Descriptions detailed HPN's accountability for the quality of the clinical care and services provided to its members. The HPN subcontract with BHI provided evidence that HPN provided a written description for all of the elements required by this element. The HPN contract with HBI entities defined the delegated activities and the participation required for quality-of-care reviews, appeals, quality improvement, prior authorizations, concurrent review, retrospective review, disenrollment determinations, and encounter reporting. During the on-site review, HPN staff reiterated that while HBI was required to participate in quality of care reviews and quality improvement activities, HPN maintained responsibility for the activities.		
	Recommendations: None.		
DHCFP Contract Section 4.8.19.1	47. Scope of IQAP Documentation The MCO documents that it monitors the quality of care across all services and all treatment modalities, according to its written QAP. (This review of the entire range of care is expected to be carried out over multiple review periods and not on a concurrent basis.)	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc- pg. 6-8 • 2013 QI Program Eval- pg. 43-116 • 2014 HPN SHL QI Program Desc- pg. 6-8 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HPN's 2013 and 2014 QI Program Descriptions included the entire range of services required by the contract, which are provided by the MCO. The 2013 QI Program Evaluation and 2013 UM Program Evaluation provided evidence of HPN's monitoring and evaluation of the entire range of services managed by the MCO. The two documents also provided evidence that the review of the entire range of care was carried out over multiple review periods. The QIC meeting minutes confirmed that the review occurred over multiple review periods.		
	Recommendations: None.		

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DHCFP Contract Section 4.8.19.2	48. Maintenance and Availability of Documentation The MCO maintains and makes available to the DHCFP, and upon request to the Secretary, studies, reports, protocols, standards, worksheets, minutes, or such other documentation as requested concerning its quality assurance activities and corrective actions.	**Documents Submitted:** • Quality related documentation is available on site **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HPN provided all documents requested by HSAG for the compliance review to include studies, reports, protocols, standards, worksheets, minutes, or such other documentation as requested concerning its quality assurance activities and corrective actions. Contracts with network providers also contained evidence that the providers needed to produce documents when requested by the health plan. HPN's policy, Utilization Management Compliance, contained the requirement that the policy incorporates the requirements of CMS, Medicaid, and Nevada Revised Statutes and that the processes set forth in the document meet the intent of the requirements.		
	Recommendations: None.		
DHCFP Contract Section 4.8.20	49. Coordination of QA Activities 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.	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc-pg. 8-10 • 2013 QI Program Eval-entire doc • 2014 HPN SHL QI Program Desc-pg. 8-10 • QIC Meeting Minutes **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The QI Program Evaluation provided evidence of the findings, conclusions, recommendations, and actions taken as a result of the quality improvement activities undertaken by HPN. QIC meeting minutes of July 25, 2013, September 12, 2013, November 14, 2013, January 9, 2014, and May 29, 2014, validated that the committee met on a regular basis, and the minutes		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	contained evidence that the committee discussed quality activities at every meeting and provided findings and recommended actions as a results of the quality report provided. A review of the provider newsletters for winter 2013 and summer 2014 validated that the MCO informed providers about subjects reviewed as part of quality improvement activities. The HPN and SHL QI Evaluation Highlights presentations also provided evidence that the MCO presented the results of quality improvement activities to the Customer Centric Task Force.		
	Recommendations: None.		
DHCFP Contract Section 4.8.20.1	50. Using QA Information Quality assurance information is used in recredentialing, recontracting and/or annual performance evaluations.	**Documents Submitted:** • 2013 Cred-Recred_Policy • 2013 HPN and SHL QI Program Desc-pg. 31-32; 37-38 • 2014 HPN SHL QI Program Desc-pg. 29-30; 35-36 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2013 and 2014 QI Program Descriptions included descriptions about the credentialing and recredentialing programs and how quality assurance information is shared with the credentialing committee if a provider should be reviewed in more depth by the credentialing committee. The 2013 QI Program Evaluation provided evidence that HPN used quality improvement information in its credentialing program and credentialing information as part of its quality improvement program.		
	Recommendations: None.		
DHCFP Contract Section 4.8.20.2	51. Coordination of QA Activities with Other Performance Monitors Quality assurance activities are coordinated with other performance monitoring activities, including utilization management, risk management and resolution and	**Documents Submitted:** • 2013 HCO 100 UM Policy • 2013 HPN and SHL QI Program Desc-pg. 10 • 2013 QI Program Eval--199-205 • 2014 HPN SHL QI Program Desc- pg. 10	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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	monitoring of recipient grievances and appeals.	• Health Management Policy 2013 **Description of Process:** N/A	
	Findings: The 2013 and 2014 QI Program Descriptions included information about the MCO's coordination of quality improvement and quality assurance activities with quality management, utilization management, credentialing, member services, customer response and resolution, marketing, information services, provider services, grievance and appeals, and case management. The 2013 UM Policy also described how quality assurance activities were coordinated with utilization management activities. The 2013 QI Program Evaluation contained evidence that HPN annually evaluated the activities associated with grievance and appeals and utilization management. The Health Management Policy 2013 provided evidence of the MCO's process for coordinating risk management activities.		
	Recommendations: None.		
DHCFP Contract Section 4.8.20.3	52. Linking QA Activities and Other Management Functions There is a linkage between quality assurance and the other management functions of the MCO such as: a) Network changes; b) Benefits redesign; c) Medical management systems (e.g., pre-certification); d) Practice feedback to practitioners; e) Patient education; and	**Documents Submitted:** • 01NVUHC1433 Prenatal Class Mailer 01162014 • 1278 Nevada Check Up March 2013 Revision eng and span • 1936 Mar 2013 revision_smartchoice eng and span • 2013 Clinical Practice Guidelines Policy pg.14 • 2013 Cred-Recred_Policy-pg. 13-15; 27-28 • 2013 HCO 100 UM Policy-pg. 55-60 • 2013 HPN and SHL QI Program Desc-pg. 8-10	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I. Internal Quality Assurance Program

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	f) Recipient services.	• 2013 UM Program Description-pg. 5-7; 40-41 • 2014 HPN SHL QI Program Desc-pg. 8-10 • 2014 UM Program Description-pg. 5-7; 40-41 • 21NVHP13484 Look Out For Lead Card • 21NVHPN14170 REVISED Well Child Incentive Mailer SPN • 21NVHPN14170 REVISED Well Child Incentive Mailer • 21NVMDCD12960 Urgent Care ClingZ Northern Nevada • 21NVMDCD14226 Pregnancy Case Management Brochure • 21NVUHC1465 Cling Z Card Southern Nevada • Diabetes Cover Letter • Gaps in Care Rpt Format • NorthernChoice April 2014 • NORTHERNCHOICE August 2013 • NorthernChoice Dec 2013 • NorthernChoice Jan 2014 • NORTHERNCHOICE July 2013 • NorthernChoice June 2014 • NorthernChoice March 2014 • NorthernChoice May 2014	

Standard I. Internal Quality Assurance Program

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		• NorthernChoice November 2013 • NORTHERNCHOICE October 2013 • NorthernChoice October 2014 • NORTHERNCHOICE September 2013 • PD 5285 Urgent Care ClingZ Northern Nevada Spanish 21NVMDCD13622S • Provider Order Form • SmartChoice April 2014 • SMARTCHOICE August 2013 • SmartChoice August 2014 • SmartChoice December 2013 • SmartChoice Feb 2014 • SmartChoice Jan 2014 • SMARTCHOICE July 2013 • SmartChoice June 2014 • SmartChoice March 2014 • SmartChoice May 2014 • SmartChoice November 2013 • SMARTCHOICE October 2013 • SmartChoice October 2014 • SMARTCHOICE September 2013 • SmartChoice September 2014 • website request form 01172014 • website request form 03112014 • website request form 04162014 **Description of Process:**	

Standard I. Internal Quality Assurance Program

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		N/A	
	Findings: The document, 2013 Clinical Practice and Prevention Health Guidelines, provided evidence of HPN's policy to promote the development, revision, dissemination, and use of clinical practice and preventive health guidelines to help practitioners and members make decisions about appropriate health care for clinical circumstances. The 2013 and 2014 QI Program Descriptions detailed the structure and responsibilities of the QIC. HPN structured the QIC to include membership from every area in the health plan: the chief nursing officer; the medical directors from Southwest Medical Associates (e.g., a sister multi-specialty medical group); the Vice President of Healthcare Quality and Education (medical director); health care informatics; the executive director of Behavioral Healthcare Options (e.g., a sister behavioral health care organization); network development and contracts; provider services; Medicaid operations; pharmacy; member services; customer response and resolution; quality improvement; provider services; practitioners from participating provider groups; and multiple individuals from utilization management. QIC meeting minutes provided evidence of the discussions that occurred at the QIC, which included a review of activities by subcommittees, such as the Customer Centric Task Force. The QIC meeting minutes and other documents, such as the NorthernChoice and SmartChoice newsletters, incentive mailers, and urgent care clingz (cling materials for members that contain information on available health benefits and incentives) provided evidence that information on health benefit incentives and changes were disseminated to committees and HPN members.		
	Recommendations: None.		
DHCFP Contract Section 4.13.1	53. Accountability to the Governing Body The Medical Director and the MCO's Utilization Management and Internal Quality Assurance Plan Committee are accountable to the MCO's governing body.	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc-pg. 11-25 • 2013 UM Program Description-pg. 32-35 • 2014 HPN SHL QI Program Desc-pg. 11-24 • 2014 UM Program Description-pg. 32-35 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I. Internal Quality Assurance Program

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: A review of the Quality Improvement Committee Structure for HPN validated that all committees, including the QI Committee and the UM Committee, reported to the HPN Board of Directors. A review of the minutes of the Board of Directors (September 10, 2013; December 10, 2013; and June 10, 2014) provided evidence that quality and utilization management reports were brought to the board of directors for review and discussion.		
	Recommendations: None.		
DHCFP Contract Section 4.13.1-10	54. Responsibilities of the Medical Director The responsibilities of the Medical Director include the following: a) Serves as co-chairman of the MCO's Utilization Management and Quality Assurance Plan committee; b) Directs the development and implementation of the MCO's IQAP and utilization management activities and monitors the quality of care MCO enrollees receive; c) Oversees the development and revision of the MCO's clinical care standards and practice guidelines and protocols; d) Reviews all potential quality of care problems, and oversees the development, and implementation of, as well as the adherence to, Plans of Correction; and e) Oversees the MCO's referral process for specialty and out-of-network services. All services prescribed	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc-pg. 20-21 • 2013 UM Program Description-pg. 31-32 • 2014 HPN SHL QI Program Desc-pg. 21-22 • 2014 UM Program Description-pg. 31-32 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I. Internal Quality Assurance Program

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	by a PCP or requested by an enrollee which are denied by the MCO must be reviewed by a physician, physician assistant, or advanced nurse practitioner with the reason for the denial being documented and logged. f) Serves as a liaison between the MCO and its providers, communicating regularly with the MCO's providers, including oversight of provider education, in-service training and orientation; g) Serves as the MCO's consultant to medical staff with regard to referrals, denials, grievances, and problems; h) Ensures enrollee Individual Family Service Plans (IFSPs) and Individualized Education Programs (IEPs) are followed; and i) Ensures coordination of out-of-network services.		
	Findings: The 2013 and 2014 QI Program Descriptions provided evidence that the Vice President, Healthcare Quality and Education (medical director) was responsible for serving as the chair of the QIC and the co-chair of the Utilization Management Committee. In that capacity, the medical director was responsible for the directing the MCO's quality program and utilization management activities. The medical director job description provided on-site provided evidence that the medical director was responsible for analyzing utilization data to identify trends and opportunities for process improvement related to inpatient and outpatient medical treatment. The job description also required that the medical director was responsible for ensuring appropriate care and services were provided to members and that those services met best practice standards. During the on-site review, HPN staff stated that the QIC, which was chaired by the medical director, reviewed all potential quality of care issues and also provided oversight and implementation of plans of correction.		

Standard I. Internal Quality Assurance Program

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None.		

Results for Standard I: Internal Quality Assurance Program							
Total	Met	=	53	X	1.00	=	53.0
	Partially Met	=	1	X	.50	=	0.5
	Not Met	=	0	X	.00	=	0.0
Total Applicable		=	54	**Total Score**		=	53.5

Total Score ÷ Total Applicable	=	99.0%

Standard II. Credentialing and Recredentialing

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.214(a) *42 XFR 438.214(b)(2)* *DHCFP Contract Section 4.5.10*	1. Provider Credentialing The MCO has written credentialing and recredentialing policies and procedures for determining and assuring that all providers under contract to the MCO, including PCPs and PCSs, specialists, and other health care professionals, are licensed by the State and qualified to perform their services, excluding non-contracted obstetrical providers.	**Documents Submitted:** • Cred-Recred Policy_ CR 300.00 pg 3-4 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Definition of Providers section of the Credentialing and Recredentialing Policy (CR 300.04) provided evidence of meeting the requirements of this element. The file review for credentialing and recredentialing also validated that HPN followed the policies and procedures when verifying credentials for the network providers.		
	Recommendations: None.		
42 CFR 438.214(d) *DHCFP Contract Section 4.5.10*	2. Providers Excluded from Participation in Federal Health Care Programs The MCO may not employ or contract with providers excluded from participation in federal health care programs under section 1128 of the Social Security Act.	**Documents Submitted:** • Cred-Recred Policy_ CR 300.00 pg 4_CR 300.11 pg 27_CR 300.30 pg 55 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Medicare/Medicaid/Federal Employees Health Benefits Program (FEHBP) Sanction and Eligibility Verification section of the Credentialing and Recredentialing Policy (CR 300.30) provided evidence of meeting the requirements of this element.		
	Recommendations: None.		
42 CFR 438.12(a)(1) *42 CFR 438.214(c)* *DHCFP Contract Section*	3. Discrimination Against Providers The MCO:	**Documents Submitted:** • 2013 HPN Access Availability Policy_QI 222.01 pg 2	☒ Met ☐ Partially Met ☐ Not Met

Standard II. Credentialing and Recredentialing

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
4.5.2.9	a) May not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license, specialty, or certification; and b) Must give written notice of the reason for its decision to decline and individual or group of providers to the affected network providers.	• Cred-Recred Policy_ CR 300.01 pg 5_ CR 300.06 pg 16 **Description of Process:** N/A	☐ N/A
	Findings: The Chair and Credentialing Committee File Review section of the Credentialing and Recredentialing Policy (CR 300.06) provided evidence of meeting the requirements of this element concerning non-discrimination for participation in the network. The Access Availability Policy (QI 222.01) and the Access and Availability Plan 2013 (QI 222.00.08) also contained statements concerning the non-discrimination requirements found in this element. The Credentialing Disapprovals of Practitioners section of the Credentialing and Recredentialing Policy (CR 300.07) also provided evidence of meeting the requirements of this element. A review of a letter sent to a provider who was not accepted in the HPN network during credentialing validated that the written notice contained the reason the provider was not granted privileges with the MCO.		
	Recommendations: None.		
DHCFP Contract Section 4.5.10	4. Credentialing Criteria The MCO provides credentialing criteria for review and approval by DHCFP and ensures that all network providers meet the criteria.	**Documents Submitted:** • Cred-Recred Policy_ CR 300.05 pg 13 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Credentialing and Recredentialing Policies provided detailed explanations of the criteria established for providers participating in the HPN network and the responsibilities of the Credentialing Committee to ensure that all providers met the criteria. A review of an email dated May 16, 2013 confirmed that DHCFP approved the Credentialing and Recredentialing Policies used during the review period.		
	Recommendations: None.		

Standard II. Credentialing and Recredentialing

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.8.13	5. Credentialing Provisions in IQAP The IQAP contains provisions to determine whether physicians and other health care professionals, who are licensed by the State and who are under contract to the MCO, are qualified to perform their services.	**Documents Submitted:** • Cred-Recred Policy_ CR 300.00 pg 3-4_CR 300.06 pg 16 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Health Plan of Nevada and Sierra Health & Life 2013 Quality Program Description included the objective to maintain an ongoing credentialing and recredentialing process that complied with NCQA standards and federal and State regulations. The program description also described the committee structure and noted that the Credentialing Committee reported activities and corrective action plans to the Quality Review Committee. The 2013 QI Program Evaluation also contained a review of the Credentialing activities in 2013.		
	Recommendations: None.		
42 CFR 438.214(b)(1) *DHCFP Contract Section 4.8.13.1*	6. Written Credentialing Policies and Procedures The MCO has written policies and procedures for the credentialing process, which include the MCO's initial credentialing of practitioners, as well as its subsequent recredentialing, recertifying and/or reappointment of practitioners. The MCO complies with NAC 679B.0405 which requires the use of Form NDOI-901 for use in credentialing providers.	**Documents Submitted:** • Cred-Recred Policy_ CR 300.00 pg 4_CR 300.13 pg 34 • NV Initial Credentialing Form • NV ReCredentialing Form **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Credentialing and Recredentialing Policies provided validation that HPN developed written policies and procedures for the credentialing process, which included the MCO's initial credentialing of practitioners, as well as its subsequent recredentialing, recertifying, and/or reappointment of practitioners. HPN submitted copies of the credentialing and recredentialing forms completed by providers to confirm that the MCO uses Form NDOI-901. A review of the credentialing and recredentialing files also confirmed that the MCO complied with NAC 679B.0405 by using Form NDOI-901 during the credentialing of providers.		

Standard II. Credentialing and Recredentialing

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None.		
DHCFP Contract Section 4.8.13.2	7. Credentialing Oversight The Governing Body, or the group or individual to which the Governing Body has formally delegated the credentialing function, has reviewed and approved the credentialing policies and procedures.	**Documents Submitted:** • Cred-Recred Policy_ CR 300.01 pg 5_CR 300.02 pg 6_CR 300.03 pg 8 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Credentialing Reporting Structure and Responsibilities policy (CR 300.01) stipulated that the HPN Board of Directors delegated all operational aspects of the credentialing and recredentialing of providers to the Credentialing Committee. The Credentialing Committee Approval section of the Credentialing Committee Membership and Meeting Schedule policy (CR 300.02) provided evidence that the Credentialing Committee was responsible to approve credentialing policies and procedures. A review of the Credentialing Committee minutes dated August 13, 2013 validated that the committee approved the credentialing policies and procedures.		
	Recommendations: None.		
DHCFP Contract Section 4.8.13.3	8. Credentialing Entity The MCO designates a credentialing committee, or other peer review body, which makes recommendations regarding credentialing decisions.	**Documents Submitted:** • Cred-Recred Policy_ CR 300.02 pg 6_CR 300.03 pg 8_CR 300.06 pg 16 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Credentialing Committee Approval section of the Credentialing and Recredentialing Policy (CR 300.06) provided evidence of meeting the requirements of this element. A review of the Credentialing Committee Minutes provided the dates of the meetings held during the study period: July 9, 2013; August 13, 2013; September 10, 2013; October 8, 2013; November 12, 2013; December 10, 2013; January 14, 2014; February 11, 2014; March 11, 2014; April 8, 2014; May 13, 2014; and June 10, 2014.		

Standard II. Credentialing and Recredentialing

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None.		
DHCFP Contract Section 4.8.13.4	9. Scope of Credentialing The MCO identifies those practitioners who fall under its scope of authority and action. This includes, at a minimum, all physicians and other licensed independent practitioners included in the MCO's literature for recipients, as an indication of those practitioners whose service to recipients is contracted or anticipated.	**Documents Submitted:** • Cred-Recred Policy_ CR 300.04 pg 10 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Definition of Providers section of the Credentialing and Recredentialing Policy (CR 300.04) provided evidence of meeting the requirements of this element.		
	Recommendations: None.		
42 CFR 1002.3 *DHCFP Contract Section 4.8.13.5 (N–O)*	10. Recredentialing: Reporting to the State The MCO's provider recredentialing must comply with 42 CFR §1002.3. If the MCO has denied recredentialing or enrollment to a provider where the denial is due to the MCO concerns about provider fraud, integrity or quality the MCO is required to report this to the State, with 15 calendar days.	**Documents Submitted:** • Cred-Recred Policy_ CR 300.07 pg 19 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Credentialing Disapprovals of Practitioners policy provided evidence of meeting the requirements of this element. Interviews with staff confirmed that HPN did not terminate any providers for fraud or integrity during the study period.		
	Recommendations: None.		
DHCFP Contract Section	11. Recredentialing: Decredentialing, Terminating, or	**Documents Submitted:**	☒ Met

Standard II. Credentialing and Recredentialing

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
4.8.13.5 (P)	Disenrolling Providers If the MCO decredentials, terminates disenrolls a provider the MCO must inform the State within 15 calendar days. If the decredentialing, termination, or disenrollment of a provider is due to suspected criminal actions, or disciplinary actions related to fraud or abuse the State notifies HHS-OIG.	• 100-12 Medicaid Provider Termination Policy_pg 3 • Cred-Recred Policy_ CR 300.07 pg 21 **Description of Process:** N/A	☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Credentialing Disapprovals of Practitioners section of the Credentialing and Recredentialing Policy (CR 300.07) and the Medicaid Provider Termination policy provided evidence of meeting the requirements of this element. Interviews with staff confirmed that HPN did not terminate any providers for fraud or integrity during the study period.		
	Recommendations: None.		
DHCFP Contract Section 4.8.13.7	12. Delegation of Credentialing Activities If the MCO delegates credentialing and recredentialing, recertification, or reappointment activities: a) There is a written description of the delegated activities, and the delegate's accountability for these activities; b) There is also evidence that the delegate accomplished the credentialing activities; and c) The MCO monitors the effectiveness of the delegate's credentialing and reappointment or recertification process.	**Documents Submitted:** N/A **Description of Process:** N/A	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
	Findings: Interviews with staff confirmed that HPN does not delegate credentialing activities.		

Standard II. Credentialing and Recredentialing

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None.		
DHCFP Contract Section 4.8.13.8	13. Retention of Credentialing Authority The MCO retains the right to approve new practitioners and sites, and to terminate or suspend individual practitioners. The MCO has policies and procedures for the suspension, reduction, or termination of practitioner privileges.	**Documents Submitted:** • Cred-Recred Policy_ CR 300.07 pg 19 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Credentialing Disapprovals of Practitioners section of the Credentialing and Recredentialing Policy (CR 300.07) provided evidence of meeting the requirements of this element.		
	Recommendations: None.		
DHCFP Contract Section 4.8.13.9	14. Reporting to Appropriate Authorities There is a mechanism for, and evidence of, implementation of the reporting of serious quality deficiencies resulting in suspension or termination of a practitioner, to the appropriate authorities.	**Documents Submitted:** • Cred-Recred Policy_ CR 300.07 pg 19 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Credentialing Disapprovals of Practitioners section of the Credentialing and Recredentialing Policy (CR 300.07) provided evidence of meeting the requirements of this element.		
	Recommendations: None.		
DHCFP Contract Section 4.8.13.10	15. Provider Dispute Process There is a provider appeal process for instances wherein the MCO chooses to deny, reduce, suspend, or terminate a practitioner's privileges with the MCO.	**Documents Submitted:** • Cred-Recred Policy_ CR 300.07 pg 19 • Practitioner Disciplinary Appeal Process 2013_pg 2-5	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II. Credentialing and Recredentialing

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		Description of Process: N/A	
	Findings: The Practitioner Disciplinary Appeals Process policy CR305 provided evidence of meeting the requirements of this element.		
	Recommendations: None.		
DHCFP Contract Section 4.13.1.6	16. Medical Director Oversight The Medical Director oversees the MCO's provider recruitment and credentialing activities.	**Documents Submitted:** • Cred-Recred Policy_ CR 300.01 pg 5_CR 300.02 pg 6 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Credentialing Reporting Structure and Responsibilities policy noted that the HPN Board of Directors delegated all operational aspects of the credentialing and recredentialing of providers to the Credentialing Committee. The HPN 2013 Quality Program Description included the statement that the Credentialing Committee was chaired by the medical director. A review of the Credentialing Committee minutes validated that the medical director attended all the meetings held during the study period.		
	Recommendations: None.		

Results for Standard II: Credentialing and Recredentialing							
Total	Met	=	15	X	1.00	=	15.0
	Partially Met	=	0	X	.50	=	0.0
	Not Met	=	0	X	.00	=	0.0
Total Applicable		=	15	**Total Score**		=	15.0

Total Score ÷ Total Applicable	=	100%

Standard III. Member Rights and Responsibilities

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.6(h)(2)(i) *DHCFP Contract Section 4.4.1.2*	1. Advance Directives Pursuant to Section 1902(w)(1) of the Social Security Act, the Patients' Self-Determination Act, including advance directives, the MCO has written policies and procedures with respect to all emancipated adult enrollees receiving medical care through the MCO.	**Documents Submitted:** • 1278 Nevada Check Up March 2013 Revision eng and span pg 21 • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH pg 22 • 1936 Mar 2013 revision_smartchoice eng and span pg 22 • WRHCO 286 Medicaid Advance Directive **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HPN's policy, Medicaid Advance Directive, outlined rights of adult members. The policy established that adult members had the right to refuse treatment and to formulate advance directives and that the health plan would not make treatment decisions or discriminate on the basis of whether an individual had executed an advance directive. The policy stated that if a provider could not implement an advance directive based on conscience, he or she must provide a statement to the member and the health plan would assist the member to find another provider. Providers were educated on the different types of advance directives in the Provider Summary Guide. The guide also included a Nevada-specific form for a durable power of attorney for health care decisions. The guide required providers to inquire if their patients had an executed advance directive and to note in the medical record whether there was an executed document or not. The health plan reviewed for the presence of this information during annual medical record audits.		
	Recommendations: None.		
42 CFR 438.6(h)(3) *DHCFP Contract Section 4.4.1.2 (A)*	2. Written Information concerning Advance Directives – Part 1 The MCO provides written information to each enrollee at	**Documents Submitted:** • 1278 Jun 2014 NV Check Up Revision (2) pg 20 1278 Jun 2014 revision Nv Check Up span pg 20	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III. Member Rights and Responsibilities

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	the time of enrollment concerning: a) The member's rights, under State law, to make decisions concerning medical care, including the right to accept or refuse medical treatment and the right to formulate advance directives; b) The MCO's policies with regard to a member's right to execute an advance directive, including a requirement that the network provider present a statement of any limitations in the event the provider cannot implement an advance directive on the basis of conscience. c) At a minimum, the MCO's statement of limitation, if any, must: i. Clarify any differences between institution-wide conscience objections and those that may be raised by individual network providers; ii. Identify the State legal authority pursuant to NRS 449.628 permitting such objections; and iii. Describe the range of medical conditions or procedures affected by the conscience objection.	• 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH pg 21 • 2013 Provider Summary Guide-Section 22 Advanced Directives WRHCO 286 Medicaid Advance Directive **Description of Process:** N/A	
	The HPN member handbooks for the SmartChoice and NorthernChoice and Nevada Check Up detailed members' rights to accept or refuse medical treatment and the right to formulate advance directives. The HPN Medicaid Advance Directive policy stated that if a provider could not implement an advance directive based on conscience, he or she must provide a statement to the member that		

Standard III. Member Rights and Responsibilities

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	included the differences between institution-wide objections and those raised by the individual provider, identified the state legal authority permitting the objection, and described the range of medical conditions or procedures affected by the conscientious objection.		
	Recommendations: None.		
42 CFR 438.6(h)(4) *DHCFP Contract Section 4.4.1.2 (B–E, V)*	3. Written Information concerning Advance Directives – Part 2 The MCO must: a) Educate the member to inform his/her provider to document in the enrollee's medical record whether the enrollee has executed an advance directive; b) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive; c) Ensure compliance with requirements of State laws regarding advance directives, including informing members that any complaints concerning the advance directives requirements may be filed with the appropriate State agency which regulates MCOs; and, d) Educate MCO staff and providers on issues concerning advance directives, at least annually. e) Ensure that Advance Directive information must reflect changes in the State law as soon as possible, but no later than 90 days after the effective dates of the change	**Documents Submitted:** • 1278 Jun 2014 NV Check Up Revision (2) pg 21 • 1278 Jun 2014 revision Nv Check Up span pg 21 • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH pg 22 • HPN Provider Summary Guide 2014_ Section 5.10 pg 35 and 5.11 pg 38_Section 8.9 pg 69_Section 22 pg 239 • 2013 Provider Summary Guide-Section 22 Advanced Directives **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III. Member Rights and Responsibilities

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: (a) The HPN member handbooks encouraged members to let their doctor and family know if they had an advance directive and if there was one, to make sure that the doctor and family members had copies of it. (b) The HPN Medicaid Advance Directive policy stated that the health plan would not make treatment decisions or discriminate on the basis of whether an individual had executed an advance directive. Similarly, the member handbooks stated that HPN did not discriminate on the basis of whether a member did or did not have an advance directive. (c) The member handbooks informed members that they could contact the Division of Health Care Financing and Policy regarding complaints they had concerning advance directives information and a toll-free number was provided. (d-e) Annually, the member and provider newsletters included articles about advance directives, including any changes in the State law. The information was continuously available in the member handbooks and Provider Summary Guide which were available on the HPN website. Members were notified annually that they could request their rights, a member handbook, or other resources at any time.		
	Recommendations: None.		
42 CFR 438.6(d)(1,3,4) *DHCFP Contract Section 4.4.3.4*	4. Changing PCP or PCS An enrolled recipient may change a PCP or PCS for any reason. The MCO notifies enrolled recipients of procedures for changing PCPs. The material used to notify enrolled recipients is approved by DHCFP prior to publication and/or distribution.	**Documents Submitted:** • 1278 Jun 2014 NV Check Up Revision (2) pg 7 • 1278 Jun 2014 revision Nv Check Up span pg 7 • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH pg 7 • Approval HPN Handbooks submitted for approval 03.25.13 • WRHCO 283 Changing Primary Care Provider at the Request of Medicaid or Nevada Check Up Member • WRHCO 330 Enrollment and Disenrollment Requirements and	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III. Member Rights and Responsibilities

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		Limitations **Description of Process:** N/A	
	Findings: HPN notified members in the member handbooks that they could call the health plan at any time to change their PCP. The health plan had policies detailing its processes for provider changes and the enrollment and disenrollment requirements: Changing Primary Care Provider at the Request of Medicaid or Nevada Check Up Member, and Enrollment and Disenrollment Requirements and Limitations, respectively. The health plan provided documentation that it submitted member materials to DHCFP for approval prior to publication.		
	Recommendations: None.		
42CFR 438.10(f)(5) *DHCFP Contract Section 4.4.3.4.(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:** • 100-12 Medicaid Provider Termination Policy pg 3_pg 6-7 • 1278 Jun 2014 NV Check Up Revision (2) pg 7 • 1278 Jun 2014 revision Nv Check Up span pg 7 • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH pg 7 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The policy, Medicaid Provider Termination, required that when a primary care physician was terminated by the health plan, all affected members were to be notified within 15 days of HPN's notice of the termination. The policy detailed the process for obtaining an updated patient roster from the provider, identifying members who were in active treatment, and internal coordination with the medical director, member services, and utilization management to develop transition plans for pregnant members and those in active treatment, as applicable. The policy included a template notification letter to members of terminating providers.		

Standard III. Member Rights and Responsibilities

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None.		
42 CFR 438.100(b)(2)(iii, iv) *42 CFR 438.102(a)(1)(i-iv)* *DHCFP Contract Section 4.5.5.13 (E)*	6. Restricting Provider Communication to Members An MCO may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an member who is his or her patient: a) For the member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. b) For any information the member needs in order to decide among all relevant treatment options. c) For the risks, benefits, and consequences of treatment or non-treatment. d) For the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.	**Documents Submitted:** • 2013 Provider Summary Guide-Section 8 Medicaid Members • WRHCO 340 Prohibition Against Interference with Patient Relationship • HPN-SHL-SHO Hospital Template Article III; N Hospital Communication 1-3 pg 8-9 • MEDICAID Consulting Provider Template Article III; E Physician Patient Communication 1- 3 pg 4 • MEDICAID Primary Care Physician FFS Template Article III; G Physician Patient Communication 1-3 pg 4 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HPN's policies and provider agreements were congruent in ensuring the health plan did not prohibit or restrict providers from advising or advocating for members. The policy, Prohibition Against Interference with Patient Relationship, stated that HPN supported open communication between its Medicaid members and physicians and identified each of the elements (a) through (d) above. The PCP, consulting provider, and hospital agreement templates encouraged providers to discuss details regarding the diagnosis, recommended treatment procedures, and any reasonable treatment alternatives with the patient.		
	Recommendations: None.		

Standard III. Member Rights and Responsibilities

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.100(a)(1) *DHCFP Contract Section 4.8.14.2*	7. Written Policy on Recipient Responsibilities The MCO has a written policy that addresses members' responsibility for cooperating with those providing health care services. The written policy addresses members' responsibility for: a) Providing, to the extent possible, information needed by professional staff in caring for the recipient; and b) Following instructions and guidelines given by those providing health care services	**Documents Submitted:** • 1278 Jun 2014 NV Check Up Revision (2) pg 20 • 1278 Jun 2014 revision Nv Check Up span pg 20-21 • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH pg 21-22 • Prov Summary Guide Section 8 Medicaid Members Sect 8.9 • WRHCO 273 New Member Orientation for Medicaid and Nevada Check Up Members **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The policy, New Member Orientation for Medicaid and Nevada Check Up Members, stated that new member packets were mailed within five days of receipt of the monthly enrollment file. The new member packets included a member handbook which contained information about the member's responsibilities. Member responsibilities included telling the doctor or healthcare provider all the information needed to take care of the member, to follow the doctor's or dentist's treatment advice, and to take prescribed medication.		
	Recommendations: None.		
DHCFP Contract Section 4.8.14.3	8. Communicating Rights and Responsibilities to Providers A copy of the MCO's policies on recipients' rights and responsibilities is provided to all participating providers.	**Documents Submitted:** • HPN Provider Summary Guide 2014 Section 8 Medicaid_8.9 pg 68-70 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III. Member Rights and Responsibilities

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		N/A	
	Findings: The Provider Summary Guide included a copy of Medicaid member rights and responsibilities and was given to all providers at the initial provider site visit and was continuously available on the HPN website. Additionally, a list of member rights was included in the 2013 UM Program Description.		
	Recommendations: None.		
42 CFR 438.10(f)(6)(iii) *42 CFR 438.100(b)(2)(i)* *DHCFP Contract Section 4.8.14.4*	9. Communicating Rights and Responsibilities to Members Upon enrollment, recipients are provided a written statement that includes information on their rights and responsibilities.	**Documents Submitted:** • 1278 Jun 2014 NV Check Up Revision (2) pg. 21 • 1278 Jun 2014 revision Nv Check Up span pg.21 • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH pg.21 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The policy, New Member Orientation for Medicaid and Nevada Check Up Members, stated that new member packets were mailed within five days of receipt of the monthly enrollment file. The new member packets included a member handbook which contained information the member's responsibilities. During the on-site review, health plan staff members provided documentation substantiating that the new member packets were mailed to members within five days of the health plan's receipt of the enrollment file.		
	Recommendations: None.		
DHCFP Contract Section 4.8.14.6	10. Member Suggestions Opportunity is provided for recipients to offer suggestions	**Documents Submitted:** • 1278 Jun 2014 NV Check Up Revision (2) pg 23	☒ Met ☐ Partially Met ☐ Not Met

Standard III. Member Rights and Responsibilities

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	for changes in policies and procedures.	• 1278 Jun 2014 revision Nv Check Up span pg 23 • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH pg 23 **Description of Process:** N/A	☐ N/A
	Findings: The member handbooks included text encouraging members to contact member services to offer any suggestions they had to improve HPN's services or programs. Additionally, one of the health plan's on-hold telephone messages encouraged members to let the health plan know of any suggestions the member had. HPN's website included a Quality tab where results of member satisfaction surveys were posted and at the end of each section was a statement encouraging readers to contact the HPN Quality Improvement Department; the telephone number was provided.		
	Recommendations: None.		
DHCFP Contract Section 4.8.14.10	11. Treatment of Minors The MCO has written policies regarding the treatment of minors.	**Documents Submitted:** • 1278 Jun 2014 NV Check Up Revision (2) pg 21 • 1278 Jun 2014 revision Nv Check Up span pg 21 • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH pg 21-22 • Nevada Privacy Policy • Prov Summary Guide Section 8 Medicaid Members Sect 8.8 **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard III. Member Rights and Responsibilities

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: The Nevada Privacy Policy included requirements regarding handling of protected health information (PHI) for emancipated and unemancipated minors. The Check Up and SmartChoice handbooks included information relevant to making advance directives for children 18 and over. The on-site review included a discussion with health plan staff members regarding additional policy topics the health plan should consider adopting which could include family planning for individuals of childbearing age who are eligible under the State plan and who desire such services and supplies, treatment of minors in emergency situations, minors who are parents, and minors who are married.		
	Recommendations: HPN should adopt a written policy or polices regarding the treatment of minors.		
DHCFP Contract Section 4.8.14.11 (A–B)	12. Assessment of Member Satisfaction The MCO conducts periodic survey(s) of recipient satisfaction with its services, and the survey(s) include content on perceived problems in the quality, availability and accessibility of care. The survey(s) assess at least a sample of: a) All recipients; b) Recipient requests to change practitioners and/or facilities; and c) Disenrollment by recipients.	**Documents Submitted:** • 2013 QI Program Eval FINAL pg.128-131; 138; 144-145; 148-149; 170; 177-181 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HPN conducted a variety of survey activities of its population groups in 2013. These included annual CAHPS surveys of adult and child Medicaid and the Nevada Check Up members, as well as annual surveys of individuals in the Health Management and Complex Case Management programs. Additionally, HPN conducted quarterly surveys of individuals in the Care For Me Program and callers to the Telephone Advice Nurse. The health plan initiated a new quarterly survey of the individuals who had interactions with the social work program. The health plan's 2013 QI Program Evaluation provided the analysis of member satisfaction, complaint, and appeals data. The report documented that the health plan reviewed all quality of care complaints and disenrollment request reasons.		

Standard III. Member Rights and Responsibilities

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None		
DHCFP Contract Section 4.8.14.11 (C–D)	13. Survey Results As a result of the survey(s), the MCO: a) Identifies and investigates sources of dissatisfaction; b) Outlines action steps to follow up on the findings; c) Informs practitioners and providers of assessment results; and d) The MCO re-evaluates the effects of the above activities.	**Documents Submitted:** • 2013 Provider Summary Guide pg. 420 • 2013 QI Program Eval FINAL pg.128-131; 138; 144-145; 148-149; 170; 177-181 • HPN Provider Summary Guide 2014 Quality Improvement Program pg 204 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2013 QI Program Evaluation included a summary of results for each of the surveys the health plan conducted, as well as barriers and opportunities for improvement, interventions and activities conducted, and recommendations for the subsequent year. HPN's website included a Quality tab where results of three years of member satisfaction surveys were posted. At the end of each sub section was a statement encouraging readers to contact the HPN Quality Improvement Department with questions and the telephone number was provided.		
	Recommendations: None		
42 CFR 438.56(b)(2) *42 CFR 438.100(d)* *42 CFR 438.6* *DHCFP Contract Section 4.3*	14. Non-discrimination Based on Health Status The MCO does not, on the basis of health status or need for health services, discriminate against recipients eligible to enroll. The MCO does not deny the enrollment nor discriminate against any Medicaid or Nevada Check Up recipients eligible to enroll on the basis of race, color or national origin and will not use any policy or practice that	**Documents Submitted:** • 2013 Provider Summary Guide-Section 8 Medicaid Members Sect. 8.8 • WRHCO 330 Enrollment and Disenrollment Requirements and Limitations **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III. Member Rights and Responsibilities

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	has the effect of discrimination on the basis of race, color or national origin.	N/A	
	Findings: HPN's processes ensured that it did not discriminate against potential enrollees. The health plan did not deny enrollment or discriminate against any potential Medicaid or Nevada Check Up individual. The health plan's Enrollment and Disenrollment Requirements and Limitations policy described that the DHCFP's Fiscal Agent managed all enrollment files. HPN's Information Technology Department retrieved the enrollment files from the Fiscal Agent's file transfer site. Enrollment records that successfully passed the HIPAA-compliant editing were auto-loaded into the Facets system as new, terminated or re-enrollment records as of the effective dates on the file. The HPN Provider Summary Guide prohibited providers from discriminating against any patient on the basis that the patient was a member of Health Plan of Nevada or on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability, medical condition, sexual orientation, claims experience, medical history, evidence of insurability, disability, genetic information, or source of payment. Providers were required to maintain policies and procedures to demonstrate that they did not discriminate in the treatment services provided and that they accepted into treatment any members in need of the services they offered.		
	Recommendations: None		

Results for Standard III: Member Rights and Responsibilities							
Total	Met	=	13	X	1.00	=	13.0
	Partially Met	=	1	X	.50	=	0.5
	Not Met	=	0	X	.00	=	0.0
Total Applicable		=	14	**Total Score**		=	13.5

Total Score ÷ Total Applicable	=	96.4%

Standard IV. Member Information

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.10 (e)(1)(i) *DHCFP Contract Section 4.4.1*	1. Written Information about Access to Services The MCO has written information about its services and access to services available upon request to members and potential members. The written information is available in the prevalent non-English languages, as determined by the State, in its particular geographic service area.	**Documents Submitted:** • 1278 Jun 2014 NV Check Up Revision (2) • 1278 Jun 2014 revision Nv Check Up span • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH • WRHCO 273 New Member Orientation for Medicaid and Nevada Check Up Members **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The New Member orientation for Medicaid and Nevada Check Up Members policy required that the new member packets must be mailed within five days of receipt of the monthly enrollment file. The health plan provided documentation of a date of enrollment files and corresponding dates when new member packets were mailed; the health plan met the time line requirement. The new member packet included a member handbook which included information the member's rights and responsibilities. The health plan provided its member handbooks and other member materials in both English and Spanish. HPN used the United States Census Bureau's American Community Survey as its guide to assess the number of households in its coverage areas where languages other than English were spoken and how fluent the residents were at speaking the English language. HPN found that the top two languages spoken by Nevada residents, other than English, were Spanish and Tagalog. For the Tagalog language, the state of Nevada and Clark County have a rate of less than one percent for residents who speak English less than very well. Washoe County was not reported by the American Community Survey in 2012 due to the number in the sample size being too small. Open enrollment materials were available in both English and Spanish. In addition, benefits information was available to anyone on the HPN website under the Plan Information tab.		
	Recommendations: None		

Standard IV. Member Information

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.10(c)(4) *DHCFP Contract Section 4.4.1*	2. Oral Interpretation Services The MCO makes free, oral interpretation services available to each member and potential member. This applies to all non-English languages, not just those that the State identifies as prevalent.	**Documents Submitted:** • 1278 Jun 2014 NV Check Up Revision (2) Inside Cover Page • 1278 Jun 2014 revision Nv Check Up span Inside Cover Page • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH Inside Cover Page • WRHCO 273 New Member Orientation for Medicaid and Nevada Check Up Members ◆ **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HPN offered free, oral interpretation services to members and potential members. The member handbook included information on interpretation services and local and toll free numbers were provided. This information was posted on the HPN website. The 2013 QI Program evaluation documented the numbers of calls and languages involved over four quarterly periods. Calls were transferred to the language line from the Member Services Department, Complex Case Management, Health Management and the Telephone Advice Nurse Line.		
	Recommendations: None		
42 CFR 438.10(c)(5)(i-ii) *42CFR 438.10(e)(2)(i)(A and C)* *42 CFR 438.10(e)(2)(ii)(B)*	3. Notifying Enrollees about Interpretation Services The MCO notifies all members and potential members that oral interpretation is available for any language and written information is available in prevalent languages. The MCO	**Documents Submitted:** • 1278 Jun 2014 NV Check Up Revision (2) • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IV. Member Information

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.10(e)(2)(i)(C)(ii) *42 CFR 438.10(e)(2)(i)(C)(ii)(A-E)* *DHCFP Contract Section 4.4.1*	notifies all members and potential members how to access this information.	**Description of Process:** N/A	
	Findings: The member handbooks were printed in both English and Spanish and included information that oral interpretation services in languages other than English were available through the member services department. Local and toll free numbers were provided. Similarly, the member newsletter included an information block informing readers that the member services department could communicate in any language, toll-free. The member handbooks and newsletters were mailed to members and were also posted on the HPN website.		
	Recommendations: None.		
42 CFR 438.10(b)(3) *DHCFP Contract Section 4.13.7*	4. Potential Enrollees If requested by potential enrollees, the MCO must provide an accurate oral and written information so that he/she needs to make an informed decision regarding whether to enroll with the MCO	**Documents Submitted:** • 21NVMDCD13125 Make the Choice for Good Health Flyer • 21NVMDCD13126 Your Child's Health is Important Flyer • 21NVMDCD13127 Medicaid Enrollment Letter • 28172 North Comparison Chart English and Spanish FINAL 2014 • 28172 South Comparison Chart English and Spanish FINAL 2014 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The health plan had processes to provide information about its services in oral and written formats. The plan documented that it provided oral translation services to callers in over 40 different languages via its vendor, the Language Line. Language translation services were provided for callers to Member Services as well as to the HPN Complex Case Management, Health		

Standard IV. Member Information

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Management and Health Education and Wellness programs. HPN provided health plan comparison charts in English and Spanish so potential enrollees could make an informed decision about enrolling with the health plan.		
	Recommendations: None.		
42 CFR 438.10(b)(1) *42 CFR 438.10(d)(1)(i-ii)* *42 CFR 438.10(d)(2)* *DHCFP Contract Section 4.4.1*	5. Appropriate Format for Communications Written material is in an easily understood format. The MCO develops appropriate alternative methods for communicating with visually and hearing-impaired members, and accommodating physically disabled recipients in accordance with the requirements of the Americans with Disabilities Act of 1990. All members and potential members are informed that the information is available in alternative formats and how to access those formats. The MCO is responsible for effectively informing Title XIX Medicaid members who are eligible for EPSDT services, regardless of any thresholds.	**Documents Submitted:** • 1278 Jun 2014 NV Check Up Revision (2) Inside Cover • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH Inside Cover Page **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The HPN member handbooks included text in English and Spanish that assistance and information was available for those who spoke languages other than English, as well as for individuals who were hearing or visually impaired. The handbook stated that documents in large print were available. The local and toll free numbers for the HPN Member Services Department were provided.		
	Recommendations: None.		
DHCFP Contract Section 4.4.1.1	6. Member Handbook The MCO provides all members with a Member Handbook. The MCO meets this requirement by sending the Member Handbook to the head of the household.	**Documents Submitted:** • May 27 Sample List Member Mailing • Member Mailing for Audit • WRHCO 273 New Member Orientation for Medicaid and Nevada Check Up Members	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IV. Member Information

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		Description of Process: N/A	
	Findings: The health plan provided members with a member handbook within five days of receiving enrollment files. Mail was sent to the head of household as applicable. The health plan provided a sample member mailing list and documentation that mailing occurred within specified timeframe.		
	Recommendations: None.		
DHCFP Contract Section 4.4.1.1	7. Enrollee Handbook Prose and Required Statement The handbook is written at no higher than an eighth grade reading level and conspicuously states the following in bold print: "THIS HANDBOOK IS NOT A CERTIFICTAE OF INSURANCE AND SHALL NOT BE CONSTRUED OR INTERPRETED AS EVIDENCE OF INSURANCE COVERAGE BETWEEN THE VENDOR AND THE ENROLLEE."	**Documents Submitted:** • 1278 Jun 2014 NV Check Up Revision (2) Inside Front Cover • 1278 Jun 2014 revision Nv Check Up span Inside Front Cover • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH Inside Front Cover • Readability Flesch-Kincaid Page Five of SmartChoice Member Handbook **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The plan provided documentation of Flesch-Kincaid grade reading level that met the eighth-grade standard. The required statement was included in the handbooks.		
	Recommendations: None.		
DHCFP Contract Section 4.4.1.1.(A)	8. Updating Handbook Annually The MCO maintains documentation that the handbook is	**Documents Submitted:** • 1278 Nevada Check Up March 2013 Revision eng and span	☒ Met ☐ Partially Met ☐ Not Met

Standard IV. Member Information

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	updated at least once per year, and the annual updates must be submitted to DHCFP for approval before publication and/or distribution.	• 141027 approval member update for handbooks • 1936 Mar 2013 revision_smartchoice eng and span • Emailing 1278 Nevada Check Up March 2013 Revision eng and span 1936 Mar 2013 revision_smartchoice eng and span • IMPORTANT UPDATES TO YOUR PLAN INFORMATION Spanish • IMPORTANT UPDATES TO YOUR PLAN INFORMATION • Medicaid Member Handbook Updated Files **Description of Process:** N/A	☐ N/A
	Findings: The plan provided documentation that the handbook was updated annually and that approval for changes had been sought and obtained from DHCFP.		
	Recommendations: None.		
42 CFR 438.10(f)(2-3) *42 CFR 438.10(i)(2)(ii)* *DHCFP Contract Section 4.4.1.1 (B)*	9. Distributing Handbooks The MCO mails the handbook to all enrollees within five (5) business days of receiving notice of the recipient's enrollment and notifies all members of their right to request and obtain this information at least once per year or upon request.	**Documents Submitted:** • 1278 Jun 2014 NV Check Up Revision (2) Page 22 • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH Page 21 • Mailing Compliance	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IV. Member Information

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		Description of Process: N/A	
	Findings: The health plan provided members with a member handbook within five days of receiving the enrollment files. The health plan provided documentation that mailing occurred within specified timeframe. Member newsletters were mailed to members and posted on the HPN website that informed members they could request handbooks, member rights, and other enrollee information from member services at any time. During the on-site interview, reviewers recommended that with the next member handbook update, HPN should clarify text in the member handbook section titled "When You Should Contact Us." The handbooks stated, "Every year you may ask us for…a list of providers, member rights and responsibilities, member benefits and how to access them." The health plan should revise this text to state that the member can request this information *at any time*. The federal requirement [*42 CFR 438.10(f)(2)]* specifies that the health plan must inform the member of this right at least once a year. That is, the health plan is required to do this annually, the member's right to request information is not limited to once per year**. Because the information is correct in the member newsletters, a formal recommendation is not made, but the health plan is strongly encourage to ensure that its Medicaid and Nevada Check Up member handbooks (English and Spanish) are corrected.**		
	Recommendations: None.		
DHCFP Contract Section 4.4.1.1 (B)	10. Handbooks on the Internet The MCO publishes the Member Handbook on the MCO's Internet website upon contract implementation and updates the website as needed, to keep the Member Handbook current.	**Documents Submitted:** • 141027 approval member update for handbooks • Handbook Update for June 2014 • Medicaid Web Page Home **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HPN published its member handbooks for Medicaid and Nevada Check up on its website and provided documentation that it updated them as necessary.		

Standard IV. Member Information

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None.		
DHCFP Contract Section 4.5.7	11. Provider Directory The MCO: a) Publishes its provider directory and any subcontractor's provider directory via an Internet website upon contract implementation and updates the website on a monthly basis for all geographic service areas. b) Provides DHCFP with the most current provider directory upon contract award for each geographic service area. c) Confirms, upon request by DHCFP, the network adequacy and accessibility of its provider network and any subcontractor's provider network.	**Documents Submitted:** • 100-4 Provider Directory Scheduling and Process Overview pg 3; 5 - 6 • April 2014 Medicaid Excel Directory • February 2014 Medicaid Excel Diretory • FW Provider Directories jul upload complete • HPN Network Adequacy sec 4_2nd Qtr 2014 • HPN Network Adequacy sec 4_2nd Qtr 2014_Hosp • HPN Network Adequacy_3rd Q 2013 • HPN Network Adequacy_3rd Q 2013_Hosp • HPN Network Hospital Adequacy_1st Q 2014 • HPN Network Hospital Adequacy_1st Q 2014_Hosp • HPN Network Hospital Adequacy_4thQ 2013 • HPN Network Hospital Adequacy_4thQ 2013_Hosp • January 2014 Medicaid Excel Directories • June 2014 Medicaid Provider Excel Directory	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IV. Member Information

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		• March 2014 Medicaid Excel Directory • Medicaid Provider Directories - Excel Format_October 2013 • Medicaid Provider Directories-SN-NN 091213 • Medicaid Provider Directory SN-NN Excel • NorthernChoice April 2014 online Print • NORTHERNCHOICE August 2013 online • NorthernChoice Dec 2013 online and print • NorthernChoice Feb 2014 online • NorthernChoice Jan 2014 online • NORTHERNCHOICE July 2013 online • NorthernChoice June 2014 online • NorthernChoice March 2014 online • NorthernChoice November 2013 online • NORTHERNCHOICE October 2013 online • NORTHERNCHOICE September 2013 online • November2013 Medicaid Excel Directory • SmartChoice April 2014 online print • SMARTCHOICE August 2013 online • SmartChoice December 2013 online and print	

Standard IV. Member Information

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		• SmartChoice Feb 2014 online • SmartChoice Jan 2014 online • SMARTCHOICE July 2013 online • SmartChoice June 2014 online • SmartChoice March 2014 online • SmartChoice May 2014 online print • SmartChoice November 2013 online • SMARTCHOICE October 2013 online • SMARTCHOICE September 2013 online • SMARTCHOICE_MAY 2014 Online • SOP MCAD 23 Provider Directory Update • website request form 10172014 Directories • website_request_form 02112014 • website_request_form 12022013 • website_request_form September Dir **Description of Process:** N/A	
	Findings: The provider directories were produced and updated on a specified schedule established by the Network Development and Contract Internal Operations Manager throughout the year. The directories contained provider specialty, demographic information, board certification, languages spoken, and whether the provider was accepting new members. Staff members ensured that information was correct by multiple internal manual and electronic reviews.		
	Recommendations: None		

Standard IV. Member Information

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.5.8.2 (C)	12. Recipient Newsletter The MCO, subject to the prior review and approval of DHCFP, publishes a newsletter for enrolled recipients at least twice per year. The newsletter focuses on topics of interest to enrolled recipients and must be written at an eighth grade level of understanding reflecting cultural competence and linguistic abilities.	**Documents Submitted:** • AMC-032-NV_CHIP • Approval Member Newsletter - Summer 2013 - Final Version (Translated and Certificate) • FALL Member Newsletter AMC-028-NV_CHIP_E • Medicaid Member Newsletters Health Talk • RE Submitted For Approval HPN Member Newsletter 101013 HJONES • Summer Member Newsletter AMC-031-NV_CHIP (FINAL) **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HPN provided documentation that it had obtained DHCFP approval prior to publishing the Summer and Fall newsletters; they were published in both English and Spanish. The newsletters contained information for healthy lifestyles and how to obtain maximum benefit from plan services. Articles were on topics such as finding the right physician, appropriate use of antibiotics, the importance of oral health, and encouraging pediatric well visits.		
	Recommendations: None.		

Standard IV. Member Information

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.8.14.8 (A)	13. Written Level for Recipient Information Recipient information (for example, subscriber brochures, announcements, newsletters, and handbooks) in prose, is written at an eighth (8th) grade level that is readable and easily understood.	**Documents Submitted:** • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH • 21NVHPN14170 REVISED Well Child Incentive Mailer • Flesch Kincaid of Health Talk • MCAD Mbr Newsletter Page 2 (FINAL) • Readability Flesch-Kincaid Page Five of SmartChoice Member Handbook • Well Child Incentive Mailer sample **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HPN provided examples of having used Flesch-Kincaid Grade Level Scale to ensure that the handbooks, newsletters, flyers, website announcements and other member materials were written at an eighth-grade reading level.		
	Recommendations: None.		
42 CFR 438.10(c)(2-3) *DHCFP Contract Section 4.8.14.8 (B)*	14. Prevalent Languages for Written Information Written information is available in the prevalent languages of the population groups served.	**Documents Submitted:** • 0057 NVCU Welcome eng 2014 • 0057 NVCU Welcome spa 2014 • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH • 21NVMDCD143010 - Southern Nevada Medicaid Provider Directory Cover • 21NVMDCD1432 Urgent Care ClingZ Northern Nevada • 21NVUHC13500S Cling Z Card	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IV. Member Information

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		Southern Nevada Spanish NEW • PD 0872 Health Survey Form eng • PD 7306 Warning Signs During Pregnancy EN-SP • PD0872 Health Survey Form spn **Description of Process:** N/A	
	Findings: Using the United States Census Bureau's publication of the American Community Survey, HPN assessed the linguistic needs of its members. The survey data indicated that the only language with a high percentage spoken at home in Nevada was Spanish. All significant member materials were published in English and Spanish, as well as numerous patient education materials.		
	Recommendations: None.		

Results for Standard IV: Member Information							
Total	Met	=	14	X	1.00	=	14.0
	Partially Met	=	0	X	.50	=	0.0
	Not Met	=	0	X	.00	=	0.0
Total Applicable		=	14	**Total Score**		=	14.0

Total Score ÷ Total Applicable	=	100%

Standard V. Availability and Accessibility of Services

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.206(b)(1) *42 CFR 438.207(b)(2)* *42 CFR 438.208(b)(2-4)* *DHCFP Contract Section 4.2.1.7*	1. Network of Providers The MCO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for both the FMC/TANF/CHAP and CHIP (Nevada Check Up) populations as well as the Adult Medicaid Expansion Group.	**Documents Submitted:** • 100-11 Provider Summary Guide Policy • 100-3 Provider Site Visit Policy • 2013 HPN Access and Availability Policy • HPN Provider Summary Guide 2014 Section 8 Medicaid pg 64 • MEDICAID Consulting Provider Template Attachment B pg 15 • MEDICAID Primary Care Physician FFS Template Attachment B pg 15 • PCPAfterHrs_Final-Medicaid_7.1.13-6.30.14.xls **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Access and Availability Plan 2013 (QI 222.00.08) included the statement that the Quality Improvement Committee (QIC) performed oversight to ensure the accessibility and availability of the HPN network. The Network Development and Contracts Department was responsible for network development, contracting, and reporting of network availability. The Provider Relations Department was charged with education, support, and enforcement of contracts and guidelines. The Medicaid Consulting Provider Template and the Medicaid PCP Fee-for-Service (FFS) Template provided evidence of the written agreements executed with network providers. The Mechanisms for Monitoring Adequacy of Practitioners policy (QI 222.07) noted that HPN monitored the network by reviewing reports from the provider relations database, conducting secret shopper calls, performing GeoAccess studies, and reviewing trends in member satisfaction through the use of the annual member survey, complaint analysis, and reports from quality management and provider services. Interviews with staff confirmed that the Provider Services Department completed the quarterly access reports and forwarded the reports to the Medicaid QI Subcommittee for review. The minutes from the May 28, 2014 meeting of the Medicaid QI Subcommittee validated that the committee reviewed the first quarter 2014 access report.		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None.		
42 CFR 438.206(b)(1)(i-v) *42 CFR 438.207(b)(1)* *DHCFP Contract Section 4.2.1.7 (A–E)*	2. Establishing and Maintaining a Network of Providers In establishing and maintaining the network, the MCO considers the following: a) The anticipated DHCFP recipient managed care enrollment; b) The numbers of network providers who currently are and are not accepting new Medicaid and Nevada Check Up recipients; c) The expected utilization of services, taking into consideration the characteristics and heath care needs of specific Medicaid and Nevada Check Up populations represented in the RFP; d) The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid covered services; and e) The geographic location of providers and enrolled recipients, considering distance (pursuant to NAC 695C.160), travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities.	**Documents Submitted:** • 2013 HPN Access and Availability Policy pg 4, 6, 8, 10, 13 and 15 • HPN Network Adequacy sec 4_2nd Qtr 2014 • HPN Network Adequacy sec 4_2nd Qtr 2014_Hosp • HPN Network Adequacy_3rd Q 2013 • HPN Network Adequacy_3rd Q 2013_Hosp • HPN Network Hospital Adequacy_1st Q 2014 • HPN Network Hospital Adequacy_1st Q 2014_Hosp • HPN Network Hospital Adequacy_4thQ • HPN Network Hospital Adequacy_4thQ 2013_Hosp **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Access and Availability Plan 2013 (QI 222.00.08) noted that HPN monitored the adequacy of PCPs, high-volume specialty providers, and primary care dentists to ensure its network was sufficient in numbers and types of practitioners. The Medicaid Access Availability Reports provided information concerning the PCP-to-recipient ratios, the physician specialist-to-		

Standard V. Availability and Accessibility of Services

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	recipient ratios, the dentist-to-recipient ratios, the 25-mile rule for medical care, the 25-mile rule for behavioral health providers and facilities, and the number of hospitals by county and statewide. The quarterly reports validated that the monitoring was reviewed and reported to DHCFP on a quarterly basis.		
	Recommendations: None.		
42 CFR 438.207(c)(2)(i-ii) *DHCFP Contract Section 4.5.2*	3. Reporting Requirements The MCO submits documentation to the State demonstrating the capacity to serve the expected enrollment when there has been a change in the MCO's services, benefits, geographic service area or payments, or enrollment of a new population in the network.	**Documents Submitted:** • HPN Network Adequacy sec 4_2nd Qtr 2014 • HPN Network Adequacy_3rd Q 2013 • HPN Network Hospital Adequacy_1st Q 2014 • HPN Network Hospital Adequacy_4thQ 2013 • HSAG Provider Access report 2014 • Network Adequacy_DHCFP Presentation_HPN_7-22-2013 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HPN submitted the 2014 quarterly reports submitted to DHCFP to provide evidence of meeting the requirements of this standard. Interviews with staff confirmed that the Provider Services Department completed the quarterly access reports and that the reports were forwarded to the Medicaid QI Subcommittee for review. The minutes from the May 28, 2014 meeting of the Medicaid QI Subcommittee validated that the committee reviewed the first quarter 2014 access report.		
	Recommendations: None.		
DHCFP Contract Section 4.2.1.8	4. Freedom of Choice of Providers The MCO allows each enrollee to choose his or her health	**Documents Submitted:** • 1278 Jun 2014 NV Check Up Revision (2) Pg 5-6	☒ Met ☐ Partially Met

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	care professional, including the PCP, to the extent possible and appropriate.	• 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH Pg 5-6 • HPN Provider Summary Guide 2014 Section 8 Medicaid_8.9 pg 68 • MEDICAID Consulting Provider Template Attachment B Article IV C • MEDICAID Primary Care Physician FFS Template Attachment B Article IV C • NorthernChoice November 2014 online • SmartChoice November 2014 online (2) **Description of Process:** N/A	☐ Not Met ☐ N/A
	Findings: The 2014 HPN Provider Summary Guide, the June 2014 NV Check Up Member Handbook, and the June 2014 SmartChoice/NorthernChoice Member Handbook included the requirements of this element in the statement of Member Rights. Interviews with staff from the Member Services Department confirmed that staff from the department conducted the new member welcome calls. During the welcome calls, staff members asked if the members had a PCP and if they did not, assistance was given to select a PCP at that time. Women also were encouraged to choose an OB/GYN during the welcome calls.		
	Recommendations: None.		
42 CFR 438.206(b)(2) *DHCFP Contract Section 4.2.1.9*	5. Direct Access to Women's Health Specialists The MCO provides female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated PCP, if that source is not a women's health specialist.	**Documents Submitted:** • 1278 Jun 2014 NV Check Up Revision (2) Pg 5-7 • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH 5-7 • HPN Provider Summary Guide 2014 Section 8 Medicaid_8.9 pg 69 • NorthernChoice November 2014 online	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		• SmartChoice November 2014 online (2) **Description of Process:** N/A	
	Findings: The 2014 HPN Provider Summary Guide, the June 2014 SmartChoice/NorthernChoice Member Handbook, and the June 2014 NV Check Up Handbook provided the statement included in this element in the Members' Rights section of the documents.		
	Recommendations: None.		
42 CFR 438.206(b)(3 and 5) *DHCFP Contract Section 4.2.1.11*	6. Second Opinions The MCO provides for a second opinion from a qualified health care professional within the network, or arrange for the member to obtain one outside of the network, at no cost to the member.	**Documents Submitted:** • 2013 UM Program Description FINAL pg.7 • 2014 UM Program Description Final pg. 7 • HPN Provider Summary Guide 2014 Section 8 Medicaid_8.9 pg 70 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2014 HPN Provider Summary Guide, the June 2014 SmartChoice/NorthernChoice Member Handbook, the June 2014 NV Check Up Handbook, and the Out-of-Plan Services for Medicaid and Nevada Check Up Members that Require HPN Reimbursement provided the statement included in this element in the Member Rights section of the documents.		
	Recommendations: None.		
42 CFR 438.206(b)(6) *DHCFP Contract Section 4.2.1.12*	7. Payment of Out-of-Network Providers The MCO coordinates with out-of-network providers with respect to payment.	**Documents Submitted:** • WRHCO 132 Out-of Plan Services for Medicaid and Nevada Check Up Members • WRHCO 141 Coordination of Non-Covered Benefits	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		• WRHCO 307 Organ Transplantation for Medicaid and Nevada Check Up Members **Description of Process:** N/A	
	Findings: The Out-of-Plan Services for Medicaid and Nevada Check Up Members that Require HPN Reimbursement policy provided evidence of meeting the requirements of this element.		
	Recommendations: None.		
42 CFR 438.206(c)(1)(i-vi) *DHCFP Contract Section 4.2.1.14*	8. Hours of Operation The MCO: a) Ensures that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid FFS, if the provider services only Medicaid enrollees pursuant to 42 CFR 438.206. b) Meets and requires its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services; c) Makes services, included in the RFP available twenty-four (24) hours per day, seven (7) days per week, when medically necessary; d) Establishes mechanisms to ensure compliance by providers;	**Documents Submitted:** • 100-3 Provider Site Visit Policy • 2013 HPN Access and Availability Policy QI 222.00; 2.0 and 3.0 pg 2_ QI 222.08 pg 17_QI 222.09 pg 20 • MEDICAID Consulting Provider Template Article III- A; 8 pg 3_ Attachment B; 11 pg 18 • MEDICAID Primary Care Physician FFS Template Article III -A pg 3_Attachment B; 11 pg 18 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	e) Monitors providers regularly to ensure compliance and takes corrective action if there is a failure to comply.		
	Findings: The HPN Provider Summary Guide provided evidence of meeting this element. The Mechanisms for Monitoring Access to Care policy included the data sources used to annually monitor access for primary care providers, specialty care providers, and dental providers also provided evidence of meeting this element. The Mechanisms for Monitoring Adequacy of Practitioners policy (QI 222.07) noted that HPN monitored the network by reviewing reports from the provider relations database, conducting secret shopper calls, performing GeoAccess studies, and reviewing trends in member satisfaction through the use of the annual member survey, complaint analysis, and reports from quality management and provider services. Interviews with staff confirmed that there were no corrective action plans developed for providers due to issues with access to care during the review period.		
	Recommendations: None.		
42 CFR 438.114(b)(1-3) *DHCFP Contract Section 4.2.1.15*	9. Emergency Coverage The MCO provides emergency coverage twenty-four (24) hours per day, seven (7) days per week. The MCO has written policies and procedures describing how recipients and providers can obtain emergency services after business hours and on weekends. Policies and procedures include provision of direct contact with qualified clinical staff.	**Documents Submitted:** • 2013 HPN Access and Availability Policy QI 222.08 pg 17 • HPN Provider Summary Guide 2014 Section 8 Medicaid; 8.6 pg 66 • MEDICAID Consulting Provider Template Article III- A; 7 and 8 pg 3 • MEDICAID Primary Care Physician FFS Template Article III -A pg 3 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2013 HPN Access and Availability Policy (QI 222.00.08) contained the requirement to provide access to care and services 24-hours a day, seven days a week. Providers were to furnish emergent care in their offices the same day as the request for services. The HPN Provider Summary Guide also contained the instructions providers were to give members who call after hours. The instructions could be given either by a person answering the call or by recording. The Guide also noted that a medical director		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	was on-call to assist providers with medical and administrative information and decisions related to emergency situations.		
	Recommendations: None.		
DHCFP Contract Section 4.2.1.15	10. Urgent Care The MCO has written policies and procedures describing how recipients and providers can obtain urgent coverage after business hours and on weekends. Policies and procedures include provision of direct contact with qualified clinical staff. Urgent coverage means those problems which, though not life-threatening, could result in serious injury or disability unless medical attention is received.	**Documents Submitted:** • 1278 Jun 2014 NV Check Up Revision (2) Pg 9 • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH Pg 9 • 2013 HPN Access and Availability Policy QI 222.08 pg 17 • 21NVUHC141046 So NV Urgent Care Clingz Revision • HPN Provider Summary Guide 2014 Section 8 Medicaid; 8.6 pg 66 • MEDICAID Consulting Provider Template Article III- A; 7 and 8 pg 3 • MEDICAID Primary Care Physician FFS Template Article III -A pg 3 • Urgent Care ClingZ Northern Nevada Spanish • Urgent Care ClingZ Northern Nevada • Urgent Care ClingZ_SO NV English • Urgent Care So Nevada Spanish NEW **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: The Accessibility Standards for Access to Care policy (QI 222.00.08) included the statement that the PCP was responsible to handle the care needed by members both during and after business hours, 24-hours a day, seven days a week. The policy further stated that urgent care was to be provided within 24 hours of the request for services. Interviews with staff confirmed that providers have established multiple locations for urgent care in the community to assist members in receiving urgent care services.		
	Recommendations: None.		
DHCFP Contract Section 4.2.10	11. Out-of-Network Providers Covering services with out-of-network providers: a) If the MCO's provider network is unable to provide medically necessary services covered under the plan to a particular member, the MCO adequately and timely covers these services out of network for the member for as long as the MCO is unable to provide them. b) The MCO benefit package includes covered medically necessary services for which the MCO must reimburse certain types of providers with whom formal contracts may not be in place. c) The MCO also coordinates these services with other services in the MCO benefit package.	**Documents Submitted:** • WRHCO 132 Out-of Plan Services for Medicaid and Nevada Check Up Members • WRHCO 141 Coordination of Non-Covered Benefits **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Out-of-Plan Services for Medicaid and Nevada Check Up Members that Require HPN Reimbursement policy and the Coordination of Non-covered Benefits for Medicaid and Nevada Check Up Members policy provided evidence of meeting the requirements of this element. Interviews with the provider services staff confirmed that out-of-network providers were seldom needed to provide services to members. Staff recalled sending a few members to the Children's Hospitals in California.		
	Recommendations: None.		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.4.3.2	12. Twenty-five (25) Mile Rule The MCO offers every enrolled recipient a PCP or PCS located within a reasonable distance from the enrolled recipient's place of residence, but in any event, the PCP or PCS may not be more than twenty-five (25) miles from the enrolled recipient's place of residence per NAC 695C.160 without the written request of the recipient.	**Documents Submitted:** • 2013 HPN Access and Availability Policy QI 222.06; 3.3 pg 13 • HPN Network Adequacy sec 4_2nd Qtr 2014 • HPN Network Adequacy sec 4_2nd Qtr 2014_Hosp • HPN Network Adequacy_3rd Q 2013 • HPN Network Adequacy_3rd Q 2013_Hosp • HPN Network Hospital Adequacy_1st Q 2014 • HPN Network Hospital Adequacy_1st Q 2014_Hosp • HPN Network Hospital Adequacy_4thQ 2013 • HPN Network Hospital Adequacy_4thQ 2013_Hosp **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Availability Standards for Geographic Distribution of Practitioners policy provided evidence that HPN required the 25-mile rule for Medicaid Primary Physicians and Dentists. The Medicaid Access Availability Reports for the second quarter of 2014, however, indicated that there were 71 members in Washoe County who did not have access to a PCP within a 25 miles radius.		
	Recommendations: HPN needs to ensure that all members have a PCP that is 25 miles or closer to the member's place of residence unless HPN has a written request from the member to allow assignment to a PCP that is greater than 25 miles from the member's place of residence.		
42 CFR 438.12(a)(1)	13. Non-discrimination	**Documents Submitted:**	☒ Met

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.114(b)(1-3) *DHCFP Contract Section 4.5.2.9*	The MCO does not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license, specialty, or certification. If the MCO declines to include an individual or group of providers in its network, it gives the affected network providers written notice of the reason for its decision.	• 2013 HPN Access and Availability Policy QI 222.01 pg 2 • Cred-Recred_Policy CR 300.06 pg 16_CR 300.01 pg 5 **Description of Process:** N/A	☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Chair and Credentialing Committee File Review section of the Credentialing and Recredentialing Policy (CF 300.06) provided evidence of meeting the requirements of this element concerning non-discrimination for participation in the network. The Access Availability Policy (QI 222.01), the Credentialing Disapprovals of Practitioners section of the Credentialing and Recredentialing Policy (CF 300.07), and the Access and Availability Plan 2013 (QI 222.00.08) also contained statement concerning the non-discrimination requirements of this element. A review of the letter sent to providers who were declined participation in the network validated that HPN gave written notice of the reason for its decision.		
	Recommendations: None.		
DHCFP Contract Section 4.5.5	14. Access and Availability The MCO: a) Ensures adequate physical and geographic access to covered services for enrolled recipients; b) On a quarterly basis, uses geo-access mapping and data-driven analyses to ensure compliance with access standards, and takes appropriate corrective action, if necessary, to comply with such access standards; c) Partners actively with DHCFP, community providers and stakeholders to identify and address	**Documents Submitted:** • 2013 HPN Access and Availability Policy QI 222.05 pg 10-13_QI 222.06 pg 13-14_QI 222.07 pg 15-16_ QI 222.08 pg 17-19 • HPN Network Adequacy sec 4_2nd Qtr 2014 • HPN Network Adequacy_3rd Q 2013 • HPN Network Hospital Adequacy_1st Q 2014 • HPN Network Hospital Adequacy_4thQ 2013	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	issues and opportunities to improve health care access and availability for Medicaid and CHIP members. d) Assures access to health screenings, reproductive services and immunizations through county and state public health clinics. e) May promote care management and early intervention services by completing welcome calls and/or visits to new members to ensure orientation with emphasis on access to care, choice of PCP, and availability of an initial health risk screening. If a screening risk level determines need for further care management, a care management referral will be completed.	**Description of Process:** N/A	
	Findings: A review of documents indicated that HPN used GeoAccess reports to ensure adequate physical and geographic access to covered services for enrolled recipients. The quarterly Medicaid Access Availability Report sent to DHCFP recorded the findings of the GeoAccess reports. Interviews with staff confirmed that the Provider Services Department completed the quarterly access reports and that the reports were forwarded to the Medicaid QI Subcommittee for review. The minutes from the May 28, 2014 meeting of the Medicaid QI Subcommittee validated that the committee reviewed the first quarter 2014 access report. HPN partnered with DHCFP in many projects to improve the health care access and availability for Medicaid and HCIP members. Staff interviews confirmed the MCO's participation in the emergency room diversion program and the creation of additional urgent care facilities to assure access to care for members with urgent care needs. Staff interviews also confirmed that members were encouraged to obtain health screenings, reproductive services, and immunizations through network providers or public health clinics. Interviews with the Member Services department confirmed that staff from the department conducted the new member welcome calls. During the welcome calls, staff members asked if the members had a PCP and if they did not, assistance was given to select a PCP at that time. Women also were encouraged to choose an OB/GYN during the welcome calls.		
	Recommendations: None.		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.5.5.6	15. PCP-to-Recipient Ratios The MCO has at least one full-time equivalent (FTE) primary care provider, considering all lines of business for that provider, for every 1,500 enrollees per service area. However, if the PCP practices in conjunction with a health care professional the ratio is increased to one FTE PCP for every 1,800 recipients per service area.	**Documents Submitted:** • 2013 HPN Access and Availability Policy QI 222.05 pg 10-13_QI 222.07 pg 15-16 • HPN Network Adequacy sec 4_2nd Qtr 2014 • HPN Network Adequacy sec 4_2nd Qtr 2014_Hosp • HPN Network Adequacy_3rd Q 2013 • HPN Network Adequacy_3rd Q 2013_Hosp • HPN Network Hospital Adequacy_1st Q 2014 • HPN Network Hospital Adequacy_1st Q 2014_Hosp • HPN Network Hospital Adequacy_4thQ 2013 • HPN Network Hospital Adequacy_4thQ 2013_Hosp **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Availability Standards for Number of Practitioners policy (QI 222.05) indicated that the ratio of primary care physicians was one for every 1,500 members. The quarterly Medicaid Access Availability Report sent to DHCFP also monitored compliance with this requirement.		
	Recommendations: None.		
42 CFR 438.114(c)(3)(i) *DHCFP Contract Section*	16. Access to Emergency Services	**Documents Submitted:** • 2013 HPN Access and Availability Policy	☒ Met ☐ Partially Met

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
4.5.5.7 (A)	Emergency Services are provided immediately on a twenty-four (24)-hour basis, seven (7) days a week, with unrestricted access, to enrolled recipients who present at any qualified provider, whether a network provider or an out-of-network provider.	QI 222.08 pg 17 • HPN Provider Summary Guide 2014 Section 8 Medicaid; 8.9 pg 69 **Description of Process:** N/A	☐ Not Met ☐ N/A
	Findings: The 2013 HPN Access and Availability Policy and the HPN Provider Summary Guide contained the requirement to provide access to care and services 24-hours a day, seven days a week. The Guide also provided information concerning the instructions providers were to give members who call after hours. The instructions could be given either by a person answering the call or by recording. The June 2014 Nevada Check Up Member Handbook and the June 2014 SmartChoice and NorthernChoice Member Handbook advise members to go to the nearest hospital emergency room for medical emergencies.		
	Recommendations: None.		
DHCFP Contract Section 4.5.5.7 (B)	17. PCP Appointments PCP appointments are available as follows: a) Same-day, medically necessary, primary care provider appointments are available; b) Urgent care PCP appointments are available within two calendar days; and c) Routine care PCP appointments are available within two weeks. The two week standard does not apply to regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every two weeks.	**Documents Submitted:** • 2013 HPN Access and Availability Policy QI 222.08 pg 17 QI 222.09 PG 20 • HPN Provider Summary Guide 2014 Section 8 Medicaid; 8.6 pg 66 • MEDICAID Consulting Provider Template Article III- A; 8 pg 3 Attachment B; Article III 1 pg 16 • MEDICAID Primary Care Physician FFS Template Article III -A pg 3_Attachment B Article III 1 pg 16 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: The Medicaid/Nevada Check-Up PCP Agreement and the Accessibility Standards for Access to Care policy (QI 222.08) included the requirements found in this element. The Access Standards found in the 2014 HPN Provider Summary Guide provided more stringent requirements: Emergent care was to be given the same day or within 12 hours; urgent care was to be given within 24 hours; and routine care was to be given within seven days from the date of referral or request.		
	Recommendations: None.		
DHCFP Contract Section 4.5.5.7 (C)	18. Specialist Appointments For specialty referrals to physicians, therapists, behavioral health services, vision services, and other diagnostic and treatment health care providers, the MCO provides: a) Same day, medically necessary appointments within twenty-four (24) hours of referral; b) Urgent care appointments within three calendar days of referral; and c) Routine appointments within 30 calendar days of referral. The MCO must allow access to a child/adolescent specialist if requested by the parents.	**Documents Submitted:** • 2013 HPN Access and Availability Policy QI 222.08 pg 17 • HPN Provider Summary Guide 2014 Section 8 Medicaid; 8.6 pg 66 • MEDICAID Consulting Provider Template Attachment B Article III 2 pg 16 • MEDICAID Primary Care Physician FFS Template Attachment B Article III 2 pg 16 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Medicaid/Nevada Check-Up PCP Agreement and the Accessibility Standards for Access to Care policy (QI 222.08) included the specialist healthcare accessibility standards found in this element. Additional information to meet the standard was found in HPN Provider Summary Guide which noted that members had the right to have direct access to medically necessary specialist care in conjunction with an approved treatment plan developed with the PCP.		
	Recommendations: None.		
DHCFP Contract Section 4.5.5.7 (D)	19. Prenatal Care Appointments	**Documents Submitted:** • 2013 HPN Access and Availability Policy	☒ Met ☐ Partially Met

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Initial prenatal care appointments are provided for enrolled pregnant recipients as follows: a) First trimester within seven calendar days of the first request; b) Second trimester within seven calendar days of the first request; c) Third trimester within three calendar days of the first request; and d) High-risk pregnancies within three calendar days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists.	QI 222.08 pg 17 • HPN Provider Summary Guide 2014 Section 8 Medicaid; 8.6 pg 67 • MEDICAID Consulting Provider Template Attachment B Article III 3 pg 16 • MEDICAID Primary Care Physician FFS Template Attachment B Article III 3 pg 16 **Description of Process:** N/A	☐ Not Met ☐ N/A
	Findings: The Medicaid Primary Care Physician FFS Template, the HPN Provider Summary Guide, and the Accessibility Standards for Access to Care policy (QI 222.08) included the requirements of this element.		
	Recommendations: None.		
DHCFP Contract Section 4.5.5.7 (E)	20. Dental Appointments: Dental care is provided immediately for dental emergencies, urgent care or referral appointments within three calendar days and routine appointments with dentists and dental specialists are provided within 30 calendar days or sooner if possible.	**Documents Submitted:** • 2013 HPN Access and Availability Policy QI 222.08 pg 19 • HPN Provider Summary Guide 2014 Section 8 Medicaid; 8.6 pg 67 • HPN S NV Medicaid Dental Provider Template Article III Q; A pg 7-8 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: The HPN Provider Summary Guide and the Accessibility Standards for Access to Care policy (QI 222.08) included the requirements of this element.		
	Recommendations: None.		
DHCFP Contract Section 4.5.5.8 (A)	21. Appointment Standards The MCO has written policies and procedures: Disseminating its appointment standards to all network providers, and must assign a specific staff member of its organization to ensure compliance with these standards by the network.	**Documents Submitted:** • 100-3 Provider Site Visit Policy • 2013 HPN Access and Availability Policy QI 222.01 pg 4_ QI 222.02 pg 6 QI 222.03 pg 8 • HPN Provider Summary Guide 2014 Section 4.3 Access Standards pg 18 • MEDICAID Consulting Provider Template Attachment B Article III Performance Standards pg 16 • MEDICAID Primary Care Physician FFS Template Attachment B Article III Performance Standards pg 16 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Site Visit Policy (NDCPS 100-3) noted that the HPN representative discussed appointment standards with network providers during initial and subsequent site visits at the providers' offices. The 2014 HPN Provider Summary Guide also contained the HPN appointment time requirements for Medicaid members. HPN monitored the standards through reports generated from the annual member satisfaction survey, the customer response and resolution database, telephone surveys, and quarterly reports sent to DHCFP. Interviews with staff confirmed that the Manager of Provider Services remained responsible to ensure compliance with appointment standards.		
	Recommendations: None.		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.5.5.8 (B)	22. Monitoring Appointment Standards Concerning the education of its provider network regarding appointment time requirements the MCO: a) Monitors the adequacy of its appointment process and compliance; and b) Implements a POC when appointment standards are not met.	**Documents Submitted:** • 100-3 Provider Site Visit Policy • 2013 HPN Access and Availability Policy QI 222.09 pg 20 • HPN Provider Summary Guide 2014 Section 4 Provider Administrative Requirements and Resources pg 16 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Provider Site Visit Policy (NDCPS 100-3) provided evidence that the HPN representative discussed appointment standards with providers when completing a site visit. The 2014 HPN Provider Summary Guide also contained the HPN appointment time requirements for Medicaid members and included a section concerning the categories used to track provider-specific issues and the severity level coding used to track individual provider trends. Corrective actions ranged from individual written counseling to the termination of providers from the HPN network.		
	Recommendations: None.		
DHCFP Contract Section 4.5.5.9	23. Office Waiting Times The MCO establishes written guidelines that a recipient's waiting time at the PCP's or specialist's office is no more than one hour from the scheduled appointment time, except when the provider is unavailable due to an emergency. Providers are allowed to be delayed in meeting scheduled appointment times when they "work in" urgent cases, when a serious problem is found, or when the patient has an unknown need that requires more services or education than was described at the time the appointment was scheduled.	**Documents Submitted:** • 2013 HPN Access and Availability Policy QI 222.08 pg 19 • HPN Provider Summary Guide 2014 Section 8 Medicaid; 8.6 pg 67 • MEDICAID Consulting Provider Template Attachment B Article III Performance Standards 11 pg 18 • MEDICAID Primary Care Physician FFS Template Attachment B Article III Performance Standards 11 pg 18	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V. Availability and Accessibility of Services

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		Description of Process: N/A	
	Findings: The Medicaid/Nevada Check-Up PCP Agreement and the Accessibility Standards for Access to Care policy (QI 222.08) provided evidence of meeting the requirements of this element. The wait time standard found in the 2014 HPN Provider Summary Guide stipulated that wait time should be no more than one hour and the average wait time was not to exceed 30 minutes. Interviews with staff confirmed that the provider services staff members monitored complaints to respond to issues concerning wait time. During the review period, there were no complaints about office wait times.		
	Recommendations: None.		
DHCFP Contract Section 4.5.5.13	24. Prohibited Practices The MCO takes affirmative action so that recipients are provided access to covered medically necessary services without regard to race, national origin, creed, color, gender, sexual preference, religion, age, health status, physical or mental disability, except where medically indicated.	**Documents Submitted:** • 2013 HPN Access and Availability Policy QI 222.01 pg 4 • MEDICAID Consulting Provider Template_Article III -I 1 pg 6 and Attachment B Article II B pg 15 • MEDICAID Primary Care Physician FFS Template _Article III-K 1 pg 6 and Attachment B Article II B pg 15 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2014 HPN Provider Summary Guide included a section that advised practitioners of the HPN non-discrimination policies. The information included discrimination against any patient on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability, disability, genetic information, or source of payment.		
	Recommendations: None.		

Standard V. Availability and Accessibility of Services

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.5.6.1	25. Provider Contracts The MCO executes and maintains, for the term of the contract, written provider agreements with a sufficient number of appropriately credentialed, licensed or otherwise qualified providers to provide enrolled recipients with all medically necessary covered services.	**Documents Submitted:** • 2013 HPN Access and Availability Policy • MEDICAID Consulting Provider Template_Article III -I 1-5 pg 6-7 • MEDICAID Primary Care Physician FFS Template _Article III-K 1-7 pg 6-7 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Medicaid PCP FFS Contract Template and the Medicaid Consulting Provider Contract Template provided evidence of the written provider agreements executed with the HPN network providers. The HPN automated and hard copy provider directories provided evidence of a network that included appropriately credentialed, licensed or otherwise qualified providers to provide enrolled recipients with all medically necessary covered services. The Mechanisms for Monitoring Adequacy of Practitioners policy (QI 222.07) noted that HPN monitored the network by reviewing reports from the provider relations database, conducting secret shopper calls, performing GeoAccess studies, and reviewing trends in member satisfaction through the use of the annual member survey, complaint analysis, and reports from quality management and provider services.		
	Recommendations: None.		
DHCFP Contract Section 4.5.6.5	26. Monitoring Providers The MCO also has written policies and procedures for monitoring its providers, and for disciplining providers who are found to be out of compliance with the MCO's medical management standards.	**Documents Submitted:** • 100-3 Provider Site Visit Policy • 2013 HPN Access and Availability Policy QI 222.09 pg 20 • HPN Provider Summary Guide 2014 Section 5; 5.1 Office Site Visits pg 31-36 • MEDICAID Consulting Provider Template_Article III -H 1-4 pg 5-6 and K 1-16 pg 7-9	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V. Availability and Accessibility of Services

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		• MEDICAID Primary Care Physician FFS Template _Article III-J 1-4 pg 5-6 and M 1-16 pg 7-9 **Description of Process:** N/A	
	Findings: The Access and Availability Plan 2013 provided evidence of meeting the requirement of having written policies and procedures concerning routine, urgent and emergency care; telephone appointments; wait times; and advice and recipient service lines. HPN monitored the standards through reports generated from the annual member satisfaction survey, the customer response and resolution database, telephone surveys, and quarterly reports sent to DHCFP. The Mechanisms for Monitoring Adequacy of Practitioners policy (QI 222.07) noted that HPN monitored the network by reviewing reports from the provider relations database, conducting secret shopper calls, performing GeoAccess studies, and reviewing trends in member satisfaction through the use of the annual member survey, complaint analysis, and reports from quality management and provider services. The 2014 HPN Provider Summary Guide included a section concerning the categories used to track provider-specific issues and the severity level coding used to track individual provider trends. Corrective actions ranged from individual written counseling to the termination of providers from the HPN network.		
	Recommendations: None.		
DHCFP Contract Section 4.8.14.7	27. Steps to Assure Accessibility of Services The MCO takes steps to promote accessibility of services offered to recipients. The steps include: a) The points of access to primary care, specialty care and hospital services are identified for recipients; b) At a minimum, recipients are given information about: i. How to obtain services during regular hours of	**Documents Submitted:** • 2013 HPN Access and Availability Policy • NorthernChoice Jan 2014 Health Plan of Nevada NorthernChoice Nevada • SmartChoice Jan 2014 Health Plan of Nevada SmartChoiceNevada **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V. Availability and Accessibility of Services

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	operations; ii. How to obtain emergency and after-hour care; iii. How to obtain emergency out-of-service area care; and iv. How to obtain the names, qualifications and titles of the professionals who provide and/or are responsible for their care.		
	Findings: The HPN automated and hard copy provider directories furnished evidence of the identification of the primary care, specialty care, and hospital services available to Medicaid members. The June 2014 NV Check Up Member Handbook and the June 2014 NV SmartChoice/NorthernChoice Member Handbook provided information concerning how to obtain services in the *How to Get Healthcare Services* section of the manual.		
	Recommendations: None.		
DHCFP Contract Section 4.8.15	28. Standards for Availability and Accessibility The MCO: a) Establishes standards for access (e.g., to routine, urgent and emergency care; telephone appointments; advice and recipient service lines) and complies with Section 4.5.5 of this RFP**.** b) Assesses performance against the established standards.	**Documents Submitted:** • 2013 HPN Access and Availability Policy QI 222.01 pg 4_QI 222.02 pg 6 • MEDICAID Consulting Provider Template Attachment B Article III Performance Standards pg 16-18 • MEDICAID Primary Care Physician FFS Template Attachment B Article III Performance Standards pg 16-18 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V. Availability and Accessibility of Services

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: The Access and Availability Plan 2013 provided evidence of meeting the requirement of having written policies and procedures concerning routine, urgent, and emergency care; telephone appointments; and advice and recipient service lines. HPN monitored the standards through reports generated from the annual member satisfaction survey, the customer response and resolution database, telephone surveys, and quarterly reports sent to DHCFP.		
	Recommendations: None.		

Results for Standard V: Availability and Accessibility of Services							
Total	Met	=	27	X	1.00	=	27.0
	Partially Met	=	1	X	.50	=	0.5
	Not Met	=	0	X	.00	=	0.0
Total Applicable		=	28	**Total Score**		=	27.5

Total Score ÷ Total Applicable	=	98.2%

Standard VI. Continuity and Coordination of Care

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.208(b)(2-4) *45 CFR Parts 160 and 164* *42 CFR 438.208(b)(1)* *42 CFR 438.224* *DHCFP Contract Section 4.2.12*	1. Coordination with Other MCOs and Other Services Pursuant to 42 CFR 438.208(b) (2), (3), and (4) the MCO is required to implement procedures to coordinate services it provides to the member with the services the member receives from any other MCO. a) Upon request or notification of need, the MCO is required to communicate with other MCOs serving the member the results of its identification and assessment of any special health care needs to ensure that services are not duplicated, and to ensure continuity of care. The MCO's procedures ensures that, in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164 [(the Health Insurance Portability and Accountability Act (HIPAA)]. b) The MCO case managers are responsible for coordinating services with other appropriate Nevada Medicaid and non-Medicaid programs. c) This coordination includes referral of eligible members, to appropriate community resources and social service programs, including supportive housing. d) In addition to routine care coordination with other MCOs, the MCO designates a specific clinician or case manager to ensure continuity of services for	**Documents Submitted:** • 2013 UM Program Description FINAL pgs 8-9 • Referral Processing Adult - CCM • Complex Case Management Policy 2013 pages 1 - 2 • WRHCO 276 Transition of Care for Medicaid and Nevada Check Up Members • WRHCO 298 Children with Special Health Care Needs (CSHCN) **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI. Continuity and Coordination of Care

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	members with special needs.		
	Findings: HPN had defined processes through its policies and procedures to identify and manage care between providers and care settings. The Referral Processing adult-CCM policy identified the procedures for the acknowledgement and distribution of referrals within the Complex Case Management Department. The Complex Case Management Policy described the components of the complex case management program to ensure coordination and continuity of care and to access needed resources. The policy outlined steps to identify, monitor and evaluate the delivery of services in acute and non-acute settings. The Transition of Care for Medicaid and Nevada Check Up Members policy detailed the procedures to coordinate care for newly enrolled members who were receiving services through Fee-for-Services programs or from another Medicaid contractor. The policies addressed the need for care managers to assess members overall needs and to make appropriate referrals to community resources. Care plans included prompts to address whether the member had followed up on referrals. The Nevada Privacy Policy detailed the health plan's procedures to ensure that in all instances the Health Insurance Portability and Accountability Act (HIPAA) confidentiality requirements were adhered to.		
	Recommendations: None.		
42 CFR 438.208(b)(1) *DHCFP Contract Section 4.8.18, 4.8.18.2. (D)*	2. Continuity of Care System The MCO has a basic system in place to promote continuity of care and case management (CM). a) The MCO takes a comprehensive and collaborative approach to coordinate care for the eligible population and conditions as specified by DHCFP through an effective CM program, partnerships with primary care physicians and specialists, provider and recipient participation, recipient/family outreach and education, and the ability to holistically address member's health care needs.	**Documents Submitted:** • 2013 UM Program Description FINAL pgs 8-9 • Referral Processing Adult - CCM • Complex Case Management Policy 2013 page 4 • WRHCO 161 Medicaid and Nevada Check Up Members Health Survey Screening **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI. Continuity and Coordination of Care

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	b) Care coordination includes not only the specific diagnosis, but also the complexities of multiple co-morbid conditions, including behavioral health, and related issues such as the lack of social or family support. c) At a minimum, the MCO's physical health case manager attempts to coordinate care with the member's case manager from other health systems, including behavioral health.		

Findings: The health plan had a process to screen Medicaid and Nevada Check Up members at the time of enrollment to determine case management needs. A Health Survey Screening form and a self-addressed, stamped envelope were sent to new members. The case management department reviewed the Health Survey Forms for health risk triggers. When triggers were identified, the case manager contacted the member for further screening information

Referrals to the HPN Complex Case Management Program were received from disease management, discharge planning, telephonic outreach, inpatient continuity of care case management, UM, self-referrals, and practitioners. Two of the 10 records included in the case management record review were identified via a review of the Health Survey Forms; another referral was received from a member who called in a self-referral. Three referrals were for high risk pregnancies, and four of the 10 records were members who had been referred from acute care settings.

The Continuity of Care and Out of Area Departments provided initial and ongoing assessments of members receiving care in the inpatient settings. Health plan medical directors conducted on-site and telephonic hospital rounds in conjunction with the continuity of care interdisciplinary team to identify discharge planning needs of members in acute care settings to ensure smooth transitions to the next level of care. The Complex Case Management Policy described the process the health plan used to coordinate care for the populations specified by DHCFP; eligible members for case management were not limited to the State-specified conditions. The policy addressed member identification, development of a plan of care using evidence based guidelines and clinical guidelines, and a team-based collaboration of PCPs, nurses, social workers, case managers,

Standard VI. Continuity and Coordination of Care

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	specialists, member, and members' families. The HPN policy, Care Plan-Initial, required an assessment not only of the presenting medical condition, but an assessment of all sub-problems and co-morbid conditions which influenced the member's condition. There were specialized template care plans for obstetric, pediatric, complex case management, and social work.		
	Recommendations: None.		
DHCFP Contract Section 4.8.18.2 (A)	3. Components of CM Programs: Identification The following components are incorporated into the MCO's CM program: a) The MCO has mechanisms in place to identify members potentially eligible for CM services. b) These mechanisms include an administrative data review (e.g. diagnosis, cost threshold, and/or service utilization) and may also include telephone interviews; mail surveys; provider/self referrals; or home visits.	**Documents Submitted:** • Referral Processing Adult - CCM • Complex Case Management Policy 2013 page 2 • Health Survey Form - CCM 110714 • WRHCO 161 Medicaid and Nevada Check Up Members Health Survey Screening **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The health plan had mechanisms to identify members who would benefit from case management services. The procedure, Referral Processing Adult – CCM, described the process for acknowledgment and distribution of referrals that were received via the FACETS system, Touchworks (electronic medical record interface used to identify members who were appropriate for complex case management), At Your Service, phone, FAX/email, internal reports. The Complex Case Management Policy 2013 identified the administrative sources of referrals, e.g., claims and encounter data, emergency room frequency report, hospital re-admission report, high utilizers report; pharmacy data. Referrals were additionally received from member-completed health risk appraisals, and referrals from network providers, telephone advice nurse, Continuity Of Care staff, and the disease management program.		
	Recommendations: None.		

Standard VI. Continuity and Coordination of Care

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.8.18.2 (B)	4. Components of CM Programs: Assessment The following components are incorporated into the MCO's CM program: a) The MCO arranges for or conducts an initial comprehensive assessment to confirm the results of a positive identification and to determine the need for CM services within 90 days of enrollment. b) Face-to-face assessment will be conducted, as necessary c) The goals of the assessment are to identify the member's existing and/or potential health care needs and assess the member's need of CM services. d) The comprehensive assessment evaluates the member's physical health, behavioral health, co-morbid conditions, and psycho-social, environmental, and community support needs. e) The assessment is completed by a physician, physician assistant, RN, LPN, licensed social worker, or a graduate of a two-or four-year allied health program. f) If the assessment is completed by another medical professional, there should be oversight and monitoring by either a registered nurse or physician.	**Documents Submitted:** • CARE PLAN TEMPLATE • Complex Case Management Policy 2013 pages 3 - 4 • Initial Assessment Care Plan Assessment **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI. Continuity and Coordination of Care

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: The HPN Complex Case Management Policy 2013 incorporated the necessary components in the assessment process; all elements were specified in the policy and in the Complex Case Management Initial Assessment Tool. The Care Plan template had fields for member/caregiver goals and member's self-management plan, as well as the case management goals, interventions, resources, and status. The Complex Case Management Policy 2013 specified that the assessment was conducted by collaboration of the member and caregiver/family, PCP, nurse practitioner or physician assistant providers, and the case manager/care manager. Ten records of members receiving complex case management services were reviewed. All 10 records included a comprehensive assessment with an evaluation of the member's physical health, behavioral health, any co-morbid conditions, and psycho-social, environmental, and community support needs. Ten of 10 records were completed by a registered nurse.		
	Recommendations: None.		
DHCFP Contract Section 4.8.18.2 (D)	5. Components of CM Programs: Care Treatment Plan The following components are incorporated into the MCO's CM program: a) Based on the assessment, the MCO assures and coordinates the placement of the member into CM and development of a care treatment plan within 90 days of membership. The care treatment plan as defined by DHCFP is the one developed by the MCO. b) The member and the member's PCP are actively involved in the development of the care treatment plan. c) The MCO arranges or provides for professional care management services performed collaboratively by a team of professionals	**Documents Submitted:** • CARE PLAN TEMPLATE • Complex Case Management Policy 2013 page 5 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI. Continuity and Coordination of Care

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	appropriate for the member's condition and health care needs. The care treatment plan should reflect the member's primary medical diagnosis and health condition, any co-morbidity, and the member's psychological and community support needs. The designated PCP is the physician who manages and coordinates the overall care for the member. d) Ongoing communication regarding the status of the care treatment plan is accomplished between the MCO and the PCP's designee (i.e. qualified health professional). e) Revisions to the clinical portion of the care treatment plan are completed in consultation with the PCP. Revisions to the clinical portion of the care treatment plan are completed in consultation with the PCP. f) The care treatment plan also includes specific provisions for periodic review of the member's condition and appropriate updates to the plan. g) The MCO's physical health case manager attempts to coordinate care with the member's case manager from other health systems, including behavioral health.		
	Findings: **a)** Of the 10 complex case management records reviewed, eight had care treatment plans developed within 90 days of enrollment. Two records were children who developed a complex condition more than 90 days after enrollment. **b)** In 10 of 10 records, the member (or member's parent) was the primary informant for the assessment and was involved in the development of the care treatment plan. In all 10 records, the PCP was sent the care treatment plan for comment and		

Standard VI. Continuity and Coordination of Care

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	signature. c) There was evidence in all 10 records reviewed that the health plan coordinated care with the appropriate team of professionals for the member's health care needs. The care treatment plans included the member's primary medical diagnosis and health condition, any co-morbidity, and the member's psychosocial support needs. **d)** There was evidence in all 10 records reviewed that the case manager maintained ongoing communication with the member and the member's provider when applicable. **e)** Revisions to the care treatment plans were made in two of the 10 records. Two members declined further contact with case management after the initial period, and six members lost health plan eligibility; staff members indicated in most instances the members' eligibility status changed to FFS. f) In 10 of 10 records, the initial care treatment plan specified a date by which periodic review of the member's condition would be completed and the plan updated. g) In 10 of 10 records reviewed, there was no indication of the member's involvement with another health plan or the behavioral health system. In four of 10 records the patient had been in an acute care setting at the time of the referral, and there was indication of coordination of care and discharge planning assistance with the acute care staff and receiving facility or providers.		
	Recommendations: None.		
42 CFR 438.204(b)(2) *DHCFP Contract Section 4.8.18.2 (B)*	6. Member and PCP Notification and Participation The MCO provides information to the members and their PCPs that they have been identified as meeting criteria for CM, including their enrollment into CM services.	**Documents Submitted:** • Care Plan, Initial - CCM • Complex Case Management Policy 2013 pages 2-3 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: In 10 of 10 records reviewed, the member (or member's parent) was the primary informant for the assessment and was involved in the development of the care treatment plan. In all 10 records, the PCP was sent the care treatment plan for comment and signature and the member or member's parent was sent a letter.		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None.		
DHCFP Contract Section 4.8.18.2 (D)	7. CM Team The MCO arranges or provides professional care management services that are performed collaboratively by a team of professionals (which may include physicians, physician assistants, nurses, specialists, pediatricians, pharmacists, behavior health specialists, and/or social workers) appropriate for the member's condition and health care needs.	**Documents Submitted:** • 2013 UM Program Description pages 8 - 9 • Complex Case Management Policy 2013 pages 3 - 4 • WRHCO 298 Children with Special Health Care Needs (CSHCN) **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: There was evidence in 10 of 10 records reviewed that the health plan coordinated care with the appropriate team of professionals for the member's health care needs. The care treatment plans included the member's primary medical diagnosis and health condition, any co-morbidity, and the member's psychosocial support needs. There was documentation of ongoing communication with the member and with the member's providers.		
	Recommendations: None.		
DHCFP Contract Section 4.8.18.2.(E)	8. Designation of a PCP For members with CM needs, the designated PCP is the physician who manages and coordinates the overall care for the member. In addition, the MCO facilitates the coordination of the members care and ensures communication between the member, PCP, and other	**Documents Submitted:** • 2013 UM Program Description FINAL pg 4 • Complex Case Management Policy 2013 page 4 • WRHCO 298 Children with Special Health Care Needs (CSHCN)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI. Continuity and Coordination of Care

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	service providers and case managers.	**Description of Process:** N/A	
	Findings: There was evidence in 10 of 10 records reviewed that the health plan coordinated care with the member's PCP or obstetrician if the member was in the high risk pregnancy program. There was evidence in all 10 records reviewed that the health plan coordinated care with the appropriate team of professionals for the member's health care needs.		
	Recommendations: None.		
DHCFP Contract Section 4.8.18.3	9. CM Program Staffing The MCO: a) Identifies the staff involved in the operations of the CM program, including but not limited to: case manager supervisors, case managers, and administrative support staff. b) Identifies the role/functions of each CM staff member as well as the required educational requirements, clinical licensure standards, certification and relevant experience with CM standards and/or activities. c) Provides case manager staff/member ratios based on the member risk stratification and different levels of care being provided to members.	**Documents Submitted:** • Job Description - HPN Assoc Dir Case Mgmt (COC) 05-14-14 • Job Description - HPN Case Manager (• Job Description - HPN Case Manager (COC) 06-17-14 • Job Description - HPN Clinical Admin Coordinator (AC) 6-25-14 • Job Description - HPN Clinical Admin Coordinator (CCM OB Peds) 06-27-14 • Job Description - HPN Clinical Admin Coordinator (COC) 06-17-14 • Job Description - HPN Clinical Admin Coordinator Sr (AC) 6-25-14 • Job Description - HPN Dir Medical Clinical Ops (COC) 06-18-14 • Job Description - HPN Medical Director (COC) 06-18-14 • Job Description - HPN Mgr Case Mgmt (COC) 06-17-14	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI. Continuity and Coordination of Care

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		• Job Description - HPN Outpatient Case Manager (CCM) 6-10-14 • Job Description - HPN Social Worker (COC) 6-23-14 • Job Description - HPN Sr Admin Assistant (COC) 06-18-14 • Job Description - HPN Sr Case Manager (COC) CFMP 07-10-14 • Job Description - HPN_SHL Clinical Admin Coordinator (OOA) 06-26-14 • Risk Stratification **Description of Process:** N/A	
	Findings: HPN provided job descriptions of multiple staff members involved in the operations of the program which included case manager supervisors, case managers, and administrative support staff. In 10 of 10 records review, case management services were provided by registered nurses. Two additional cases also received social work support.		
	Recommendations: None.		
DHCFP Contract Section 4.8.18.1	10. Members Eligible for CM Services The MCO offers and provides CM services which coordinate and monitor the care of members with specific diagnosis and/or who require high-cost or extensive services.	**Documents Submitted:** • Referral Processing Adult - CCM • Complex Case Management Policy 2013 page 2 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: The Complex Case Management Policy 2013 identified that eligible members, included but were not limited to members who: were identified with high cost and frequent utilization patterns; diagnosed with neurological diseases and spinal cord injuries; diagnosed with cancer; were seeing multiple specialists and required coordination of care; had experienced severe trauma; were chronically ill and who may or may not also be managed by the disease management program; were high-risk children and adolescents; were high-risk pregnant women; had complex medical and psychosocial issues and who were referred to the Complex Case Management Program. Of the 10 records reviewed, three were referred from high risk pregnancy program, four were referred from an inpatient setting, two were identified from a review of the Member Health Risk Assessment Form, and one was a self-referral from a member who contacted the complex case management team directly.		
	Recommendations: None.		
DHCFP Contract Section 4.8.18.4	11. CM Conditions The MCO, at a minimum, case manages members with the following clinical and behavioral health conditions: a) Congestive heart failure (CHF b) Coronary arterial disease (CAD) c) Non-mild hypertension d) Diabetes e) Chronic obstructive pulmonary disease (COPD) f) Asthma g) Severe mental illness h) High risk or high cost substance abuse disorders	**Documents Submitted:** • Complex Case Management Policy 2013 pg 3 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI. Continuity and Coordination of Care

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	i) Severe cognitive and/or developmental limitations j) Members in supportive housing k) Members with complex conditions		
	Findings: The HPN Complex Case Management Policy 2013identified that the health plan provided case management services to members with all of the listed all of the conditions specified above in (a) through (k), and indicated that case management services were not limited to only those conditions.		
	Recommendations: None.		
DHCFP Contract Section 4.8.18.4	12. Conditions Warranting CM Services The MCO focuses on all members whose health conditions warrant CM services and does not limit the services only to members with these conditions (e.g., cystic fibrosis, cerebral palsy, and sickle cell anemia).	**Documents Submitted:** • Health Survey Form - CCM 110714 • Complex Case Management Policy 2013 page 2 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Complex Case Management Policy stated eligible members for case management included, but were not limited to, those individuals with complex health care needs (identified above in 10 (a) through (k). Item K, members with complex conditions could include any member whose health condition warranted services.		
	Recommendations:		
DHCFP Contract Section 4.8.18.5	13. CM Strategies The following strategies are used in developing the CM program: a) The MCO follows best-practice and/or evidence-based clinical guidelines when devising a member's	**Documents Submitted:** • 8-29-13 Hospitalist Meeting Agenda • Complex Case Management Policy 2013 page 3 • Implementing Health Management for HPN and SHL Members Policy[1	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI. Continuity and Coordination of Care

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	treatment plan and coordinating the CM needs. b) If the MCO employs a disease management methodology (e.g., grouper, predictive modeling, proprietary screening algorithms) to identify and/or stratify members in need of various levels of health coaching and care intervention, the methods are validated by scientific research and/or nationally accepted and recognized in the health care industry. c) The MCO develops and implements mechanisms to educate and equip physicians with evidence-based clinical guidelines or best practice approaches to assist in providing a high level of quality care to MCO members.	**Description of Process:** N/A	
	Findings: As described in the Implementing Health Management for HPN and SHL Members Policy and as documented in the 10 records reviewed for the case management record review, the health plan followed evidence-based guidelines to develop treatment plans and coordinate care. During the initial assessment, nurse case managers established goals for the member based on the problems identified by each individual for self-management and disease monitoring. The problems and goals developed with each member were evidence-based and were tracked automatically using the plan's electronic health management application. In follow-up calls, the records reviewed documented that the nurse case manager reviewed the goals and problems with the member for further re-education and monitoring. The assessment questions were created with clinical input and a thorough review of HPN/SHL clinical guidelines for each condition. HPN distributed copies of its clinical practice and preventive health guidelines to new providers during orientation and annually thereafter in the Provider Summary Guide. They were also available on the health plan's Web site. Revised or new clinical practice guidelines were distributed via a fax blast, announced in provider newsletter articles, and posted on the health plan web site. The HPN Provider Summary stated that the guidelines were considered a framework for physicians and other health care professionals to		

Standard VI. Continuity and Coordination of Care

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	use, but the provider's clinical judgment could override the guideline if the provider felt that strict adherence to the guideline was not in the member's best interest. The Provider Summary stated that if the provider deviated from the guideline, he or she should indicate the rationale for the variation in the clinical record.		
	Recommendations: None.		
DHCFP Contract Section 4.8.18.6	14. Information Technology (IT) System for CM The MCO's IT system contains the following components: a) The MCO's IT system for its CM program maximize the opportunity for communication between the MCO, PCP, the patient, other service providers and case managers. b) The MCO has an integrated database that allows MCO staff who may be contacted by a member in CM to have immediate access to and review of the most recent information within the MCO 's information systems relevant to the case. c) The integrated database may include the following: administrative data, call center communications, service authorizations, care treatment plans, patient assessments and CM notes. For example, MCO member services staff has access to a member's CM notes and recent inpatient or emergency department utilization if contacted by that member. d) The IT system also has the capability to share relevant information (i.e. utilization reports, care treatment plans, etc.) with the member, the PCP, and	**Documents Submitted:** • Implementing Health Management for HPN and SHL Members Policy section 11 • Complex Case Management Policy 2013 page 3 • Referral Processing Adult - CCM **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	other service providers and case managers.		
	Findings: The health plan used a centralized electronic health management application to facilitate effective coordination and continuity of care for members and to conduct the initial and follow-up assessments. The application allowed the health plan to integrate health information across different departments and was compliant with the Health Insurance Portability and Accountability Act. The application, called The Q, enabled health plan staff in various departments to determine the status of individuals within various health plan programs, such as case management, and to access information that showed member admissions and discharges from acute care settings, and if the member was being followed by the plan's Continuity of Care Departmental staff. The system documented member contacts to the health information line (e.g., the plan's Telephone Advice Nurses) for information on how to manage their health, included utilization information from clinic settings such as the Southwest Medical Associates' Post Discharge Clinic, Endocrinology or Cardiology, and whether the member was living in skilled a nursing facility, group home, or was receiving hospice services. Case management assessments and reassessments were conducted in another application; however, the system copied the assessment in The Q so health plan staff could access and participate in health care coordination. Confidential emails could be shared among staff in various health plan departments to discuss the status of individuals enrolled in other programs.		
	Recommendations: None.		
DHCFP Contract Section 4.8.18.2 (C)	15. Prioritizing Needs The MCO develops methods to synthesize assessment information to prioritize care needs and develop treatment plans. Once the members care needs have been identified, the MCO must, at a minimum: a) Develop a care treatment plan (as described below); b) Implement member-level interventions;	**Documents Submitted:** • Care Plan Update - CCM • Assessments, Initial and Follow-up - CCM • Care Plan, Initial - CCM **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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	c) Continuously monitor the progress of the patient; d) Identify gaps between care recommended and actual care provided, and propose and implement interventions to address the gaps; and e) Re-evaluate the member's care needs and adjust the level of CM services accordingly.		
	Findings: The HPN Care Plan policies, Care Plan Update–CCM, Assessment, Initial and Follow-up–CCM, and Care Plan, Initial, described the processes case managers used to collect assessment information and prioritize care needs to develop treatment plans. The procedures identified that plans were developed with the member and professional collaboration; interventions were selected and implemented, monitored, and reassessed as applicable. The procedures identified that upon completion of the initial assessment, a schedule for follow-up communications was developed. A schedule for follow-up communication with case managers was scheduled and tracked. The policy specified that a re-assessment would be completed after discharge from an inpatient facility and/or after any significant change in the member's health status/condition. There was evidence in all 10 case management records reviewed that the assessment procedures were followed and that appropriate care treatment plans were developed and updated as applicable.		
	Recommendations: None.		
DHCFP Contract Section 4.8.6.5 (D)	16. Identification of Race and Ethnicity The MCO works collaboratively with DHCFP to determine enrollee race and ethnicity. The MCO organizes interventions specifically designed to reduce or eliminate disparities in health care.	**Documents Submitted:** • 2013 QI Program Eval FINAL pgs 229-241 • Cultural Div and Sens Prog Overview 2014 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: HPN assessed the linguistic needs of members annually using the United States Census Bureau American Community Survey. The health Risk Assessment Form sent to all new members inquired about the language or languages spoken in the member's home. The health plan's 2013 QI Program Evaluation FINAL described HPN's activities to reduce disparities in health care including ongoing efforts to recruit providers who speak other languages, offering language translation services to all members calling the members services department and also in the Complex Case Management and Health management programs. The member handbook and other member materials were produced in both English and Spanish and the health plan offered language translation and interpretation services through written notices.		
	Recommendations: None.		

Results for Standard VI: Continuity and Coordination of Care							
Total	Met	=	16	X	1.00	=	16.0
	Partially Met	=	0	X	.50	=	0.0
	Not Met	=	0	X	.00	=	0.0
Total Applicable		=	16	**Total Score**		=	16.0

Total Score ÷ Total Applicable	=	100%

Standard VII. Grievances and Appeals

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.420(a)(1) *DHCFP Contract Section 4.3.5.1 (F)*	1. Denying Requests for Disenrollment If the MCO denies the request for disenrollment for lack of good cause, a Notice of Decision must be sent in writing to the recipient within 10 days of the decision. Appeals rights must be included with the Notice of Decision.	**Documents Submitted:** • WRHCO 284 Disenrollment at the Request of a Medicaid or Nevada Check Up p3 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The policy, WRHCO 284 Disenrollment at the Request of a Medicaid or Nevada Check Up, described HPN's policy for providing a Notice of Decision and the member's appeal rights to the member within 10 days of the decision if the MCO denies the member's request for disenrollment.		
	Recommendations: None.		
42 CFR 431.200(b) *42 CFR 431.220(5)* *42 CFR 438.414* *42 CFR 438.10(g)(1 and 2)* *42 CFR 438.10(g)(1)(i)(A-C)* *42 CFR 438.56(f)(2)* *42 CFR 438.402(b)(1)(i)* *DHCFP Contract Section 4.3.5.1 (F)*	2. Notification of State Fair Hearing Rights The MCO is required to inform the enrollee of their right to a State Fair Hearing, how to obtain such a hearing, and representation rules must be explained to the enrollee and provided by the MCO.	**Documents Submitted:** • REQUESTING A FAIR HEARING FORM 1-22-14 • WRHCO 284 Disenrollment at the Request of a Medicaid or Nevada Check Up p 3 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The policy, WRHCO 284 Disenrollment at the Request of a Medicaid or Nevada Check Up, described HPN's policy to inform enrollees of their right to a State Fair Hearing as required in this element. The HPN member handbook, 1936 June 2014 Revision SmartChoice English_Spanish, provided evidence that HPN notified its members of their right to a State Fair Hearing and how to obtain a State Fair Hearing. The document, Requesting a Fair Hearing Form, provided evidence of HPN's instructions to members about the State Fair Hearing process.		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None.		
42 CFR 438 Subpart F *DHCFP Contract Section 4.8.14.5*	3. Grievance System linked to IQAP The MCO has a system(s) linked to the IQAP for addressing recipients' grievances and providing recipient appeals.	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc FINAL pg. 6-8 • 2013 QI Program Eval FINAL pg. 199-205 • 2014 HPN SHL QI Program Desc pg. 6-8 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Grievance and Appeals policy described how the policies and procedures related to the processing of member grievances and appeals were reviewed by the Member-Centric Task Force, which reported to the HPN Quality Improvement Committee (QIC). The 2013 and 2014 QI Program Description and the Grievance and Appeals policy included the provision that all quality-of-care issues were referred to Quality Management, where the issues were investigated and reviewed by clinical personnel, including the medical director if necessary. The 2013 QI Program Evaluation documented analysis and review of member appeals and grievances by the QIC. The QIC minutes from September 12, 2013 verified that results of grievance and appeals processes were reported to the QIC for analysis. During the interview, MCO staff stated that 100 percent of grievances and appeals were referred to the quality management department, who worked with the chief medical office to determine if there was any risk associated with grievances or appeals or any quality of care concerns.		
	Recommendations:		
42 CFR 438.402(a) *DHCFP Contract Section 4.8.14.5 (A–F)*	4. Recipient Grievance and Appeals Procedures This grievance and appeals system includes: a) Procedures for registering and responding to grievances and appeals within 30 days. MCOs must establish and monitor standards for timeliness;	**Documents Submitted:** • 2013 QI Program Eval-pg. 199-205 • Medicaid Grievances and Appeals Policy Final 6-1-13 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	b) Documentation of the substance of grievances, appeals, and actions taken; c) Procedures ensuring a resolution of the grievance and providing the recipient access to the State Fair Hearing process for appeals; d) Aggregation and analysis of grievance and appeal data and use of the data for quality improvement; e) Compliance with DHCFP due process and fair hearing policies and procedures specific to NV Medicaid and NV Check Up recipients; and f) Compliance with 42 CFR 438 Subpart F Grievance and Appeals.	N/A	
	Findings: The Medicaid Grievance and Appeals policy for processing grievances and appeals and included items a-f of this element. The 2013 QI Program Evaluation provided evidence that HPN reviewed grievance and appeal information as part of its ongoing quality improvement program.		
	Recommendations: None.		
42 CFR 438.10(g)(1)(vii) *42 CFR 438.414* *DHCFP Contract Section 4.11*	5. System to Resolve Grievances and Appeals The MCO establishes: a) A system for enrollees, which includes a grievance process, an appeal process, and access to the State Fair Hearing system. b) A similar system to resolve disputes with providers.	**Documents Submitted:** • Medicaid Grievances and Appeals Policy Final 6-1-13 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Medicaid Grievance and Appeals policy for processing grievances and appeals and included HPN's system for resolving grievances and appeals according to the requirements of this element.		
	Recommendations: None.		
42 CFR 438.416	6. Informing Enrollees and Providers about the Grievance	**Documents Submitted:**	☒ Met

Standard VII. Grievances and Appeals

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.11	System The MCO provides information about the enrollee and provider grievance system to enrollees at the time of enrollment and to providers and subcontractors at the time they enter into a contract.	• 1278 Jun 2014 NV Check Up Revision (2) PG 24-26 • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH PG 23-25 • Prov Summary Guide Section 8.18 Appeals **Description of Process:** N/A	☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The documents, 1278 Jun 2014 NV Check Up Revision and 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH (member handbook), provided evidence that HPN notified enrollees about the grievance system. The Provider Summary Guide provided evidence that HPN notified providers about the grievance system for providers and members. The HPN provider subcontract template mandated that the provider cooperate with grievance review procedures. During the on-site review, HPN staff members stated that upon enrollment, new members received a new member packet that contained, among other materials, the member handbook. HPN staff members also stated that a hard copy of the Provider Summary Guide was provided to new providers during the initial site visit, which occurred after a provider signed a contract with HPN. HPN staff stated that the Provider Summary Guide was also available online so providers may review the Provider Summary Guide, prior to contracting with HPN.		
	Recommendations: None.		
DHCFP Contract Section 4.11	7. Quarterly Reports of Grievances and Appeals The MCO submits to DHCFP quarterly reports that document the grievance and appeal activities listed on the templates located in the Forms and Reporting Guide.	**Documents Submitted:** • FW 1st quarter 2014 Medicaid Nevada Check up Reports • FW 2nd quarter 2014 Medicaid Nevada Checkup Reports • FW 3rd quarter Medicaid NV Check Up reports • FW 4th quarter 2013 Medicaid Nevada	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		Check up Reports • Medicaid Grievances and Appeals Policy Final 6-1-13 **Description of Process:** N/A	
	Findings: The Medicaid and Nevada Check Up quarterly reports for quarters 1 through 4 and accompanying emails to DHCFP provided evidence that HPN submitted the required quarterly grievance and appeals reports to DHCFP.		
	Recommendations: None.		
42 CFR 438.402(b)(1)(ii) *DHCFP Contract Section 4.11.1*	8. Grievances and Appeals Process Approval The MCO's enrollee grievance and appeal system is in writing and submitted to DHCFP for review and approval at the time the MCO's Policies and Procedures are submitted, and at any time thereafter when the MCO's enrollee grievances and appeals policies and procedures have been revised or updated (not including grammatical or readability revisions or updates). The MCO does not implement any policies and procedures concerning its enrollee grievance and appeal system without first obtaining the written approval of the DHCFP.	**Documents Submitted:** • Medicaid Grievances and Appeals Policy Final 6-1-13 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The document, Medicaid Grievances and Appeals Policy Final 6-1-13, provided evidence of HPN's written grievance and appeals policies as required by the element. The policy also included a statement that it cannot be implemented without the prior approval of the DHCFP. During the site visit, HPN staff produced a copy of an email from DHCFP that approved the grievance and appeal policies and procedures.		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None.		
42 CFR 438.56(d)(5)(i) *42 CFR 438.408(f)(1)(ii)* *DHCFP Contract Section 4.11.1*	9. Filing a Grievance on Behalf of the Enrollee The following people may file a grievance on behalf of the enrollee: a) An enrollee or an enrollee's representative (including a provider on behalf of an enrollee) may file a grievance or submit an appeal directly with the DHCFP. However, such grievances and appeals are referred to the MCO for resolution. b) In the event a provider files an appeal on the enrollee's behalf, the provider must first obtain the enrollee's written permission with the exception of an expedited appeal.	**Documents Submitted:** • Medicaid Grievances and Appeals Policy Final 6-1-13 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The document, Medicaid Grievances and Appeals Policy Final 6-1-13, provided evidence of HPN's written grievance and appeals policies as required by the element.		
	Recommendations: None.		
42 CFR 438.402(b)(3)(i and ii) *DHCFP Contract Section 4.11.1*	10. Process for Filing an Appeal Grievances are not eligible for referral to the State Fair Hearing process, but in the case of appeals: a) The enrollee must first exhaust the MCO's appeal process, but if not satisfied with the outcome, may request a State Fair Hearing from the DHCFP. b) The MCO is required to provide access to and	**Documents Submitted:** • 1278 Jun 2014 NV Check Up Revision (2) PG 23-25 • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH PG 24-26 • Medicaid Grievances and Appeals Policy Final 6-1-13 • REQUESTING A FAIR HEARING	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII. Grievances and Appeals

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	information about the State Fair Hearing process in the event an enrollee's appeal is not resolved in favor of the enrollee.	FORM 1-22-14 • Welcome to Health Plan of Nevada, Inc. HPN SmartChoice and NorthernChoice_EngSpn **Description of Process:** N/A	
	Findings: The document, Medicaid Grievances and Appeals Policy Final 6-1-13, provided evidence of HPN's written grievance and appeals policies as required by the element. The document, Requesting a Fair Hearing Form 1-22-14, provided evidence that HPN informed members about the process for obtaining a State Fair Hearing.		
	Recommendations: None.		
DHCFP Contract Section 4.11.1	11. Appeals Accepted Orally or in Writing An enrollee may file an appeal or grievance either orally or in writing. a) Unless the enrollee has requested an expedited resolution, an oral appeal may be followed by a written, signed appeal. b) If a grievance or appeal is filed orally, the MCO is required to document the contact for tracking purposes and to establish the earliest date of receipt. c) There is no requirement to track routine telephone inquiries.	**Documents Submitted:** • Medicaid Grievances and Appeals Policy Final 6-1-13 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: The document, Medicaid Grievances and Appeals Policy Final 6-1-13, provided evidence of HPN's written grievance and appeals policies as required by the element.		
	Recommendations: None.		
DHCFP Contract Section 4.11.1, 4.11.1.5	12. Routine Telephone Inquiries vs. Grievances For tracking purposes, an oral appeal or grievance is differentiated from a routine telephone inquiry by the content of the inquiry. A grievance is an expression of dissatisfaction about any matter other than one of the actions listed in element 13 below. Possible issues for grievances include, but are not limited to, access to care, quality of services, interpersonal relationships between MCO staff and enrollees, and failure to respect an enrollee's rights.	**Documents Submitted:** • Medicaid Grievances and Appeals Policy Final 6-1-13 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The document, Medicaid Grievances and Appeals Policy Final 6-1-13, provided evidence of HPN's written grievance and appeals policies and the definition of a grievance.		
	Recommendations: None.		
DHCFP Contract Section 4.11.1.1–5	13. Appeals An appeal is a specific request for review of one of the following actions: a) The denial or limited authorization of a requested service; b) The reduction, suspension or termination of a previously authorized service;	**Documents Submitted:** • 2013 HCO 100 UM Policy pg. 42-50 • Medicaid Grievances and Appeals Policy Final 6-1-13 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	c) The denial, in whole or in part, of payment for a service; d) The failure to provide services in a timely manner, or e) The failure of an MCO to act within the required timeframes for resolution and notification of appeals and grievances.		
	Findings: The document, Medicaid Grievances and Appeals Policy Final 6-1-13, provided evidence of HPN's written grievance and appeals policies, which included the definition of an appeal.		
	Recommendations: None.		
42 CFR 438.210(d)(1)(i and ii) *42 CFR 438.404(c)(4)(i and ii)* *42 CFR 438.404(c)(4)(ii)* *42 CFR 438.408(c)(2)* *DHCFP Contract Section 4.11.2*	14. Standard Authorization Decisions The MCO provides standard authorization decisions as expeditiously as the enrollee's health requires and within the State's established timelines that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days if the enrollee or provider requests the extension; or, the MCO justifies (to the DHCFP upon request) a need for additional information and how the extension is in the enrollee's interests.	**Documents Submitted:** • 2013 HCO 100 UM Policy- pg. 24 • Medicaid Grievances and Appeals Policy Final 6-1-13 • NVCheckUpMemberHandbook pg.24-26 • SmartChoiceNorthernChoiceMemberHandbook pg.25-27 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The document, 2013 HCO 100 UM Policy, provided evidence that standard authorization decisions were made as soon as medically indicated, within a maximum of 14 calendar days following the receipt of the request for services, with a possible extension of up to 14 additional calendar days if the enrollee or provider requests the extension; or, if the extension is found to be in the best interest of the member.		

Standard VII. Grievances and Appeals

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	The on-site file review of denials provided evidence that HPN provided authorization decisions within the required timeframes for all 10 files randomly selected and reviewed.		
	Recommendations: None.		
42 CFR 438.210(d)(2)(i and ii) *42 CFR 438.404(c)(4)(i)* *42 CFR 438.408(b)(3)* *42 CFR 438.408(c)(1)(i and ii)* *DHCFP Contract Section 4.11.2*	15. Expedited Authorization Decisions For cases in which a provider indicates or the MCO determines that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide a notice of action as expeditiously as the enrollee's health condition warrants and no later than three working days after receipt of the request for service. The MCO may extend the three working-days time period by up to 14 calendar days if the enrollee requests an extension or if the MCO justifies (to the State upon request) a need for additional information and how the extension is in the enrollee's interest.	**Documents Submitted:** • 2013 HCO 100 UM Policy-pg. 26-27 • Medicaid Grievances and Appeals Policy Final 6-1-13 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2013 HCO 100 UM Policy contained the timeframes and processes used by HPN for expedited authorization decisions as required by this element. The document, Medicaid Grievances and Appeals Policy Final 6-1-13, contained the requirements for expedited authorization decisions, which included the required timeframes for making expedited authorization decisions. The on-site file review provided evidence that expedited authorization decisions were made within the required timeframes.		
	Recommendations: None.		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.210(c) *42 CFR 438.404(c)(3)* *DHCFP Contract Section 4.11.3*	16. Written Notice of Action and Provider Notification The MCO provides a written notice of action to the enrollee when the MCO takes action or makes an adverse determination affecting the enrollee. If a provider has made a request on an enrollee's behalf and the MCO makes an adverse determination, the provider must be notified but this notification need not be in writing.	**Documents Submitted:** • 2013 HCO 100 UM Policy-pg. 22-31 • Medicaid pre-service denial template **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The documents, 2013 HCO 100 UM Policy and 2013 HCO 100 UM Policy, contained the required processes for providing written notice of action to member or providers, if the provider made a request on an enrollee's behalf.		
	Recommendations: None.		
42 CFR 438.10(c) *42 CFR 438.10 (d)(1)(i)* *42 CFR 438.404(a)* *DHCFP Contract Section 4.11.3*	17. Language and Format of Written Notice of Action To ensure ease of understanding by non-English speaking or visually impaired enrollees, or enrollees with limited reading proficiency, the written notice to the enrollee must meet the language and format requirements of 42 CFR 438.10(c) and (d).	**Documents Submitted:** • Medicaid pre-service denial template page 6,7,10,11 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The document, Medicaid Grievances and Appeals Policy Final 6-1-13, contained the requirements related to providing notices to enrollees in language and formats that are accessible to the enrollees. The file review provided evidence that the notices of action sent to enrollees contained language in four other languages, to inform that enrollee that the enrollee may contact the member services department to obtain a copy of the notice in a language other than English.		
	Recommendations: None.		
42 CFR 438.404(b)(1-7)	18. Requirements of a Written Notice of Action	**Documents Submitted:**	☒ Met

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.404(c)(1) *42 CFR 438.408(e)(1)* *42 CFR 438.408(e)(2)(i-ii)* *42 CFR 438.420(a)(1)* *DHCFP Contract Section 4.11.3.1–10*	A written notice of action to the enrollee meets the following requirements and explains: a) The action the MCO or its subcontractor has taken or intends to take; b) The reasons for the action; c) The enrollee's or the provider's right to file an appeal; d) The enrollee's right to request a State Fair Hearing after the enrollee has exhausted the MCO's internal appeal procedures; e) The procedures for exercising the enrollee's rights to appeal; f) The circumstances under which expedited resolution is available and how to request it; g) The enrollee's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services; h) That the enrollee may represent himself or use legal counsel, a relative, a friend, or other spokesman; i) The specific regulations that support, or the change in federal or State law that requires the action; j) The enrollee's right to request an evidentiary	• Medicaid pre-service denial template page 6,7,10,11 • 2013 HCO 100 UM Policy-pg. 22-31 **Description of Process:** N/A	☐ Partially Met ☐ Not Met ☐ N/A

Standard VII. Grievances and Appeals

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	hearing if one is available or a state agency hearing, or in cases of action based on change in law, the circumstances under which a hearing is granted; and, k) The MCO gives notice at least 10 days before the date of action when the action is a termination, suspension, or reduction of previously authorized covered services. This timeframe may be shortened to five days if probable enrollee fraud has been verified.		
	Findings: The document, 2013 HCPO 100 UM Policy, contained the requirements for written notice of action, which are required by this element. The Medicaid pre-service denial letter template provided evidence that the MCO attached information regarding enrollee's appeal rights to notices of denial, suspension, reduction, or termination of services when the notices are sent to enrollees. The policy, Denial Notices HCO 100.07, provided evidence that the MCO established provisions to include the benefit provision, guideline, protocol, or other criterion that required the action, in the notice of action to members. The results of the on-site file review provided evidence that the notices of action provided to enrollees contained the required information.		
	Recommendations: None.		
42 CFR 438.402(b)(2)(i) *DHCFP Contract Section 4.11.3.11–20*	19. Timing of the Notice of Action The MCO gives notice by the date of the action for the following circumstances: a) In the death of the enrollee; b) A signed written enrollee statement requesting termination or giving information requiring termination or reduction of services (where the enrollee understands that this must be the result of	**Documents Submitted: N/A- Waiting for clarification from DHCFP.** **Description of Process:** The CFR cited for this Requirement (42 CFR 438.402 (b)(2)(i)) generally references the timing of the notice of action, but does not include the elements listed in this question. Many of these elements are not relevant to managed care. We have asked DHCFP to review this provision (similar language was	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII. Grievances and Appeals

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	supplying that information); c) The enrollee's admission to an institution where he is ineligible for further services; d) The enrollee's address is unknown and mail directed to him has no forwarding address; e) The enrollee has been accepted for Medicaid services by another local jurisdiction; f) The enrollee's physician prescribes the change in level of medical care; g) An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989; or h) The safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or the resident has not resided in the nursing facility for 30 days (applies only to adverse action for nursing facility transfers); i) The MCO must give a notice of action on the date of action when the action is a denial of payment; and, j) the MCO must give notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations; and	removed from the audit tool during the 2011-2012 IQAP audit).	

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	k) Untimely service authorizations constitute a denial and are thus adverse actions.		
	Findings: The document, 2013 HCPO 100 UM Policy, contained the requirements and timeframes for providing notice of action to enrollees when there is a reduction, suspension, or termination of service. The policy also contained the requirements and timeframes for providing notice of action when there was a denial of service authorization. Prior to the on-site review, DHCFP provided HSAG instruction that items a, b, d, e, g, and h will need to be clarified in the MCO contract and for this review, were not applicable. Item c was addressed in the MCO's document, Adverse Determination Letter Preparation and Delivery, which detailed the procedure for issuing a notice of action when a member was ineligible for further services in an institution.		
	Recommendations: None.		
42 CFR 438.404(c)(4) *DHCFP Contract Section 4.11.3.21*	20. Notice of Actions Requirements The notice of actions must include: a) The enrollee's right to file a grievance if he or she disagrees with that decision; and b) The enrollee's right to receive written resolution notice, and reasonable efforts are to be made to provide oral resolution notice.	**Documents Submitted:** • 2013 HCO 100 UM Policy pg. 40 • Medicaid pre-service denial template page 6,7,10,11 **Description of Process:** N/A	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
	Findings: This federal requirement (42 CFR 438.404(c)(4)) refers to the language that must be contained in an MCO's notice to extend the timeframe to make a decision about a service authorization request, if the MCO required more than 14 calendar days to make a decision. The HPN policies and procedures related to notices of decisions, denials, appeals, or grievances did not contain the requirement to notify enrollees about their right to file a grievance if they disagreed with the MCO's decision to extend the timeframe for rendering a service authorization decision. The policies did contain the requirement that the MCO make authorization decisions within 14 calendar days of receiving the request. The language in the DHCFP/MCO contract for this requirement was listed under notice of action (Section 4.11.3). Notices of decisions, however, occur before a decision to deny, reduce, suspend, or terminate (otherwise known as, "action") would be rendered. DHCFP staff stated that the location of the language in the contract		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	should be moved to Section 4.11.2, Authorization and Notice Timeliness Requirements, to make it more clear in the contract. HPN staff stated that they processed all service authorization requests within 14 calendar days.		
	Recommendations: The MCO must inform the enrollee of his or her right to file a grievance if he or she disagrees with the MCO's decision to extend the timeframe to make a service authorization decision. The notice provided to enrollees must also inform the enrollee that he or she has a right to receive written resolution of the grievance.		
42 CFR 438.404(c)(5 and 6) *42 CFR 438.406(c)(6)* *42 CFR 438.408(b)(1 and 2)* *42 CFR 438.408(d)(1)* *42 CFR 438.408(d)(2)(i)* *DHCFP Contract Section 4.11.4.1–3*	21. Handling of Grievances and HMO Appeals The MCO is required to dispose of each grievance and resolve each appeal and to provide notice as expeditiously as the enrollee'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 days from the date of receipt of the grievance. b) Standard resolution of appeals: The MCO is allowed no more than 30 days from the date of receipt of the appeal. c) Expedited resolution of appeals: The MCO is allowed up to three working days from the date of receipt of the appeal.	**Documents Submitted:** • 2013 HCO 100 UM Policy-pg. 42-50 • Medicaid Grievances and Appeals Policy Final 6-1-13 • NVCheckUpMemberHandbook-pg. 26 • SmartChoiceNorthernChoiceMemberHandbook-pg. 27 **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The document, 2013 HCO 100 UM Policy, contained the required timeframes for resolving appeals. The policy also contained the requirements for resolving expedited appeals within 72 hours (3 working days). The document, Medicaid Grievances and Appeals Policy Final 6-1-13, included the process for resolving grievances within 90 days of receipt of the grievance. The Nevada Check Up and Medicaid member handbooks provided evidence that the resolution requirements were communicated to members. The on-site review of grievance files provided evidence that the MCO resolved all grievances within the required timeframe of 90		

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	days. The on-site file review of appeals provided evidence that the MCO resolved all standard appeals within the required timeframe of 30 days. The file review of expedited appeals, however, showed that one of the four expedited appeal files reviewed was not resolved within three working days.		
	Recommendations: HPN must ensure that expedited appeals are resolved within the required timeframe, up to three working days from the date of the receipt of the appeal.		
42 CFR 438.408(d)(2)(i) *42 CFR 438.410(a and b)* *42 CFR 438.410(c)(1 and 2)* *DHCFP Contract Section 4.11.4.3–5*	22. Expedited Review Process for Appeals The MCO establishes and maintains an expedited review process for appeals when the MCO determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. a) The MCO ensures that punitive action is not taken against a provider who supports an expedited appeal. b) If the MCO denies a request for an expedited resolution of an appeal, it must transfer the appeal to the standard resolution of appeals and make reasonable efforts to give the enrollee oral notice of the denial and follow up within two calendar days with a written notice. c) The MCO must inform the enrollee of the limited time available to present evidence and allegations of fact or law, in person or in writing, in the case of the expedited resolution.	**Documents Submitted:** • GPCRRltr 04-25-13 Medicaid 14 day appeal extension • GPCRRltr 04-25-13 Medicaid Expedited Ack Letter • GPCRRltr 04-25-13 Medicaid expedited appeal denial • Medicaid Grievances and Appeals Policy Final 6-1-13 **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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	d) These time frames may be extended up to 14 days if the enrollee requests such an extension or the MCO demonstrates to the satisfaction of the DHCFP that there is a need for additional information and how the extension is in the enrollee's interests. e) If the State grants the MCO's request for an extension, the MCO gives the enrollee written notice of the reason for the delay.		
	Findings: The document, Medicaid Grievances and Appeals Policy Final 6-1-13, included information that met the requirements of items b through e of this element. The Provider Summary Guide provided evidence that the MCO informed providers of the expedited review process for appeals. Neither document, however, contained information that the MCO ensures that punitive action was not taken against a provider who supports an expedited appeal.		
	Recommendations: The MCO must ensure that its process for expedited appeals includes the provision that the MCO does not take punitive action against a provider who supports an expedited appeal.		
42 CFR 438.10(g)(1)(iv-v) *42 CFR 438.406(a)(1 and 2)* *42 CFR 438.406(a)(3)(i)* *42 CFR 438.406(a)(3)(ii)(A-C)* *DHCFP Contract Section 4.11.4.6–9*	23. Notification of Disposition of Grievances and Appeals In handling grievances and appeals, the MCO meets the following requirements: a) The MCO provides enrollees any reasonable assistance in completing forms and taking other procedural steps, including assisting the enrollee and/or the enrollee's representative to arrange for non-emergency transportation services to attend and be available to present evidence at the appeal hearing. This also includes, but is not limited to,	**Documents Submitted:** • GPCRRltr 04-25-13 Medicaid Ack Letter • GPCRRltr 04-25-13 Medicaid Complaint Ack Letter • Medicaid Grievances and Appeals Policy Final 6-1-13 **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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	providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability; b) Acknowledge receipt of each grievance and appeal; c) Ensure that the individuals who make decisions on grievances and appeals were not involved in any previous level of review or decision-making; and d) Ensure that the individuals who make decisions on grievances and appeals are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease if the grievance or appeal involves any of the following: i. An appeal of a denial that is based on medical necessity; ii. A grievance regarding the denial of an expedited resolution of an appeal; or iii. A grievance or appeal that involves clinical issues.		
	Findings: The document, Medicaid Grievances and Appeals Policy Final 6-1-13, described the grievances and appeals notification and handling processes in place by the MCO. The policy included the provision that grievances were acknowledged within 3 calendar days of receipt in company and resolved within 90 calendar days. The policy contained the provision that standard appeals were acknowledged within 3 calendar days and resolved within 30 calendar days. For expedited appeals, however, the policy contained language that the appeal was, "acknowledged within 72 working days of receipt within the company." During the on-site interview, HPN staff stated that there was an error in the policy and the language was changed to 72 working hours to acknowledge		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	an expedited appeal, in the 2014 policy. Staff also stated that the policy was revised in September 2014, which was outside the review period for this review. The policy did contain the provisions required by items a, c, and d of this element. The on-site appeal file review showed that 8 of 10 appeals were acknowledged within the required timeframe; 6 of 6 standard appeals were resolved within the required timeframe; 3 of 4 expedited appeals were resolved with the proper notice sent; for the 1 expedited appeal which was not resolved within the required timeframe, no extension notice was sent to the member; all decisions for appeals were made by staff who were not involved in the original decision to deny services; and all appeal decisions were made by staff with the appropriate clinical expertise. The on-site grievance file review showed that 9 of 10 grievances were acknowledged within the required timeframe; all grievances were resolved within the required timeframe; and all grievances were reviewed and decisions were made by staff with appropriate clinical expertise.		
	Recommendations: The MCO must ensure that appeals are acknowledged within the timeframes specified by its policy. For expedited appeals, the MCO must ensure that a notice of extension is sent to members when the MCO requires more time to resolve the expedited appeal and that the expedited appeal is resolved within the required timeframes specified by the MCO's policy. The MCO must ensure that grievances are acknowledged within the timeframes specified by its policy.		
42 CFR 438.406(b)(1-3) *42 CFR 438.406(b)(4)(i and ii)* *DHCFP Contract Section 4.11.4.10–13*	24. Process for Appeals The process for appeals also requires: a) That oral inquiries seeking to appeal an action are treated as appeals (in order to establish the earliest possible filing date for the appeal) and must be confirmed in writing unless the enrollee requests expedited resolution; b) That the enrollee is provided a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing, and that	**Documents Submitted:** • Medicaid Grievances and Appeals Policy Final 6-1-13 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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	the enrollee is informed by the MCO of the limited time available for this in the case of expedited resolution; c) That the enrollee and his/her representative is provided the opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other document and records considered during the appeals process; and d) Include, as parties to the appeal, the enrollee and his/her representative or the legal representative of a deceased enrollee's estate.		
	Findings: The document, Medicaid Grievances and Appeals Policy Final 6-1-13, included all of the process elements (items a-d) required for appeals.		
	Recommendations: None.		
42 CFR 438.404(c)(4)(i) *DHCFP Contract Section 4.11.4.13*	25. Notification of Disposition of Grievances and Appeals The MCO notifies the enrollee of the disposition of grievances and appeals in written format. The written notice includes the results of the resolution process and the date it was completed.	**Documents Submitted:** • Medicaid Grievances and Appeals Policy Final 6-1-13 • GPCRRltr 04-25-13 Medicaid outcome letter upheld decision • REQUESTING A FAIR HEARING FORM 1-22-14 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: The document, Medicaid Grievances and Appeals Policy Final 6-1-13, included the requirement to notify enrollees of the disposition of grievance and appeals in writing. The document, GPCRRltr 04-25-13 Medicaid outcome letter upheld decision, provided evidence of the type of letter HPN sent to enrollees regarding the outcome of the appeal. The letter template included the requirements of this element. Results from the on-site file reviews provided evidence that the MCO provided written notice of disposition of each grievance and appeal to the member. Written notices contained the results of the resolution and the date the resolution was completed. The on-site file review of grievances and appeals provided evidence that all grievances and appeals were disposed in written format and the notices of decisions contained the results of the resolution and the date the resolution was completed.		
	Recommendations: None.		
42 CFR 438.408(e)(2)(iii) *DHCFP Contract Section 4.11.4.14–16*	26. Notice for Written Appeals not Resolved in Favor of the Enrollee For appeals that are not wholly resolved in favor of the enrollee, the notice includes: a) The right of the enrollee to request a State Fair Hearing from the DHCFP and how to do so; b) The right to request to receive benefits while the hearing is pending and how to make this request; and, c) That the enrollee may be held liable for the cost of those benefits if the State Fair Hearing Officer upholds the MCO's action.	**Documents Submitted:** • Medicaid Grievances and Appeals Policy Final 6-1-13 • REQUESTING A FAIR HEARING FORM 1-22-14 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The document, Medicaid Grievances and Appeals Policy Final 6-1-13, included the requirement to notify enrollees of their right to request a State Fair Hearing, receive benefits while the hearing is pending, and HPN's ability to recover costs for		

Standard VII. Grievances and Appeals

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	services rendered if the decision is adverse to the enrollee. The Nevada Check Up and Medicaid member handbooks also contained the same information as a notice to enrollees. The on-site file review of appeals provided evidence that all appeals contained notices of decision that incorporated the rights of the member to obtain a State Fair Hearing.		
	Recommendations: None.		
DHCFP Contract Section 4.11.4.16	27. Written Notice of Expedited Appeal Resolutions For expedited appeal resolution requests, the MCO makes a good faith effort to provide an oral notice of the disposition in addition to the required written notice.	**Documents Submitted:** • Medicaid Grievances and Appeals Policy Final 6-1-13 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The document, Medicaid Grievances and Appeals Policy Final 6-1-13, included the requirement to provide oral notice of disposition in addition to written notice. In all of the expedited appeals reviewed during the on-site review, the files provided evidence that the MCO provided oral notices of the disposition of the appeal in addition to the written notice.		
	Recommendations: None.		
42 CFR 438.416 *DHCFP Contract Section 4.11.4.16*	28. Written Records of Grievances and Appeals The MCO maintains records of grievances and appeals, which the State reviews as part of the State's quality strategy.	**Documents Submitted:** • HPN Nevada Check Up Enrollee Appeal Report Q2 2014 • HPN Nevada Check Up Enrollee Grievance report Q2 2014 • HPN Nevada Check Up Provider Grievance and Appeal Report Q2 2014 • HPN Smart Choice Enrollee Appeal Report Q2 2014 • HPN Smart Choice Enrollee Grievance Report Q2 2014	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		• HPN Smart Choice Provider Grievance and Appeal Report Q2 2014 • Medicaid Grievances and Appeals Policy Final 6-1-13 • UHC NV Nevada Check Up Appeals and Grievances Resolution Forms Q3 2013 2 • UHC NV Nevada Check Up Enrollee Appeal Report Q1 2014 • UHC NV Nevada Check Up Enrollee Appeal Report Q4 2013 • UHC NV Nevada Check Up Enrollee Grievance report Q1 2014 • UHC NV Nevada Check Up Enrollee Grievance report Q4 2013 • UHC NV Nevada Check Up Provider Grievance and Appeal Report Q1 2014 • UHC NV Nevada Check Up Provider Grievance and Appeal Report Q4 2013 • UHC NV Smart Choice Appeals and Grievances Resolution Forms Q3 2013 • UHC NV Smart Choice Enrollee Appeal Report Q1 2014 • UHC NV Smart Choice Enrollee Appeal Report Q4 2013 • UHC NV Smart Choice Enrollee Grievance Report Q1 2014 • UHC NV Smart Choice Enrollee Grievance Report Q4 2013	

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		• UHC NV Smart Choice Provider Grievance and Appeal Report Q1 2014 • UHC NV Smart Choice Provider Grievance and Appeal Report Q4 2013 **Description of Process:** N/A	
	Findings: The document, Medicaid Grievances and Appeals Policy Final 6-1-13, included the requirement maintain a grievance and appeal tracking system. The grievance quarterly reports and appeal quarterly reports provided evidence that HPN tracked and reported grievance and appeal information to the DHCFP as required by this element. The on-site file review of grievances and appeals provided evidence the MCO maintained records of grievances and appeals.		
	Recommendations: None.		
42 CFR 438.408(f)(2) *DHCFP Contract Section 4.11.5*	29. State Fair Hearing Process The State Fair Hearing process is described in Chapter 3100 of the Medicaid Services Manual (MSM). An enrollee, enrollee's representative or the representative of a deceased enrollee's estate has the right to request a State Fair Hearing from the DHCFP when they have exhausted the MCO's appeal system without receiving a wholly favorable resolution decision.	**Documents Submitted:** • Medicaid Grievances and Appeals Policy Final 6-1-13 • REQUESTING A FAIR HEARING FORM 1-22-14 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The document, Medicaid Grievances and Appeals Policy Final 6-1-13, detailed the State Fair Hearing process as required by this element.		
	Recommendations: None.		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.402(b)(2)(i) *42 CFR 438.408(f)(1)(i)* *DHCFP Contract Section 4.11.5*	30. Processing Requests for State Fair Hearings The request for a State Fair Hearing must be submitted in writing within 90 calendar days from the date of the MCO's notice of resolution. The MCO participates in the State Fair Hearing process, at the MCO's expense, in each circumstance in which an enrollee for whom the MCO has made an adverse determination requests a State Fair Hearing. The MCO is bound by the decision of the Fair Hearing Officer.	**Documents Submitted:** • REQUESTING A FAIR HEARING FORM 1-22-14 • Medicaid Grievances and Appeals Policy Final 6-1-13 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The document, Medicaid Grievances and Appeals Policy Final 6-1-13, detailed the State Fair Hearing requests processing as required by this element.		
	Recommendations: None.		
42 CFR 431.200(b) *42 CFR 431.220(5)* *42 CFR 438.414* *42 CFR 438.10(g)(1)* *DHCFP Contract Section 4.11.5*	31. Informing Enrollees about State Fair Hearings The MCO is required to inform the enrollee of their right to a State Fair Hearing, how to obtain such a hearing, and representation rules must be explained to the enrollee and provided by the MCO.	**Documents Submitted:** • Medicaid pre-service denial template page 6,7,10,11 • 1278 Jun 2014 NV Check Up Revision (2) PG 24 • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH PG 24 • REQUESTING A FAIR HEARING FORM 1-22-14 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII. Grievances and Appeals

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: The Nevada Check Up and Medicaid member handbooks provided evidence of the HPN's notification to enrollees about their right to a State Fair Hearing. The document, Requesting a Fair Hearing Form 1-22-14, provided evidence of the instructions provided to enrollees to obtain a State Fair Hearing and the representation rules required by this element.		
	Recommendations: None.		
42 CFR 438.10(g)(1)(vi)(A) *42 CFR 438.420(a)(2)* *42 CFR 438.420(b)(1-5)* *DHCFP Contract Section 4.11.6.1–5*	32. Continuation of Benefits The MCO continues the enrollee's benefits while the MCO's internal appeals process is pending and while the State Fair Hearing is pending if all of the following conditions exist: a) The appeal is submitted to the MCO on or before the later of the following: within 10 days of the MCO mailing the notice of action; or, the intended effective date of the MCO's proposed action; b) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; c) The services were ordered by an authorized provider; d) The original periods covered by the original authorization have not expired; and e) The enrollee requests an extension of benefits.	**Documents Submitted:** • 1278 Jun 2014 NV Check Up Revision (2) PG 24 • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH PG 26 • Medicaid Grievances and Appeals Policy Final 6-1-13 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The document, Medicaid Grievances and Appeals Policy Final 6-1-13, detailed the State Fair Hearing requests processing as required by this element. The Nevada Check Up and Medicaid member handbooks provided evidence of the HPN's notification to		

Standard VII. Grievances and Appeals

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	enrollees about the State Fair Hearing process and continuation of benefits while a State Fair Hearing is pending. **Recommendations:** None.		
42 CFR 438.10(g)(1)(vi)(B) *42 CFR 431.230(b)* *42 CFR 438.420(c)(1-4)* *DHCFP Contract Section 4.11.5–9*	33. Continuation of Benefits while Appeal is Pending If, at the enrollee's request, the MCO continues the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs: a) The enrollee withdraws the appeal; b) Ten days pass after the MCO mails the notice of action, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day timeframe has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached; c) A State Fair Hearing Officer issues a hearing decision adverse to the enrollee; and, d) The time period of service limits of a previously authorized service has been met. e) If the final resolution of the appeal is adverse to the enrollee, the MCO may recover the cost of the services furnished to the enrollee while the appeal was pending, to the extent that they were furnished solely because of the requirements of this section and in accordance with policy set forth in 42 CFR	**Documents Submitted:** • Medicaid Grievances and Appeals Policy Final 6-1-13 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	431.230(b).		
	Findings: The document, Medicaid Grievances and Appeals Policy Final 6-1-13, detailed the State Fair Hearing requests requirements, detailed in this element, for the continuation of benefits while a State Fair Hearing is pending.		
	Recommendations: None.		
42 CFR 438.420(d) *42 CFR 438.424(a and b)* *DHCFP Contract Section 4.11.6*	34. Reversing and 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 enrollee's health condition requires. If the MCO or State Fair Hearing Officer reverses a decision to deny authorization of services, and the enrollee 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:** • Medicaid Grievances and Appeals Policy Final 6-1-13 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The document, Medicaid Grievances and Appeals Policy Final 6-1-13, contained the requirements related to reversing action to deny, limit, or delay services.		
	Recommendations: None.		
DHCFP Contract Section 4.13.1.8	35. Medical Director Oversight The responsibilities of the Medical Director include serving as the MCO's consultant to medical staff with regard to	**Documents Submitted:** • 2013 HCO 100 UM Policy- pg. 5 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII. Grievances and Appeals

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	referrals, denials, grievances and problems.	N/A	
	Findings: The 2013 and 2014 UM Program Descriptions included the provision that the chief medical officer was responsible for the UM program, which included providing direct supervision of medical management staff and directing utilization management for HPN. The document, 2013 HCO 100 UM Policy, also described the use of medical directors to make utilization management determinations, which included denials.		
	Recommendations: None.		

Results for Standard VII: Grievance and Appeals							
Total	Met	=	31	X	1.00	=	31.0
	Partially Met	=	3	X	.50	=	1.5
	Not Met	=	1	X	.00	=	0.0
Total Applicable		=	35	**Total Score**		=	32.5

Total Score ÷ Total Applicable	=	92.9%

Standard VIII. Subcontracts and Delegation

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.5.4	1. Subcontractors All Subcontracts, including delegation agreements, are in writing, are prior approved by the DHCFP, and contain all applicable items and requirements as set forth in the DHCFP Managed Care Contract, as amended.	**Documents Submitted:** • Exclusive Behavioral Health Agreement Notification to DHCFP 041211 • HPN Medicaid_HBI Contract Eff 6-1-11 • RE Exclusive Behavioral Health Agreement DHCFP Approval **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Information submitted concerning the HPN contract with the Human Behavior Institute provided evidence of meeting the requirements of this element.		
	Recommendations: None.		
42 CFR 423.208 *42 CFR 422.10* *DHCFP Contract Section 4.5.6.7*	2. Physician Incentive Plan If the MCO has a physician incentive plan, it must comply with 1876(iI) (8) and the reporting requirements outlined in 42 CFR 423.208 and 422.10.	**Documents Submitted:** N/A- there were no physician incentive plans in place during the audit time period **Description of Process:** N/A	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
	Findings: HPN noted that there were no physician incentive plans in place during the audit period. This element, therefore, is not applicable for HPN.		
	Recommendations: None.		
42 CFR 438.214 42 CFR 438.6 *DHCFP Contract Section*	3. Subcontractors The MCO complies with the requirements in 42 CFR 438.214 regarding contracts with health care professionals.	**Documents Submitted:** • HPN Medicaid_HBI Contract Eff 6-1-11 • MEDICAID Consulting Provider Template 2013	☒ Met ☐ Partially Met ☐ Not Met

Standard VIII. Subcontracts and Delegation

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
4.13.3–3.1	The MCO ensures that all subcontracts fulfill the requirements of 42 CFR 438.6 that are appropriate to the service or activity delegated under the subcontract.	• MEDICAID Primary Care Physician FFS Template 2013 **Description of Process:** N/A	☐ N/A
	Findings: The Human Behavior Institute contract, Medicaid Primary Care Provider FFS contract, and the Medicaid Consulting Provider contract provided evidence of meeting the requirements of this element.		
	Recommendations: None.		
42 CFR 438.12(a)(2) *DHCFP Contract Section 4.13.3.2*	4. MCO Oversight Requirements The MCO is responsible for oversight of all network subcontracts and is accountable for any responsibilities it delegates to any subcontracted provider (AKA, subcontractor). The MCO evaluates the prospective subcontractor's ability to perform the activities to be delegated.	**Documents Submitted:** • HBI JOC Charter 2014 • HBI Oversight Program Description 2013 • UM COMM 043 MN Request for Peer Review • UM-COM 003 Admin Denial Review Request Inpt-Outpt **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Charter of the Behavioral Healthcare Options/Human Behavior Institute and the Monitoring Performance of a Subcontractor policy provided evidence of meeting the requirements of this element. The Human Behavioral Institute Program Description also delineated the activities involved in HPN's monitoring of the subcontractor. There were no policies found, however, that confirmed the requirement that HPN evaluated a prospective subcontractor's ability to perform the activities to be delegated prior to entering into a subcontractor agreement with a provider.		
	Recommendations: HPN should maintain documentation that demonstrates HPN's evaluation of prospective subcontractor's ability to perform the activities to be delegated prior to entering into a subcontractor agreement with a provider.		
42 CFR 438.230(a)(1)	5. Prior-Approval Requirements by DHCFP	**Documents Submitted:**	☒ Met

Standard VIII. Subcontracts and Delegation

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.230(b)(1) *DHCFP Contract Section 4.13.3.3*	All subcontracts for administrative services provided pursuant to this RFP, including, but not limited to, utilization review, quality assurance, recipient services, and claims processing, are prior- approved by DHCFP.	• Exclusive Behavioral Health Agreement Notification to DHCFP 041211 • HPN Medicaid_HBI Contract Eff 6-1-11 • RE Exclusive Behavioral Health Agreement DHCFP Approval **Description of Process:** N/A	☐ Partially Met ☐ Not Met ☐ N/A
	Findings: An email from DHCFP dated April 12, 2011 provided evidence that the contract with the Human Behavior Institute was approved by the State.		
	Recommendations: None.		
DHCFP Contract Section 4.13.3.3	6. Disclosing MCO Ownership in the Subcontracted Entity Prior to the award of any subcontract or execution of an agreement with a delegated entity, the MCO provides written information to the DHCFP disclosing the MCO's ownership interest of 5 percent or more in the subcontractor or delegated entity, if applicable. All subcontracts are submitted to DHCFP for approval prior to their effective date. Failure to obtain advance written approval of a subcontract from DHCFP results in the application of a penalty of one month's current capitation payment for an adult female TANF recipient for each day that the subcontract was in effect without the DHCFP's approval.	**Documents Submitted:** • Exclusive Behavioral Health Agreement Notification to DHCFP 041211 • HBI Ownership • HPN Medicaid_HBI Contract Eff 6-1-11 • RE Exclusive Behavioral Health Agreement DHCFP Approval • WRHCO 341 Disclosure of Ownership of Subcontracted Entity **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII. Subcontracts and Delegation

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: Disclosure of Ownership of Subcontracted Entity included the requirements of this element. An email from DHCFP dated April 12, 2011 provided evidence that the contract with the Human Behavior Institute was approved by the State prior to effective date of contract. Interviews with staff confirmed that HPN does not have ownership in the Human Behavior Institute.		
	Recommendations: None.		
DHCFP Contract Section 4.13.3.4	7. Subcontractors By the service start date and whenever a change occurs, submit to DHCFP for review and approval the names of any material subcontractors the MCO has hired to perform any of the requirements of the Contract and the names of their principals.	**Documents Submitted:** • Exclusive Behavioral Health Agreement Notification to DHCFP 041211 • Exclusive Behavioral Health Agreement • HBI Ownership **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: An email from DHCFP dated April 12, 2011 provided evidence that the contract with the Human Behavior Institute was approved by the State prior to effective date of contract. A letter from the Human Behavior Institute dated November 29, 2010 confirmed that HPN obtained the names of the principals of the company prior to entering into a subcontract with the entity.		
	Recommendations: None.		
DHCFP Contract Section 4.13.3.5	8. The Subcontract Requirements a) The MCO maintains all agreements and subcontracts relating to the contract in writing. b) The MCO provides copies of all agreements and subcontracts to DHCFP within five (5) days of receiving such request. c) The MCO's agreements and subcontracts contain relevant provisions of the contract appropriate to	**Documents Submitted:** • HPN Medicaid_HBI Contract Eff 6-1-11 pgs 5,6,9,16 **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VIII. Subcontracts and Delegation

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	the subcontracted service or activity, specifically including but not limited to the provisions related to confidentiality, HIPAA requirements, insurance requirements and record retention. d) The MCO has the responsibility to assure that subcontractors are adequately insured to current insurance industry standards.		
	Findings: The HPN Human Behavioral Institute contract provided evidence of having written agreements with subcontractors. Additional information to meet the requirements of this section also was found in the Human Behavioral Institute contract with HPN and the Medicaid PCP and Consulting Provider agreements. No policies included the requirement, however, that HPN provided copies of all agreements and subcontracts to DHCFP within five (5) days of receiving such request.		
	Recommendations: HPN's documentation must include the requirement that HPN provides copies of all agreements and subcontracts to DHCFP within five (5) days of receiving such request.		
DHCFP Contract Section 4.13.3.6	9. Responsibility of MCO The MCO remains fully responsible for meeting all of the requirements of the Contract regardless of any subcontracts for the performance of any Contract responsibility. No subcontract operates to relieve the MCO of its legal responsibility under the Contract.	**Documents Submitted:** • HPN Medicaid_HBI Contract Eff 6-1-11 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2013 HPN and SHL QI Program Description stipulated that HPN was accountable for the quality of the clinical care and service provided to its members and that the MCO did not delegate the responsibility for ensuring that the function was performed appropriately.		
	Recommendations: None.		
42 CFR 438.230(b)(2)(i and ii)	10. Responsibility of the MCO	**Documents Submitted:** • HPN Medicaid_HBI Contract Eff 6-1-11	☒ Met ☐ Partially Met

Standard VIII. Subcontracts and Delegation

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.13.3.7	The MCO must have a written agreement with the subcontractor that specifies the activities and report responsibilities delegated to the subcontractor and provides for revoking delegation or imposing sanctions if the subcontractor's performance is inadequate or substandard.	pgs 14,22-25 **Description of Process:** N/A	☐ Not Met ☐ N/A
	Findings: HPN provided a copy of the written agreement with the Human Behavioral Institute to validate that the MCO had a written agreement with the subcontractor. The document contained provisions to terminate the agreement if the Human Behavioral Institute failed to abide by the standards of conduct and guidelines set forth in the Corporate Compliance Program, or for other reasons stated in the Term and Termination section of the contract.		
	Recommendations: None.		
42 CFR 438.230(a)(1) *42 CFR 438.230(b)(3 and 4)* *42 CFR 438.236(b)(1-4)* *DHCFP Contract Section 4.13.3.8*	11. Monitoring Performance of the Subcontractor The MCO monitors the subcontractor's performance on an on-going basis and subjects the subcontractor to formal review according to periodic schedules established by the State, consistent with industry standards and/or State laws and regulations. If the MCO identifies deficiencies or areas for improvement, the MCO and the subcontractor must take corrective action.	**Documents Submitted:** • WRHCO 345 Monitoring Performance of Subcontractor • HBI JOC Charter 2014 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Monitoring Performance of Subcontractor policy provided evidence of meeting the requirements of this element. The Human Behavior Institute Program Description 2013 contained a matrix listing the various monitoring reports received and generated by HPN. Interviews with staff included a review of the reports during the review period: Mid-year Quality Site Review dated April 22, 2014; and the Capitated Outpatient Treatment Request Form Reviews dated January 30, 2014 and April 22, 2014. During the interviews, the HPN staff also explained the process to conduct monthly secret shopper calls and review the quarterly Encounter Comparison Reports for the Human Behavior Institute.		

Standard VIII. Subcontracts and Delegation

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None.		
42 CFR 438.236(c and d) *DHCFP Contract Section 4.13.3.9*	12. Termination of Subcontract The MCO notifies DHCFP, in writing, immediately upon notifying any material subcontractor of the MCO's intention to terminate any such subcontract.	**Documents Submitted:** • WRHCO 342 Termination of Subcontract **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Termination of Subcontract policy provided evidence of meeting the requirements of this element. Interviews with staff confirmed that HPN did not terminate any subcontracts during the time review period.		
	Recommendations: None.		
DHCFP Contract Section 4.13.3.10	13. Ownership of Subcontractor Within 30 calendar days of the date of request, the MCO must provide full and complete information about the ownership of any subcontractor with whom the MCO has had business transactions totaling more than $25,000.00 during the 12-month period ending on the date of request as required by 42 CFR 455.105. Failure to timely comply with the request results in withholding of payment by the State to the MCO. Payment for services cease on the day following the date the information is due and begin again on the day after the date on which the information is received.	**Documents Submitted:** • WRHCO 338 Request for Subcontractor Ownership **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Request for Subcontractor Ownership policy provided evidence of meeting the requirements of this element.		

Standard VIII. Subcontracts and Delegation

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None.		

Results for Standard VIII: Subcontracts and Delegation							
Total	Met	=	10	X	1.00	=	10.0
	Partially Met	=	2	X	.50	=	1.0
	Not Met	=	0	X	.00	=	0.0
Total Applicable		=	12	**Total Score**		=	11.0

Total Score ÷ Total Applicable	=	91.7%

Standard IX. Cultural Competency Program

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.2.1.16 (A)	1. The Cultural Competency Plan (CCP) is updated annually and submitted to DHCFP in the second quarter of each calendar year.	**Documents Submitted:** • Cultural Competency Program Submission • Cultural Div and Sens Prog Overview 2014--pg. 1 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Cultural Diversity and Sensitivity Program Overview 2014 provided evidence of HPN's annual update of the CCP. The HPN email from June 27, 2014 to DHCFP staff provided evidence that HPN submitted its CCP to DHCFP in the second calendar quarter.		
	Recommendations: None.		
42 CFR 438.206(c)(2) *DHCFP Contract Section 4.2.1.16 (A)*	2. The Cultural Competency Plan (CCP) describes how care and services are delivered in a culturally competent manner.	**Documents Submitted:** • Cultural Div and Sens Prog Overview 2014-entire doc **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Cultural Diversity and Sensitivity Program Overview 2014 described how care and services were delivered in a culturally competent manner.		
	Recommendations: None.		
DHCFP Contract Section 4.2.1.16 (A)	3. The MCO CCP identifies a staff member responsible for the CCP. If there is a change in the staff member responsible for the CCP, the MCO notifies the DHCFP.	**Documents Submitted:** • Notification of Change in Quality Improvement Department • Cultural Div and Sens Prog Overview	☐ Met ☒ Partially Met ☐ Not Met

Standard IX. Cultural Competency Program

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		2014-pg. 32 **Description of Process:** N/A	☐ N/A
	Findings: Page 32 of the Cultural Diversity and Sensitivity Program Overview 2014 listed the chief medical officer as the project lead. The email from HPN to DHCFP on March 7, 2014, however, described of the staffing changes that affected the CCP. The email stated that since Rhet Perret left the QI Department, the new lead for the CCP would be Kim Johnson. During the on-site review, HPN staff stated that the lead should be the chief medical officer, although this was not communicated to DHCFP.		
	Recommendations: The MCO should identify the staff person responsible for the CCP and should communicate the information to the DHCFP.		
DHCFP Contract Section 4.2.1.16 (B)	4. Staff Recruitment and Retention The CCP contains 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 Div and Sens Prog Overview 2014-pg. 16-20 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Cultural Diversity and Sensitivity Program Overview 2014 described the staff recruitment and retention to hire and retain bilingual staff members and to encourage staff to go through Limited English Proficiency (LEP) certification. The Cultural Diversity and Sensitivity Program Overview 2014 also described HPN's encouragement for staff to attend ongoing training sessions related to culturally and linguistically appropriate services. The job descriptions for outpatient case manager, health management case manager, and medical director contained language that staff must contribute to the organization's efforts to eliminate racial and ethnic disparities and support cultural awareness.		
	Recommendations: None.		
DHCFP Contract Section 4.2.1.16 (C.1)	5. Training Program The training program:	**Documents Submitted:** • Cultural Div and Sens Prog Overview 2014-pg. 16-22	☐ Met ☒ Partially Met ☐ Not Met

Standard IX. Cultural Competency Program

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	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.	**Description of Process:** N/A	☐ N/A
	Findings: During the on-site interview, HPN staff described the training modules listed on LearnSource, which was available to HPN staff online. HPN staff stated that some departments required the training and some departments did not require the training. The Cultural Diversity and Sensitivity Program Overview 2014 included the requirement that all members of the Customer Centric Task Force, which represented the key areas of the health plan, were required to ensure their staff members completed culture and diversity courses offered by HPN. Further, the Cultural Diversity and Sensitivity Program Overview 2014 included the provision that staff who worked with members were required to take at least one of the online training classes offered by the MCO through LearnSource. The LearnSource trainings included: Diversity and Inclusion, Diversity and Inclusion—Making Health Care Work for Everyone, Diversity and Inclusion—The Changing Landscape, and Valuing Diversity and Inclusion II. During the on-site interview, HPN staff stated that there was not a requirement for staff to complete ongoing trainings, for example, annually. The Cultural Diversity and Sensitivity Program Overview 2014 did include the methods used by the MCO to conduct an organizational needs assessment, by way of survey, that was focused on culturally-appropriate staff recruitment and training efforts. The Cultural Diversity and Sensitivity Program Overview 2014 included an analysis of data that described the number of LEP certified employees in 2013 and the comparison in the rate over the previous year. The overview also included the racial and ethnic demographics of the population served by HPN for the Nevada Medicaid and Check Up programs.		
	Recommendations: The MCO must 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. The training should be tailored to the specific		

Standard IX. Cultural Competency Program

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	training needs of the staff after the assessment of training needs is performed.		
42 CFR 438.206(c)(2) *DHCFP Contract Section 4.2.1.16 (C.2)*	6. Education Program The education program: 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.	**Documents Submitted:** • Cultural Div and Sens Prog Overview 2014-pg. 8-11 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2013 Provider Summary Guide provided evidence that the MCO informed providers of the requirement to provide services to members in a culturally competent manner, taking into account limited English proficiency or reading skills, hearing or vision impairment and diverse cultural and ethnic backgrounds. The Cultural Diversity and Sensitivity Program Overview 2014 detailed the results of a provider survey that included questions that asked providers about the need for culturally appropriate tools and resources by providers and whether or not barriers existed for providers to provide health care to patients. To provide additional resources to providers, HPN staff provided a screen print from the online HPN provider page that included a link providers could use to access ongoing continuing medical education (CME) training from the Office of Minority Health, Think Cultural Health initiative. HPN staff stated that providers who access the training may receive up to nine free CMEs through culturally and linguistically appropriate services (CLAS) in health and health care.		
	Recommendations: None.		
42 CFR 438.206(c)(2) *DHCFP Contract Section 4.2.1.16 (C.2)*	7. Training Providers and Subcontractors The MCO makes additional efforts to train or assist providers and subcontractor in receiving training in how to provide culturally competent services.	**Documents Submitted:** • Cultural Div and Sens Prog Overview 2014-pg. 8-16 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2013 Provider Summary Guide provided evidence that the MCO informed providers of the requirement to provide services to members in a culturally competent manner, taking into account limited English proficiency or reading skills, hearing or		

Standard IX. Cultural Competency Program

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	vision impairment and diverse cultural and ethnic backgrounds. The Cultural Diversity and Sensitivity Program Overview 2014 detailed the results of a provider survey that included questions that asked providers about the need for culturally appropriate tools and resources by providers and whether or not barriers existed for providers to provide health care to patients. To provide additional resources to providers, HPN staff provided a screen print from the online HPN provider page that included a link providers could use to access ongoing CME training from the Office of Minority Health, Think Cultural Health initiative. HPN staff stated that providers who access the training may receive up to nine free CMEs through CLAS in health and health care.		
	Recommendations: None.		
42 CFR 438.206(c)(2) *42 CFR 438.10(c)(1)* *DHCFP Contract Section 4.2.1.16 (D)*	8. Culturally Competent Services and Translation/Interpretation Services The MCO describes the ongoing evaluation of the cultural diversity of its membership, including maintaining an up-to-date demographic and cultural profile of the MCO's members.	**Documents Submitted:** • Cultural Div and Sens Prog Overview 2014-pg. 5-7 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Cultural Diversity and Sensitivity Program Overview 2014 included up-to-date demographic and cultural profile of HPN's members.		
	Recommendations: None.		
DHCFP Contract Section 4.2.1.16 (D)	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:** • Cultural Div and Sens Prog Overview 2014-pg. 26-31 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Cultural Diversity and Sensitivity Program Overview 2014 showed the assessment of needs of the population. Further, the annual QI Evaluation also provided evidence of HPN's race and ethnicity analysis of the population for each of the performance measures listed in the State Quality Strategy.		

Standard IX. Cultural Competency Program

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None.		
DHCFP Contract Section 4.2.1.16 (D)	10. Evaluating the Network Culturally competent care requires that the MCO regularly evaluates its network, outreach services and other programs to improve accessibility and quality of care for its membership. It also describes the provision and coordination needed for linguistic and disability-related services.	**Documents Submitted:** • Cultural Div and Sens Prog Overview 2014-pg. 8-16 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Cultural Diversity and Sensitivity Program Overview 2014 showed the assessment of needs of the population through an evaluation of the network to improve accessibility of the population. Further, the annual QI Evaluation also provided evidence of HPN's race and ethnicity analysis of the population for each of the performance measures listed in the State Quality Strategy to determine where disparities exist.		
	Recommendations: None.		
DHCFP Contract Section 4.2.1.16 (D)	11. Translation Services The MCO makes 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 should not be encouraged to substitute a friend or relative for translation services.	**Documents Submitted:** • Cultural Div and Sens Prog Overview 2014-pg. 21-25 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Cultural Diversity and Sensitivity Program Overview 2014 detailed the limited English Proficiency (LEP) services available for members. The Nevada Check Up and Medicaid provider manuals provided evidence that the MCO notified members of the language services available to members.		

Standard IX. Cultural Competency Program

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None.		
42 CFR 438.10(c)(1) *DHCFP Contract Section 4.2.1.16 (D)*	12. 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:** • Cultural Div and Sens Prog Overview 2014-pg. 21-25 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Cultural Diversity and Sensitivity Program Overview 2014 described the certified-contractor that was used to translate materials into Spanish and ensure the translation did not change the intent or meaning of the materials.		
	Recommendations: None.		
42 CFR 438.10(c)(1) *DHCFP Contract Section 4.2.1.16 (D1)*	13. Ten Percent Threshold for Providing Written Translation All materials are 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 who also have limited English proficiency (LEP) in that language.	**Documents Submitted:** • Cultural Div and Sens Prog Overview 2014-pg. 21-25 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Cultural Diversity and Sensitivity Program Overview 2014 described the certified-contractor that was used to translate materials into Spanish and ensure the translation did not change the intent or meaning of the materials. Spanish was the only language that surpassed the 3,000 or 10 percent threshold.		
	Recommendations: None.		
42 CFR 438.10(c)(2-3) *DHCFP Contract Section 4.2.1.16 (D2)*	14. Five Percent Threshold for Providing Written Translation All vital materials are translated when the MCO is	**Documents Submitted:** • Cultural Div and Sens Prog Overview 2014-pg. 21-25	☒ Met ☐ Partially Met ☐ Not Met

Standard IX. Cultural Competency Program

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	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, and vital information from the member handbook.	**Description of Process:** N/A	☐ N/A
	Findings: The Cultural Diversity and Sensitivity Program Overview 2014 described the translation of member materials into Spanish, which was the only language that surpassed the 3,000 or 10 percent threshold. The Cultural Diversity and Sensitivity Program Overview 2014 did not describe, however, the process for translating vital materials when the language was spoken by 1,000 or 5 percent of members also have LEP in that language. Instead, the Cultural Diversity and Sensitivity Program Overview 2014 listed the top eight most prevalent languages spoken by the membership. English represented 80 percent of the population followed by Spanish at 19 percent of the population. All other languages represented less than 1 percent of the population. The member handbook and notices of decision and notices of action included statements written in the top five most prevalent non-English languages that the information contained in the notice or member handbook was available to members in their preferred non-English language on request. HPN staff stated that they would translate vital materials in languages other than English or Spanish on request by members even though there was no policy that mandated the translation of vital materials. Further, HPN staff reported that in 2013, verbal translation services were requested for 41 different languages, with Spanish being the most requested language at 95 percent. Mandarin was the second most common requested translation at 1 percent.		
	Recommendations: Although the contract standard did not require a policy, the MCO should consider updating its policies and procedures or CCP plan to ensure that all vital materials are 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.		
DHCFP Contract Section 4.2.1.16 (D3)	15. Written Notices Informing Members of Interpretation and Translation Services All written notices informing members of their right to interpretation and translation services in a language are translated when the MCO is aware that 1,000 or 5% (whichever is less) of the MCO's	**Documents Submitted:** • Cultural Div and Sens Prog Overview 2014-pg. 21-25 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX. Cultural Competency Program

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	members speak that language and have LEP.		
	Findings: The Cultural Diversity and Sensitivity Program Overview 2014 listed the top eight most prevalent languages spoken by the membership. English represented 80 percent of the population followed by Spanish at 19 percent of the population. All other languages represented less than 1 percent of the population. The member handbook, notices of decision, and notices of action included statements written in the top five most prevalent non-English languages that the information contained in the notice or member handbook was available to members in their preferred non-English language on request. HPN staff stated that they would translate vital materials in languages other than English or Spanish on request by members. Further, HPN staff reported that in 2013, verbal translation services were requested for 41 different languages, with Spanish being the most requested language at 95 percent. Mandarin was the second most common requested translation at 1 percent.		
	Recommendations: Although the contract standard did not require a policy, the MCO should consider updating its policies and procedures or CCP plan to ensure that all written notices informing members of their right to interpretation and translation services in a language are translated when the MCO is aware that 1,000 or 5% (whichever is less) of the MCO's members speak that language and have LEP.		
DHCFP Contract Section 4.2.1.16 (E)	16. Evaluation and Assessment of CCP The MCO evaluates the CCP to determine its effectiveness and identify opportunities for improvement. Evaluations are completed on an annual basis and a copy of the evaluation sent to DHCFP. 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 are tracked and trended, and actions are taken to resolve the issue(s).	**Documents Submitted:** • Cultural Div and Sens Prog Overview 2014-entire doc **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Cultural Diversity and Sensitivity Program Overview 2014 provided evidence of the data collected and analyzed for use in the CCP and recommended activities for the following year. The assessment included an evaluation of member satisfaction surveys, outcomes for certain cultural groups, member complaints, grievances, provider feedback, and MCO employee surveys.		

Standard IX. Cultural Competency Program

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None.		

Results for Standard IX: Cultural Competency Program							
Total	Met	=	14	X	1.00	=	14.0
	Partially Met	=	2	X	.50	=	1.0
	Not Met	=	0	X	.00	=	0.0
Total Applicable		=	16	**Total Score**		=	15.0

Total Score ÷ Total Applicable	=	93.8

Standard X. Coverage and Authorization of Services

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 440.230 *42 CFR 438.210(a)(2)* *42 CFR 438.210(a)(3)(i-iii)(A-B)* *42 CFR438.210(a)(3)(ii)(A and B)* *42 CFR 438.210(a)(4)(i)* *DHCFP Contract Section 4.2.1.1–4*	1. MCO Managed Care Benefit Package The MCO furnishes services in the same amount, duration and scope as services furnished to recipients under fee-for-service Medicaid as set forth in 42 CFR 440.230, which states that the MCO: a) Ensures the services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished; b) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member; c) May place appropriate limits on a service on the basis of criteria applied under the State plan, such as medical necessity, or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in Section 4.2.2; d) Specifies what constitutes “medically necessary services” in a manner that is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures, including the Medicaid Services Manual (MSM).	**Documents Submitted:** • 1278 Jun 2014 NV Check Up Revision (2) PGS 10-16 • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH PG 10-16 • 2013 Medicaid Nevada Check Up Medical Dental Plans • UM Process section 3.1.1 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X. Coverage and Authorization of Services

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: The HPN benefit package was described in the member handbooks and services were available to members in the same amount, duration and scope as services available to individuals in fee-for service Medicaid. As described in the UM Process policy, the health plan made UM determinations using the standardized nationally recognized Milliman Care Guidelines, as well as diagnosis or procedure-specific protocols ,e.g. Health Care Operations (HCO) protocols and/or UnitedHealthcare medical policies). The policy specified that the criteria HPN used for decision making was applied based on individual member needs in consideration of medical necessity, age, comorbidities, psychosocial issues, home environment when applicable and the presence of acute or life-threatening illness. The health plan provided the criterial to practitioners through its Web site or upon request. Service limitation and prior authorization criteria were addressed in the Provider Summary Guide. The HPN Prior Authorization Department was responsible for responding to authorization requests. HPN's application of the guidelines and protocols ensured that criteria were applied consistently. The health plan evaluated the accuracy and consistency of UM staff decision making via an annual assessment of inter-rater reliability which required a score of 90 percent or greater to pass.		
	Recommendations: None.		
42 CFR 438.210(a)(4)(ii)(A-C) *DHCFP Contract Section 4.2.1.5 (A–C)*	2. Covered Services The MCO addresses the extent to which it is responsible for covering services related to the following: a) The prevention, diagnosis, and treatment of health impairments; b) The ability to achieve age-appropriate growth and development; and c) The ability to attain, maintain or regain functional capacity.	**Documents Submitted:** • NVCheckUpMemberHandbook pg.10-14 • SmartChoiceNorthernChoiceMemberHandbook pg. 11-15 • UM Process section 3.1.2 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: UM Process Policy described the criteria were applied based on individual member needs, at a minimum the following conditions are considered when apply criteria to individual cases, age, comorbidities, complications, progress of treatment psychosocial situation, home environment, presence of acute or life-threatening illness.		

Standard X. Coverage and Authorization of Services

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations:		
42 CFR 438.210(b)(1) *DHCFP Contract Section 4.2.1.6*	3. Written Policies and Procedures The MCO has in place and follows, for itself and its subcontractors, written policies and procedures for the processing of requests for initial and continuing authorizations of services.	**Documents Submitted:** • 2013 HCO 100 UM Policy • PA-010 Prior Authorization (Routine Requests) • UM-03 Notification Only Process **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The HPN UM Policy included procedures for pre-service, concurrent review, inpatient case management, and post-service review; the Prior Authorization (Routine Requests) policy described how requests for prior authorization were obtained for a consult, procedure test, equipment, or other medical service; and the policy, Notification Only Process, described the procedures that allowed non-clinical personnel to provide notification for certain types of requests after ensuring that the member was eligible and benefits were consistent with the request.		
	Recommendations: None.		
42 CFR 438.206(b)(4) *DHCFP Contract Section 4.2.10*	4. Out-of-Network Services If the MCO's provider network is unable to provide medically necessary services covered under the plan to a particular member, the MCO must adequately and timely cover these services out-of-network for the member for a long as the MCO is unable to provide them	**Documents Submitted:** • UM Process section 3.1.3 • 2013 UM Program Eval FINAL pg. 55-57 • WRHCO 132 Out-of Plan Services for Medicaid and Nevada Check Up Members **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X. Coverage and Authorization of Services

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: The health plan had processes to provide medically necessary services to members from out-of-network providers when the medically necessary services were unavailable within its network. When an in-network provider was not available, the Out-of-Plan Services for Medicaid and Nevada Check Up Members policy stated that the plan would coordinate with the out of network provider , invite the provider to join the network, or negotiate a contract or letter of agreement to determine the reimbursement rate. The provider would be informed that they could not bill Medicaid members.		
	Recommendations: None.		
42 CFR 438.210(b)(2)(i) *DHCFP Contract Section 4.2.1.6*	5. Consistent Application of Review Criteria The MCO has in effect mechanisms to ensure consistent application of review criteria for authorization decisions and consult with the requesting and/or servicing provider, when necessary.	**Documents Submitted:** • 2013 UM Program Description FINAL pg. 5-12 • 2014 UM Program Description Final pg. 5-12 • PA-002 Peer to Peer Post Adverse Determination • PA-004 Pend process • UM Process sections 3.1 and 3.2 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: To ensure the inter-rater reliability of utilization review functions, the health plan evaluated the accuracy and consistency of UM staff decision making via an annual assessment of inter-rater reliability which required a score of 90 percent or greater to pass. The UM Program Description Final described the process and results of the most recent assessment process. Staff members described during the on-site interview that the scenarios were different each year and included a mix of routine and complex decisions.		
	Recommendations: None.		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.2.1.6	6. Monitoring Prior Authorization Requests The MCO monitors prior authorization requests. DHCFP, at its sole discretion, may require removal of the prior authorization requirement for various procedures based on reported approval data and any other relevant information.	**Documents Submitted:** • February Medicaid Approvals • WRHCO 298 Children with Special Health Care Needs (CSHCN) **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The plan provided an excel spread sheet, February Medicaid Approvals. Staff members described during the on-site interview the data was filtered and reviewed for various uses, for example, by provider to look for patterns of use. The 2013 UM Program Evaluation described the Prior Authorization Department's review of strengths and opportunities for improvement. The department had identified a lack of standardized reports as a barrier to trending which providers were not adhering to health plan guidelines and was collaborating with the Information Systems team to develop reports that would identify provider trends. The health plan's goals included in the 2013 UM Program Evaluation were to continue to encourage providers to submit prior authorization requests via the Web site and to educate them on the information required at submission in an effort to reduce denials for lack of clinical information. The health plan had identified its barriers and opportunities and was positively addressing methods to improve monitoring of prior authorization requests.		
	Recommendations: None.		
42 CFR 438.208(c)(1)(i) *42 CFR 438.208(c)(2)* *DHCFP Contract Section 4.2.8*	7. Assessing CSHCN The MCO implemented mechanisms to assess each member identified to the MCO as an individual with SHCN in order to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring.	**Documents Submitted:** • WRHCO 298 Children with Special Health Care Needs (CSHCN) **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The health plan had a policy, Children with Special Health Care needs (CSHCN). The policy described the process to assess members who were identified as an individual with special health care needs. The policy addressed situations in which the		

Standard X. Coverage and Authorization of Services

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	member had a treatment plan developed by another entity, e.g., the Nevada Early Intervention Services or School Based Health Services, and also for individuals who did not have another entity treatment plan. The health plan had a template assessment form for pediatric case management. Three of the ten records reviewed for Case Management record review were high risk pediatric members. The records documented that these members were assessed and care coordination services provided.		
	Recommendations: None.		
DHCFP Contract Section 4.2.8	8. Personnel Completing the Assessment The assessment of CSCN is completed by appropriate health care professionals.	**Documents Submitted:** • WRHCO 298 Children with Special Health Care Needs (CSHCN) **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The health plan had a pediatric assessment template and staff members reported that all assessments were completed by registered nurses. The three pediatric records reviewed for Case Management record review were all completed by registered nurses.		
	Recommendations: None.		
42 CFR 438.208 (c)(3) *42 CFR 438.208(c)(3)(i and ii)* *DHCFP Contract Section 4.2.8.1–3*	9. Treatment Plans for CSHCN The MCO produces a treatment plan for members with special health care needs who are determined through an assessment to need a course of treatment or regular care monitoring. The treatment plan is: a) Developed by the member's primary care provider with member participation, and in consultation with any specialists caring for the member; b) Approved by the MCO in a timely manner, if	**Documents Submitted:** • 2013 Medicaid Nevada Check Up Medical Dental Plans • Care Plan, Initial - CCM • UM Process Pages 1-2 • WRHCO 298 Children with Special Health Care Needs (CSHCN) **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	approval is required by the MCO; and, c) In accordance with any applicable State quality assurance and utilization review standards.		
	Findings: The three pediatric records reviewed for Case Management record review documented that the treatment plans were developed using the member's medical records and were provided to the primary care provider for signature and comment. All of the assessments and treatment plans were completed within one to five days of receipt of the referral and medically necessary services were authorized and provided timely.		
	Recommendations: None.		
42 CFR 438.208(c)(4) *DHCFP Contract Section 4.2.8*	9. CSHCN For members with special health care needs who are determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, the MCO has a mechanism in place to allow the members access to a specialist through a standing referral or an approved number of visits, as deemed appropriate for the member's condition and identified needs.	**Documents Submitted:** • WRHCO 298 Children with Special Health Care Needs (CSHCN) **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The policy, Children with Special Health Care Needs (CSHCN), stated that the pediatric case manager would collaborate with the medical director and the specialist to develop a referral/prior authorization for an estimated number of specialist visits for a member who required ongoing specialist care. The records reviewed provided evidence that members received timely referrals and authorizations as necessary.		
	Recommendations: None.		
42 CFR 438.114(c)(3)(i)	10. Emergency Services	**Documents Submitted:**	☒ Met

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.114(c)(3)(ii)(A and B) *42 CFR 438.114(d)(1)(i-ii)* *42 CFR 438.114(d)(3)* *DHCFP Contract Section 4.2.10.2*	The MCO covers and pays for emergency services regardless of whether the provider who furnished the services has a contract with the MCO. a) The MCO pays the out-of-network provider for emergency services, applying the "prudent layperson" definition of an emergency, rendered at a rate equivalent to that paid by DHCFP, unless otherwise mutually agreed to between the MCO and the party(ies) rendering service. b) No prior or post-authorization can be required for emergency care provided by either in-network or out-of-network providers. The MCO does not deny payment for treatment obtained when the member has an emergency medical condition and seeks emergency services, applying the "prudent layperson" definition of an emergency; this includes the prohibition against denying payment in those instances in which the absence of immediate medical attention would have resulted in placing the health of the member in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily part or organ. c) The MCO does not deny payment for emergency services treatment when a representative of the MCO instructs the member to seek emergency services care. d) Pursuant to 42 CFR 438.114, the MCO does not limit what constitutes an emergency medical condition as defined in this section on the basis of	• WRHCO 132 Out-of Plan Services for Medicaid and Nevada Check Up Members • 2013 UM Program Description FINAL pgs 35-36 **Description of Process:** N/A	☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	lists of diagnoses or symptoms, nor refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agency not notifying the member's PCP, MCO, or the DHCFP of the member's screening, and treatment within 10 calendar days of the presentation for emergency services. e) The attending physician or the provider actually treating the member is responsible for determining when the member is sufficiently stabilized for transfer or discharge and that determination is binding on the Vendor.		
	Findings: The policy, Out-of Plan Services for Medicaid and Nevada Check Up Members, stated that HPN would pay the network or non-network provider for emergency services, applying the prudent layperson definition of an emergency. It stated that neither prior or post authorization would be required for emergency care by contracted or non-network providers. The 2014 UM Program Description iterated that prior authorization was not required for emergency care provided by either in-network or out-of-network providers, applying the prudent layperson standard. It stated that post-stabilization care services were covered when the health plan did not respond to a request for approval within one hour of being requested. It stated the MCO would not deny payment for treatment obtained when the member had an emergency medical condition and sought emergency services, applying the "prudent layperson" definition of an emergency. The policy, HCO-100.12, Emergency Services-Evaluation, Stabilization, Post-Stabilization and Transfer, stated that the treating physician would make the determination as to when the member was considered stabilized for transfer or discharge.		
	Recommendations: None.		
42 CFR 438.114(d)(2) *DHCFP Contract Section 4.2.10.3 (A)*	11. Post-Stabilization Services The MCO is financially responsible for post-stabilization services obtained within or outside the network that are pre-approved by a network provider or organization	**Documents Submitted:** • WRHCO 132 Out-of Plan Services for Medicaid and Nevada Check Up Members	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	representative.	• 2013 UM Program Description FINAL pg 36 **Description of Process:** N/A	
	Findings: The Out-of Plan Services for Medicaid and Nevada Check Up Members policy stated that HPN would be financially responsible for post-stabilization services obtained within or outside the network that are pre-approved by a network provider or plan representative. The policy, HCO-100.12, Emergency Services-Evaluation, Stabilization, Post-Stabilization and Transfer stated that post-stabilization care services were covered when pre-approved and when they were not pre-approved but the health plan could not be contacted or failed to respond within one hour to the request for pre-approval by the provider of the post stabilization care services. The policy stated that the treating physician would make the determination as to when the member was considered stabilized for transfer or discharge.		
	Recommendations: None.		
DHCFP Contract Section 4.5.1.1–4	12. Adopting Practice Guidelines The MCO adopts practice guidelines and protocols which: a) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; b) Consider the needs of the MCO's members; c) Are adopted in consultation with contracting health care professionals; and d) Are reviewed and updated periodically as needed to reflect current practice standards.	**Documents Submitted:** • 2013 Clinical Practice Guidelines Policy • 2013 HCO 100 UM Policy pgs 7-8 • 2013 Provider Summary Guide pg. 94-95 • 2014 Provider Summary Guide pg. 93-94 • Asthma Guidelines_3-14 • Diabetes Guidelines_3-14 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: HPN has a series of clinical practice guidelines that were developed with the input and direction of HPN providers. In most cases, national expert consensus recommendations provided the basis for the final HPN guidelines. National expert recommendations were modified to be applicable to Nevada. Corporate policy was to review the guidelines at least every two years or more often if necessary.		
	Recommendations: None.		
DHCFP Contract Section 4.5.2.1–2	13. Dissemination of Practice Guidelines The MCO: a) Disseminates its practice guidelines to all affected providers prior to the contract start date and, upon request, to members and potential members, including prior authorization policies and procedures; and b) Ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply, are consistent with the guidelines.	**Documents Submitted:** • 2013 Clinical Practice Guidelines Policy- pg. 12-13 • 2013 Provider Summary Guide pg. 94-95- pg. 94-95 • 2014 Provider Summary Guide pg. 93-94- pg. 93-94 • Asthma Guidelines_3-14 • Diabetes Guidelines_3-14 • Faxblast Guidelines **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HPN distributed copies of clinical practice and preventive health guidelines to new providers during orientation and annually thereafter in the Provider Summary Guide. They were also available on the health plan's Web site. Revised or new clinical practice guidelines were distributed via a fax blast, announced in provider newsletter articles, and posted on the health plan web site. The HPN Provider Summary stated that the guidelines were considered a framework for physicians and other health care professionals to use, but the provider's clinical judgment could override the guideline if the provider felt that strict adherence to the guideline was not in the member's best interest. The Provider Summary stated that if the provider deviated from the guideline, he or she should indicate the rationale for the variation in the clinical record.		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None.		
DHCFP Contract Section 4.8.6.4	14. Monitoring Care Using Clinical Care Standards/Practice Guidelines The IQAP studies and other activities monitor quality of care against clinical care or health service delivery standards or practice guidelines specified for each area identified 4.8.6.2 (A)(e.g., Childhood Immunizations, Pregnancy, Cervical Cancer/Pap Smears, Comprehensive Well-Child Periodic Health Assessment, Lead Toxicity, Pregnancy Prevention and/or Family Planning, and Hearing and Vision Screening and Services) and 4.8.6.2. (B)(e.g., Access to Care, Utilization of Services, Coordination of Care, Continuity of Care, Health Education and Emergency Services).	**Documents Submitted:** • 2013 HPN Access and Availability Policy pg. 15-16; 20-22 • 2013 HPN and SHL QI Program Desc FINAL pg. 6-9; 24 • 2013 QI Program Eval FINAL pg. 80; 83-88; 91-97; 132-138; 160-161; 168-169 • 2013 UM Program Description-entire doc • 2014 HPN SHL QI Program Desc pg. 6-9; 23 • 2014 UM Program Description-entire doc • AMB_PIP Summary Form FINAL • CAP_PIP Summary Form_FINAL • Continuity and Coordination of Care Policy 2013 • EPSDT patient brochure • Medicaid ER Presentation **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HPN utilization management and quality improvement documentation substantiated that the health plan monitored clinical care and service delivery in accordance with its established guidelines. The Provider Summary Guide stated that provider compliance with the clinical guidelines was monitored by chart review and analysis of health care utilization data. HPN used current NCQA HEDIS methodology to monitor and report findings in the following clinical areas: • Children: childhood immunizations, lead screening, access to primary physicians, well child/adolescent visits, and access to		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	primary physicians. • Women: prenatal care, postpartum care, breast cancer screening, cervical cancer screening and osteoporosis management in women who had a fracture. • Adults: cholesterol management for individuals with cardiovascular conditions, controlling high blood pressure, colorectal cancer screening, glaucoma screening in older adults and persistence of beta-blockers after heart attack. • Chronic conditions: Comprehensive diabetes (eye exams, A1C testing, cholesterol screening and nephropathy monitoring), appropriate medication use for people with asthma, and follow-up appointments after hospitalization. The health plan conducted performance improvement project studies on avoidable emergency room use and children and adolescent access to primary care providers, and promoted its EPSDT program through member and provider newsletters and informational pamphlets.		
	Recommendations: None.		
DHCFP Contract Section 4.8.6.4 (B–G)	15. Use of Clinical Care Standards/Practice Guidelines The standards/guidelines: a) Are based on reasonable scientific evidence and developed or reviewed by the MCO's providers; b) Focus on the process and outcomes of health care delivery, as well as access to care; c) Provide a mechanism for continuously updating the standards/guidelines; d) Are included in provider manuals developed for use by MCO providers, or otherwise disseminated, including but not limited to dissemination on the provider website, to all affected providers as they are adopted and to all members and potential	**Documents Submitted:** • 2013 Clinical Practice Guidelines Policy • 2013 Provider Summary Guide-pg. 94-313 • 2014 Provider Summary Guide • Screenshot_Clinical Guidelines **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	members upon request; e) Address preventive health services; and f) Are developed for the full spectrum of populations enrolled in the plan.		
	Findings: HPN's clinical practice guidelines were developed with the input and direction of HPN providers. In most cases, national expert consensus recommendations provided the basis for the final HPN guidelines. For example, the guideline for heart failure had an embedded link to the American College of Cardiology/American Heart Association guidelines. The guidelines addressed the process and outcomes of treatment. The corporate policy was to review the guidelines at least every two years or more often if necessary. The guidelines were listed in the Provider Summary Guide and were posted on the HPN Web site. When revisions were made, providers were sent a FAX update. The guidelines included preventive aspects of care as well as treatment. There were 25 guidelines listed in the Provider Summary Guide and they included topics for treating children, adults with chronic conditions, and behavioral health; they addressed the full spectrum of populations enrolled in the plan.		
	Recommendations: None.		
DHCFP Contract Section 4.8.6.4 (H)	16. Evaluating Care Using the Clinical Care Standards/Practice Guidelines The IQAP uses these standards/guidelines to evaluate the quality of care provided by the MCO's providers, whether the providers are organized in groups, as individuals, or in combinations thereof.	**Documents Submitted:** • 2013 Clinical Practice Guidelines Policy pg 14-15 • 2013 HPN and SHL QI Program Desc FINAL pg. 5 • 2014 HPN SHL QI Program Desc pg. 5 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Clinical Practice Guidelines Policy described how the health plan measured performance of important aspects of select clinical practice guidelines most likely to impact health care. Performance on two important elements of four clinical practice guidelines was measured annually. The health plan documents described that it monitored primary care, obstetrical and		

Standard X. Coverage and Authorization of Services

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	gynecological, dental, mental health, substance abuse, and specialty provider' adherence to practice guidelines.		
	Recommendations: None.		
DHCFP Contract Section 4.8.6.5 (A)	17. Monitoring and Evaluating Quality Qualified clinicians monitor and evaluate quality through the review of individual cases where there are questions about care, and through studies analyzing patterns of clinical care and related service.	**Documents Submitted:** • 2013 HPN and SHL QI Program Desc-pg. 28-32 • 2014 HPN SHL QI Program Desc-pg. 26-30 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Quality Management Department staff monitored and evaluated quality through the review of individual cases when there were questions about quality of care. The department was staffed by nurse reviewers who had been trained to identify, investigate and evaluate potential quality of care issues. A registered nurse experienced in quality assurance managed the department and oversight was provided by the QM medical director. HPN tracked quality of care investigations to identify whether there were trends or patterns of issues that were provider specific or system-wide. On a quarterly basis, provider-specific reports by issue category were prepared for a rolling 24-month period and were analyzed by the QM nurse manager and medical director.		
	Recommendations: None.		
DHCFP Contract Section 4.8.17.1	18. Written Program Description for Utilization Review The MCO has a written utilization review management program description, which includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services.	**Documents Submitted:** • 2013 UM Program Description-entire doc • 2014 UM Program Description-entire doc **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: HPN had a comprehensive utilization review management program description; the plan provided both the 2013 and 2014 versions. The documents included the procedures the health plan used to evaluate medical necessity, the criteria used and information sources and process that were used to review and authorize services.		
	Recommendations: None.		
42 CFR 438.240(b)(3) *DHCFP Contract Section 4.8.17.2*	19. Scope of the Utilization Review Program The program has mechanisms to detect under-utilization as well as over-utilization.	**Documents Submitted:** • Over and Under Utilization Analysis **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The health plan annually conducted an analysis for potential over- and under-utilization. Documentation provided showed that utilization was monitored using HEDIS data that was collected in 2012, 2013 and 2014 for services provided in 2011, 2012 and 2013. The rates for all indicators were reported and compared to national benchmarks in order to determine areas of potential over- and under-utilization.		
	Recommendations: None.		
42 CFR 438.210(b)(2)(ii) *42 CFR 438.210(c)* *DHCFP Contract Section 4.8.17.3 (A–D)*	20. Pre-authorization and Concurrent Review Requirements For MCOs with pre-authorization or concurrent review programs: a) Pre-authorization and concurrent review decisions are supervised by qualified medical professionals; b) Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating	**Documents Submitted:** • 2013 UM Program Description-pg. 5-12 • 2014 UM Program Description-pg. 5-12 • ADT-01 Elective Adverse Determination Process (Denial) • ADT-02 Adverse Determination Team Provider contact SOP • PA-002 Peer to Peer Post Adverse Determination • PA-004 Pend process	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X. Coverage and Authorization of Services

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	physician, as necessary; c) The reasons for decisions are clearly documented and available to the recipient; d) The MCO's prior authorization policies and procedures must be consistent with provision of covered medically necessary medical and dental care in accordance with community standards of practice.	• UM Process Pages 1-2 • UM-03 Notification Only Process **Description of Process:** N/A	
	Findings: The HPN pre-authorization and concurrent review programs were supervised by qualified medical professionals. Prior authorization staff had the authority to approve all requests that met criteria and to refer potential adverse determination decisions to the medical director for review. The prior authorization unit was supervised by a registered nurse licensed in the state of Nevada. If an authorization request required more information, the case was pended by an RN. The health plan's procedure, Pend Process for Medicare/Medicaid and Commercial Prior Authorization Cases, required the prior authorization representative to send a fax request to the requesting provider requesting further information if more was needed. The Peer to Peer Post Adverse Determination procedure described that inpatient case management or prior authorization staff members offered peer to peer (P2P) communication when notifying the requesting physician of an adverse determination, if no discussion had occurred prior to the initial decision. The procedural steps were structured to ensure processing would occur within the allowable timeframes. The health plan's template adverse determination letter to members was written in easily understood language and offered the opportunity for the member's provider to contact the HPN medical director for further discussion. Adverse Determination letters to providers advised the requesting provider of the availability of P2P discussion.		
	Recommendations: None.		
42 CFR 438.6(h) *42 CFR 423.208* *42 XFR 438.210(d)(3)* *42 CFR 438.230(a)(1)*	21. Appeals, Grievances, and Provider Disputes Concerning the Utilization Review Program: a) There are mechanisms to evaluate the effects of the program using data on recipient satisfaction,	**Documents Submitted:** • 2013 UM Program Description-pg. 14-23 • 2014 UM Program Description-pg. 14-23 • Incentives	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.8.17.3 (G–I)	provider satisfaction or other measures; b) Consistent with 42 CFR 438.6(h) and 42 CFR 423.208, MCOs ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member; and, c) If the MCO delegates responsibility for utilization management, it has mechanisms to ensure that the delegate meets these standards.	**Description of Process:** N/A	
	Findings: HPN had mechanisms in place to evaluate the effects of the program. The health plan monitored over- and under-utilization. Annual provider satisfaction surveys were administered and results analyzed to measure the effectiveness of the programs. Ten elements on the provider satisfaction survey rated satisfaction with the prior authorization processes. HPN analyzed complaint and appeals data and conducted various member satisfaction surveys, e.g., complex case management, health management, and CAHPS. The health plan distributed a statement to all members and to all practitioners, stating that provides and employees who made UM decisions based decision only on appropriateness of care and eligibility and that the health plan did not reward practitioners or other individuals for denying services. The affirmative statement was posted on the Web site and distributed annually to the UM staff. The HPN UM Committee provided oversight to any delegated UM functions, including program descriptions, regular reports and annual audits.		
	Recommendations: None.		
DHCFP Contract Section 4.13.1.3, 4.13.1.5	22. Medical Director Responsibilities The Medical Director is responsible: a) To oversee the development and revision of the	**Documents Submitted:** • 2013 UM Program Description-pg. 31 • 2014 UM Program Description-pg. 31 • LT resume 2013 (Updated 12-13)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	MCO's clinical care standards and practice guidelines and protocols; and b) To oversee the MCO's referral process for specialty and out-of-network services.	**Description of Process:** N/A	
	Findings: The HPN UM Program Description and the resume' of the HPN Chief Medical Officer documented that the individual in this position was responsible for medical management strategy development and implementation to ensure that appropriate care and services provided to members met best practice standards and regulatory compliance requirements. This individual provided oversight of the development and revision of the HPN clinical guidelines and protocols and of the referral process for specialty and out-of-network services.		
	Recommendations: None.		
42 XFR 438.210(b)(2)(ii) *42 CFR 438.406(a)(3)(ii)(A-C)* *DHCFP Contract Section 2.12.1.5* *4.2.1.6, 4.13.1.5*	23. Clinical Expertise of Staff Denying Services All services prescribed by a PCP or requested by an enrollee which are denied by the MCO are reviewed by a physician, physician assistant, or advanced nurse practitioner with the reason for the denial being documented and logged. Any decision made by the MCO to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease	**Documents Submitted:** • 2013 UM Program Description-pg. 45-48 • 2014 UM Program Description-pg. 45-49 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Prior authorization staff had the authority to approve all situations that met criteria and were required to refer potential adverse determination decisions to the medical director for review. The policy, HCO 100.00, Utilization Management, specified that medical denial files were required to contain documentation that a physician reviewed all denial decisions for medical services made on the basis of medical necessity; the pharmaceutical denial files were required to contain		

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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	documentation to show that a physician or a pharmacist reviewed all denial decisions for pharmaceutical services on the basis of medical necessity; dental denial files were required to contain documentation that a physician or dentist reviewed all denial decisions for dental procedures on the basis of medical necessity; and that a physician, appropriate behavioral health practitioner or pharmacist, as appropriate, reviewed any behavioral health denial of care based on medical necessity.		
	Recommendations: None.		

Results for Standard X: Coverage and Authorization of Services							
Total	Met	=	23	X	1.00	=	23.0
	Partially Met	=	0	X	.50	=	0.0
	Not Met	=	0	X	.00	=	0.0
Total Applicable		=	23	**Total Score**		=	23.0

Total Score ÷ Total Applicable	=	100%

Standard XI. Provider Dispute and Complaint Resolution

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.8.22	1. Dispute Resolution The MCO maintains a provider services unit to handle provider questions and disputes.	**Documents Submitted:** • CRR Org Chart • Network Development Contracting_Provider Services_Credentialing Org Chart **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Government Programs Customer Response and Resolution Organizational Chart and the Network Development and Contracting/Provider Services/Credentialing for Medicaid Organizational Chart provided evidence of meeting the requirements of this element. Interviews with staff confirmed that provider disputes and complaints were handled by the Provider Services Department at HPN.		
	Recommendations: None.		
DHCFP Contract Section 4.8.22.1	2. Resolving Disputes The MCO resolves 90% of written, telephone or personal contacts within 90 calendar days of the date of receipt.	**Documents Submitted:** • WRHCO 350 Provider Contacts pg 2 • Medicaid Report_1Qtr14 • Medicaid Report_2Qtr14 Combined • Medicaid Report_3rd Qtr13 combined • Medicaid Report_4th Qtr13 combined **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Provider Contacts policy and the 2014 quarterly MCO Provider Grievance and Appeal Reports provided evidence of meeting the requirements of this element.		

Standard XI. Provider Dispute and Complaint Resolution

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None.		
DHCFP Contract Section 4.8.22.2	3. Log of Provider Disputes A written record in the form of a file or log is maintained by the MCO for each provider dispute to include the nature of it, the date filed, dates and nature of actions taken, and final resolution.	**Documents Submitted:** • WRHCO 275 Provider Grievances and Appeals • WRHCO 350 Provider Contacts pg 2.2 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The WRHCO 275 Provider Grievances and Appeals policy stipulated that a written or electronic record of the grievance or appeal was maintained to include a description of the issue, the date filed, dates and nature of actions taken, and the final resolution. Interviews with the Provider Services staff members confirmed that the department manager generated reports concerning provider disputes and monitored the resolution of the issues.		
	Recommendations: None.		
DHCFP Contract Section 4.11.7	4. Provider Grievances and Appeals The MCO establishes a process to resolve any provider grievances and appeals that are separate from, and not a party to, grievances and appeals submitted by providers on behalf of enrollees. Written Grievance and Appeals procedures must be included, for review and approval, at the time the MCO policies and procedures are submitted to the DHCFP and at any time thereafter when the MCO's provider grievance and appeals policies and procedures have been revised or updated. The MCO may not implement any policies and procedures concerning its provider grievance and appeal	**Documents Submitted:** • Contract Deliverable- Grievance Appeals Policy • WRHCO 275 Provider Grievances and Appeals **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI. Provider Dispute and Complaint Resolution

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	system without first obtaining the written approval of the DHCFP.		
	Findings: The Provider Grievances and Appeals policy and an email from DHCFP approving the HPN Grievance and Appeals Policy dated May 23, 2013 provided evidence of meeting the requirements of this element.		
	Recommendations: None.		
DHCFP Contract Section 4.11.7.1	5. Accepting Provider Grievances and Appeals When handling Grievances and Appeals: a. The MCO accepts written or oral grievances and appeals that are submitted directly by the provider as well as those that are submitted from other sources, including the DHCFP. b. An oral appeal must be followed by a written, signed appeal; however, the oral appeal must count as the initial date of appeal.	**Documents Submitted:** • Medicaid Grievances and Appeals Policy Final 6-1-13 • WRHCO 275 Provider Grievance and Appeals pg 3 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Medicaid Grievances and Appeals Policy provided evidence of meeting the requirement of this element. Interviews with staff confirmed that grievances and appeals may be submitted orally, and oral appeals must be followed by a written, signed appeal.		
	Recommendations: None.		
DHCFP Contract Section 4.11.7.1	6. Written Record of Provider Grievances and Appeals The MCO keeps a written or electronic record of each provider grievance and appeal to include a description of the issue, the date filed, the dates and nature of actions taken, and the final resolution.	**Documents Submitted:** • WRHCO 275 Provider Grievances and Appeals pg3 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI. Provider Dispute and Complaint Resolution

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: The Provider Grievances and Appeals policy provided evidence of meeting the requirements of this element. Interviews with staff confirmed that the department manager generated reports concerning provider disputes and monitored the resolution of the issues. Staff members also confirmed that the electronic records of each provider grievance and appeal included a description of the issue, the date filed, the dates and nature of actions taken, and the final resolution.		
	Recommendations: None.		
DHCFP Contract Section 4.11.7.1	7. Timing of Final Decisions The MCO issues a final decision, in writing, no later than: a. Ninety (90) days after a grievance is filed; and, b. Thirty (30) days after an appeal is filed.	**Documents Submitted:** • GPCRRltr 04-25-13 Medicaid Ack Letter • GPCRRltr 04-25-13 Medicaid Complaint Ack Letter • Medicaid Grievances and Appeals Policy Final 6-1-13 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Medicaid Grievances and Appeals Policy provided evidence of meeting the requirements of this element. Staff interviews and the grievance and appeals file reviews confirmed HPN's compliance with the standards.		
	Recommendations: None.		
42 CFR 431.200(b) *42 CFR 431.220(5)* *42 CFR 438.414;* *42 CFR 438.10(g)(1)* *DHCFP Contract Section 4.11.7.2*	8. State Fair Hearings Pursuant to Nevada Revised Statute 422.306, when a provider has exhausted the MCO's internal appeals process, the provider has the right to submit a written request to the DHCFP for a State Fair Hearing.	**Documents Submitted:** • WRHCO 275 Provider Grievances and Appeals pgs 3-4 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI. Provider Dispute and Complaint Resolution

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	The MCO notifies the provider of the right to request a State Fair Hearing at the time the provider enters into a contract with the MCO and when the outcome of an appeal is not wholly in favor of the provider pursuant to 42 CFR 431.200(b); 42 CFR 431.220(5); 42 CFR 438.414; and 42 CFR 438.10(g)(1).		
	Findings: The Medicaid Grievance and Appeals Policy outlined the process for providers to follow when requesting a State Fair Hearing after exhausting HPN's appeals process. The HPN Provider Summary Guide included a section explaining the process to request a Fair Hearing.		
	Recommendations: None.		
DHCFP Contract Section 4.11.7.2 (A–E)	9. Disputes Eligible for State Fair Hearings Disputes eligible for the State Fair Hearing process include: a. Denial or limited authorization of a requested service; b. Reduction, suspension or termination of a previously authorized service; c. Denial, in whole or in part, of payment for a service; d. Demand for recoupments; or, e. Failure of the MCO to meet specified timeframes (e.g., authorization, claims processing, appeal resolution).	**Documents Submitted:** • Medicaid Grievances and Appeals Policy Final 6-1-13 • WRHCO 275 Provider Grievances and Appeals page 3 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI. Provider Dispute and Complaint Resolution

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: The HPN Provider Summary Guide included a section delineating the requirements of this element.		
	Recommendations: None.		

Results for Standard XI: Provider Dispute and Complaint Resolution							
Total	Met	=	9	X	1.00	=	9.0
	Partially Met	=	0	X	.50	=	0.0
	Not Met	=	0	X	.00	=	0.0
Total Applicable		=	9	**Total Score**		=	9.0

Total Score ÷ Total Applicable	=	100%

Standard XII. Confidentiality and Recordkeeping

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.224 *DHCFP Contract Section 4.6*	1. Medical Records The MCO has written policies and procedures to maintain the confidentiality of all medical records and pursuant to Standard XII, Section 4.8.16, accessibility and availability or medical records, record keeping, and record review process. Not more than 10 calendar days after submitting a request, the State has access to a member's medical record, whether electronic or paper, and has the right to obtain copies at the MCO's expense.	**Documents Submitted:** • 2013 HIPAA Privacy Policy • Cred-Recred_Policy_CR 300.33 pg 60 • HPN Provider Summary Guide 2014 Section 8; 8.7 Medical Records pg 68 • HPN-SHL-SHO Hospital Template Article III H Records Reports and Billing 4 pg 6 • MEDICAID Consulting Provider Template Article III H Records and Reports 4 pg 5-6 • MEDICAID Primary Care Physician FFS Template Article III J Records and Reports 4 pg 5-6 **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Notice of Privacy Practices policy (Privacy Policy P1), the Clinical Medical Records Review policy (CR 200.00), and the Disclosures to Third Parties policy (Privacy Policy P9) provided evidence of written policies and procedures to maintain the confidentiality of medical records. The 2014 HPN Provider Summary Guide informed practitioners that they had 30 calendar days to produce medical records requested by HPN. The Medicaid PCP FFS Contract Template and the Medicaid Consulting Provider Template included the requirement that providers respond appropriately to all quality referred issues within a reasonable time frame but not to exceed 14 days of receipt. (pg. 7) The templates further stipulated that providers must cooperate with HPN in obtaining and/or allowing access to an enrollee's medical records, upon written request, within thirty (30) calendar days of request (pg. 17). HPN needs to review the inconsistent timeframes established in the policies, summary guide, and contract templates. HPN also needs to establish the requirements with the health plan produces medical records to DHCFP within 10 calendar days of receiving the request for records.		

Standard XII. Confidentiality and Recordkeeping

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: HPN must to establish the requirements with the health plan produces medical records to DHCFP within 10 calendar days of receiving the request for records.		
42 CFR 438.224 *DHCFP Contract Section 4.8.14.9*	2. Confidentiality of Patient Information The MCO acts to ensure that the confidentiality of specified patient information and records is protected.	**Documents Submitted:** • 2013 HIPAA Privacy Policy • Cred-Recred_Policy_CR 300.33 pg 60 • HPN Provider Summary Guide 2014 Section 8; 8.7 Medical Records pg 68 • HPN-SHL-SHO Hospital Template Article III H Records Reports and Billing 4 pg 6 • MEDICAID Consulting Provider Template Article III H Records and Reports 4 pg 5-6 • MEDICAID Primary Care Physician FFS Template Article III J Records and Reports 4 pg 5-6 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Notice of Privacy Practices policy included requirements concerning the use and disclosure of protected health information. The Clinical Medical Record Review policy (CR 300.33) contained confidentiality standards for medical records. The Standards of Provider Office Facilities template provided in the HPN Provider Summary Guide validated that during provider site visits, the HPN representative reviewed the requirement to have a written authorization form to release medical records and the need to ensure that records were released to the patient or the patient's authorized representative. During the site visits, the HPN representative also validated that records were stored in an area inaccessible to patient, or if electronic, the computer systems were password-protected to gain access to patient documents.		
	Recommendations: None.		

Standard XII. Confidentiality and Recordkeeping

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.224 *DHCFP Contract Section 4.8.14.9 (A)*	3. Policies and Procedures Regarding Confidentiality of Patient Information The MCO has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical record.	**Documents Submitted:** • 2013 HIPAA Privacy Policy • Cred-Recred_Policy_CR 300.33 pg 60 • HPN Provider Summary Guide 2014 Section 8; 8.7 Medical Records pg 68 • HPN-SHL-SHO Hospital Template Article III H Records Reports and Billing 4 pg 6 • IS Security Policy section 4.3.7 • MEDICAID Consulting Provider Template Article III H Records and Reports 4 pg 5-6 • MEDICAID Primary Care Physician FFS Template Article III J Records and Reports 4 pg 5-6 • **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Notice of Privacy Practices policy (Privacy Policy P1), the Clinical Medical Records Review policy (CR 200.00), and the Disclosures to Third Parties policy (Privacy Policy P9) provided evidence of written policies and procedures to maintain the confidentiality of medical records. Interviews with staff confirmed that upon hire and on an annual basis, employees receive training concerning confidentiality.		
	Recommendations: None.		
42 CFR 438.224 *DHCFP Contract Section 4.8.14.9. (B)*	4. Office Sites Maintaining Confidentiality of Patient Information The MCO ensures that patient care offices/sites have	**Documents Submitted:** • Cred-Recred_Policy_CR 300.33 pg 60 • HPN Provider Summary Guide 2014 Section 8; 8.7 Medical Records pg 68	☒ Met ☐ Partially Met ☐ Not Met

Standard XII. Confidentiality and Recordkeeping

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	implemented mechanisms to guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the MCO.	• HPN-SHL-SHO Hospital Template Article III H Records Reports and Billing 4 pg 6 • MEDICAID Consulting Provider Template Article III H Records and Reports 4 pg 5-6 • MEDICAID Primary Care Physician FFS Template Article III J Records and Reports 4 pg 5-6 **Description of Process:** N/A	☐ N/A
	Findings: The Notice of Privacy Practices policy (Privacy Policy P1), the Clinical Medical Records Review policy (CR 200.00), and the Disclosures to Third Parties policy (Privacy Policy P9) provided evidence of written policies and procedures to maintain the confidentiality of medical records. The Standards of Provider Office Facilities template provided in the HPN Provider Summary Guide validated that during provider site visits, the HPN representative reviewed the requirement to have a written authorization form to release medical records and the need to ensure that records were released to the patient or the patient's authorized representative. During the site visits, the HPN representative also validated that records were stored in an area inaccessible to patient, or if electronic, the computer systems were password-protected to gain access to patient documents.		
	Recommendations: None.		
42 CFR 438.224 *DHCFP Contract Section 4.8.14.9 (C)*	5. Releasing Confidentiality of Patient Information The MCO holds confidential all information obtained by its personnel about recipients related to their examination, care and treatment, and does not divulge it without the recipient's authorization, unless: a) It is required by law, or pursuant to a hearing	**Documents Submitted:** • 2013 HIPAA Policy 9 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XII. Confidentiality and Recordkeeping

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	request on the recipient's behalf; b) It is necessary to coordinate the recipient'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.		
	Findings: The Notice of Privacy Practices policy (Privacy Policy P1), the Clinical Medical Records Review policy (CR 200.00), and the Disclosures to Third Parties policy (Privacy Policy P9) provided evidence of written policies and procedures to maintain the confidentiality of medical records. The 2014 HPN Provider Summary Guide noted that medical records could be shared when necessary to coordinate the member's care with physicians, hospitals, or other health care entities. The Notification of Release of Information Pursuant to Court Order policy (WRHCO343) and the Disclosures to Third Parties policy provided information concerning the release of Medicaid member information in response to a court order. The Disclosures to Third Parties policy included a statement concerning the disclosure of protected health information to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.		
	Recommendations: None.		
42 CFR 438.224 *DHCFP Contract Section 4.8.14.9 (D)*	6. Reporting the Release of Confidential Patient Information The MCO reports any release of information in response to a court order to the recipient in a timely manner.	**Documents Submitted:** • WRHCO 343 Notification of Release of Information **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Notification of Release of Information Pursuant to Court Order policy (WRHCO343) stipulated that the member would be notified of the release of information in response to a court order within a timely manner.		
	Recommendations: None.		

Standard XII. Confidentiality and Recordkeeping

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.224 *DHCFP Contract Section 4.8.14.9.(E)*	7. Requirements for Confidentiality of Patient Information The MCO may disclose recipient records whether or not authorized by the recipient, 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:** • 2013 HIPAA Policy 9 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Disclosures to Third Parties policy (Privacy Policy P9) maintained that disclosure of PHI was allowed to health oversight agencies, such as state licensing agencies responsible for administering public health programs, or state licensing agencies for auditing purposes.		
	Recommendations: None.		
DHCFP Contract Section 4.8.16.1 (A)	8. Accessibility and Availability of Medical Records The MCO includes provisions in all provider contracts for HIPAA compliance with regard to access to medical records for purposes of quality reviews conducted by the Secretary of the United States Department of Health and Human Services (the Secretary), DHCFP, or agents thereof.	**Documents Submitted:** • HPN-SHL-SHO Hospital Template H 2 pg 5 and K 6 pg 7 • MEDICAID Consulting Provider TemplateH 1 pg 5 and K 7 pg 8 • MEDICAID Primary Care Physician FFS Template J 1 pg 5 and M 7 pg 8 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Medicaid PCP FFS Template contained the statements that the PCP agreed that HPN reserved the right to conduct periodic audits and/or site surveys for the purpose of evaluating compliance with quality management. The template further stipulated that HPN and applicable state and federal government agencies would have access at reasonable times to the books, records, and papers of the PCP relating to the health care services provided to members.		
	Recommendations: None.		

Standard XII. Confidentiality and Recordkeeping

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.8.16.1 (B)	9. Availability of Medical Records Records are available to health care practitioners at each encounter.	**Documents Submitted:** • HPN Provider Summary Guide 2014 Section 8; 8.7 Medical Records pg 68 • HPN-SHL-SHO Hospital Template H2 and H 4 pg 5_ K 2 pg 7 • MEDICAID Consulting Provider Template H1 and H 4 pg 5_K 2 pg 7 • MEDICAID Primary Care Physician FFS Template J 1 and J 4 pg 5_M 2 pg 7 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Clinical Medical Record Reviews policy (CR 300.33) included the statement that medical records and information pertinent to the provision of care provided to the member were available to authorized medical health care providers at the time of member visits.		
	Recommendations: None.		

Results for Standard XII: Confidentiality and Recordkeeping							
Total	Met	=	8	X	1.00	=	8.0
	Partially Met	=	1	X	.50	=	0.5
	Not Met	=	0	X	.00	=	0.0
Total Applicable		=	9	**Total Score**		=	8.5

Total Score ÷ Total Applicable	=	94.4%

Standard XIII. Provider Information

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.5.8.2 (A)	1. Provider Workshops The MCO conducts, at least annually, provider workshops in the geographic service area to accommodate each provider site. The MCO also must conduct sessions for each discrete class of providers whenever the volume of recent changes in policy or procedures in a provider area warrants such a session. All sessions reinforce the need for providers to verify recipient eligibility and enrollment prior to rendering services in order to ensure that the recipient is Medicaid-eligible and that claims are submitted to the responsible entity. Individual provider site visits will suffice for the annual training requirement.	**Documents Submitted:** • 100-3 Provider Site Visit Policy **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HPN conducted individual provider site visits in lieu of annual provider workshops. The HPN Provider Site Visit Policy described the process for the initial provider site visit and ongoing annual site visits for SmartChoice /Nevada Check-Up providers. At the site visit, health plan provider services advocates delivered applicable educational material that included the Provider Summary Guides, provider directories applicable to the contract affiliation, provider newsletters, and educational pamphlets. The provider service advocates served as a direct point of contact for the assigned providers. During the on-site review, health plan staff provided an accounting of site visits conducted by the provider service advocates.		
	Recommendations: None		
DHCFP Contract Section 4.5.8.2. (C)	2. Posting on Website The MCO must publish newsletters and announcements regarding provider workshops on the MCO's Website.	**Documents Submitted:** • Online Verification of Medicaid Newsletter posted at www.myhpnmedicaid.com **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIII. Provider Information

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		N/A	
	Findings: The health plan mailed provider newsletters to providers, notified them via fax blast that they were also available on the website		
	Recommendations: None.		
DHCFP Contract Section 4.5.8.2. (B)	3. Provider Newsletter The MCO publishes, subject to the prior review and approval of DHCFP, a semi-annual newsletter for network providers. DHCFP must prior approve all provider announcements, regardless of method of dissemination. If the DHCFP does not respond within 10 days, the newsletter is considered approved.	**Documents Submitted:** • Approved HPN Provider Newsletter Summer 2013 • Approved HPN Provider Newsletter Summer 2014 • Approved HPN Provider Newsletter Winter 2013 • HPN Provider Newsletter Summer 2013 • HPN Provider Newsletter Summer 2014 • HPN Provider Newsletter Winter 2013 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The health plan submitted its semi-annual newsletters to DHCFP for approval prior to distributing and publishing on the website. HPN provided documentation of the approval process.		
	Recommendations: None.		

Results for Standard XIII: Provider Information							
Total	Met	=	3	X	1.00	=	3.0
	Partially Met	=	0	X	.50	=	0.0
	Not Met	=	0	X	.00	=	0.0
Total Applicable		=	3	**Total Score**		=	3.0

Total Score ÷ Total Applicable	=	100%

Standard XIV. Enrollment and Disenrollment

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.3.5.1	1. Changing MCOs Recipients are locked into their MCO, with the exceptions of disenrollment due to good cause and during an annual open enrollment period.	**Documents Submitted:** • MEDICAID DISENROLLMENT--HANDLING MEMBER REQUESTS MS078C • WRHCO 284 Disenrollment at the Request of a Medicaid or Nevada Check Up **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The HPN policy, Medicaid Disenrollment–Handling Member Requests, included a policy statement and the specific procedures to ensure that members were locked into the health plan enrollment with three exceptions: during open enrollment, during the first 90 days of enrollment, and if they had a qualifying "good cause reason."		
	Recommendations: None.		
42 CFR 438.56(c)(2)(i-iii) *42 CFR 438.56(g)* *DHCFP Contract Section 4.3.5.1; 4.3.4; Amendment 3*	2. Open Enrollment and Automatic Enrollment/Re-enrollment During open enrollment, held at least once per year, recipients are free to change MCOs. Recipients who elect to change MCOs after open enrollment or who are automatically enrolled/re-enrolled will have 90 days to request membership in the other MCO. The only exceptions to this policy are recipients who lost their Medicaid or Nevada Check Up eligibility for less than two months: They will not be allowed to change MCO's without cause	**Documents Submitted:** • MEDICAID DISENROLLMENT--HANDLING MEMBER REQUESTS MS078C • WRHCO 284 Disenrollment at the Request of a Medicaid or Nevada Check Up **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XIV. Enrollment and Disenrollment

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	until the next open enrollment period.		
	Findings: The HPN policy, Medicaid Disenrollment–Handling Member Requests, included the procedures to ensure that during the annual open enrollment period, members could disenroll from the health plan and that member who elected to change health plans after open enrollment or who had been automatically enrolled/re-enrolled, had 90 days to request to switch health plans. The policy and flow-chart training aid within it, did not identify the exception that members who had lost their Medicaid or Nevada Check Up eligibility for less than two months and who were automatically reenrolled, would not be allowed to change MCO's without cause until the next open enrollment period. The policy identified a process for members who lost eligibility for longer than six months, but did not address those who were automatically reenrolled after an eligibility break of less than two months. Additionally, the June 2014 revision of the SmartChoice member handbooks informed members that if they lost eligibility for a short time and got back on Medicaid, they would be an HPN member again, "unless you choose another health plan." Similarly, the June 2014 Nevada Check Up handbook stated that if a child lost coverage for a short time and was reenrolled within the year, they would be an HPN member unless the parent chose another plan for the child. Recipients who lose their Medicaid or Nevada Check Up eligibility for two months or more are allowed a ninety day right to change period, but members with less than a two month break are not allowed the 90-day right to change.		
	Recommendations: HPN should ensure that its policy, procedures, and member materials align with contract requirements that members automatically enrolled after a break in eligibility of less than two months may not be allowed to disenroll without cause until the next open enrollment period.		
42 CFR 438.56(d)(1)(i-ii) *DHCFP Contract Section 4.3.5.1*	3. Request for Disenrollment during Lock-in Once locked in to an MCO, if a recipient wishes to disenroll during the lock-in period, he or she must notify their MCO in writing.	**Documents Submitted:** • MEDICAID DISENROLLMENT--HANDLING MEMBER REQUESTS MS078C • WRHCO 284 Disenrollment at the Request of a Medicaid or Nevada Check Up **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIV. Enrollment and Disenrollment

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: The HPN policy, Medicaid Disenrollment–Handling Member Requests, included procedures to ensure that members requesting disenrollment provided written notification. Members were sent a Medicaid disenrollment packet that included a letter and a disenrollment request form to complete.		
	Recommendations: None.		
42 CFR 438.56(b)(1) *42 CFR 438.56(c)(1)* *42 CFR 438.56(c)(2)(iv)* *42 CFR 438.56(d)(2)(i-iv)* *42 CFR 438.56(d)(3)(i)* *DHCFP Contract Section 4.3.5.1*	4. Good Cause for Member Disenrollment A member may request disenrollment from the MCO with cause at any time. Good cause for disenrollment includes: a) The recipient moves out of the MCO service area; b) The MCO does not, because of moral or religious objections, cover the service the recipient seeks; c) The recipient needs related services to be performed at the same time; not all related services are available within the network; and the recipient's PCP or another provider determines that receiving the services separately would subject the recipient to unnecessary risk. d) Other reasons, not limited to poor quality of care, lack of access to services covered under the contract, lack of access to providers experienced in dealing with the recipient's health care needs, or when the State imposes intermediate sanctions.	**Documents Submitted:** • WRHCO 284 Disenrollment at the Request of a Medicaid or Nevada Check Up **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The HPN policy, WRHCO 284 Disenrollment at the Request of a Medicaid or Nevada Check Up Member detailed the good-cause reasons which would allow approval of a member's request for disenrollment from the health plan.		

Standard XIV. Enrollment and Disenrollment

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Recommendations: None.		
DHCFP Contract Section 4.3.5.1	5. MCO-Requested Disenrollment If the MCO determines that there is sufficient cause to disenroll, the MCO will notify DHCFP's Business Lines Unit by fax using the form supplied in the RFP. The MCO must make a determination as expeditiously as the member's health requires and within a timeline that may not exceed 14 calendar days following the receipt of request for disenrollment.	**Documents Submitted:** • WRHCO 284 Disenrollment at the Request of a Medicaid or Nevada Check Up **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The HPN policy, WRHCO 284 Disenrollment at the Request of a Medicaid or Nevada Check Up Member, included the requirement that when the health plan determined that there was sufficient cause to disenroll a member, HPN would notify the DHCFP's Business Lines Unit by fax within 14 days of having received the member's request for disenrollment.		
	Recommendations: None.		
DHCFP Contract Section 4.3.5.2	6. Disenrollment at the Request of the MCO The MCO may request disenrollment of a recipient if the continued enrollment of the member seriously impairs the MCO's ability to furnish service to either the particular member or other members. The MCO must confirm that the member has been referred to the MCO's Enrollee 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:** • DHCFP Approval to Disenroll • Involuntary Disenrollment letter • Disenrollment letter 2-20-14 • WRHCO 351 Disenrollment at the Request of HPN **Description of Process:** During the audit time period, HPN sought to disenroll a member for the first time, pursuant to section	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIV. Enrollment and Disenrollment

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		4.3.5.2 of the Medicaid contract #1988. Documents used in this process have been uploaded for review. Policy WRCHO #351 was implemented as a result, in November 2014. N/A	
	Findings: HPN had recently developed a policy to request disenrollment of a recipient. The policy, Disenrollment at the Request of HPN, was implemented in November 2014. The health plan documented that it had attempted to accommodate a particular member and that its request to disenroll the member had been approved by DHCFP.		
	Recommendations: None.		
DHCFP Contract Section 4.3.5.1	7. DHCFP's Determination of the MCO's Disenrollment Request DHCFP will make a determination on an MCO disenrollment request within five days.	**Documents Submitted:** • WRHCO 351 Disenrollment at the Request of HPN **Description of Process:** During the audit time period, HPN sought to disenroll a member for the first time, pursuant to section 4.3.5.2 of the Medicaid contract #1988. Documents used in this process have been uploaded for review. Policy WRCHO #351 was implemented as a result, in November 2014.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: During the audit time period, HPN sought to disenroll a member for the first time, pursuant to section 4.3.5.2 of the Medicaid contract #1988. Documents used in this process were provided for review. The Disenrollment at the Request of HPN policy		

Standard XIV. Enrollment and Disenrollment

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	was adopted. The health plan submitted the request to DHCFP. At the time of the audit, the appeal process was still in process.		
	Recommendations: None.		
42 CFR 438.56(d)(5)(i) *42 CFR 438.56(e)(1-2)* *DHCFP Contract Section 4.3.5.1*	8. Use of the MCO's Grievance System DHCFP requires that the recipient seek redress through the MCO's grievance system before making a determination on the recipient's request. IF the grievance system is used, the 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 recipient files the request.	**Documents Submitted:** • WRHCO 351 Disenrollment at the Request of HPN **Description of Process:** During the audit time period, HPN sought to disenroll a member for the first time, pursuant to section 4.3.5.2 of the Medicaid contract #1988. Documents used in this process have been uploaded for review. Policy WRCHO #351 was implemented as a result, in November 2014.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HPN provided documentation that the member was provided appeal rights information with the disenrollment letter. Health plan staff members reported that the member was currently exercising his appeal rights.		
	Recommendations: None.		
DHCFP Contract Section 4.3.5.1	9. Appeal Rights Appeal rights must be included with the Notice of Decision to include the member's right to a State Fair Hearing, how to obtain a hearing, and representation rules.	**Documents Submitted:** • WRHCO 351 Disenrollment at the Request of HPN **Description of Process:** During the audit time period, HPN sought to disenroll a	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIV. Enrollment and Disenrollment

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
		member for the first time, pursuant to section 4.3.5.2 of the Medicaid contract #1988. Documents used in this process have been uploaded for review. Policy WRCHO #351 was implemented as a result, in November 2014.	
	Findings: HPN provided documentation that the member was provided appeal rights information with the disenrollment letter which included the member's right to a State Fair Hearing, how to obtain a hearing, and representation rules.		
	Recommendations: None.		
42 CFR 438.56(d)(3)(ii) *42 CFR 438.56€(2)* *DHCFP Contract Section 4.3.5.1; 4.3.5.2*	10. Failure to Act If the MCO or State agency fails to make a disenrollment determination so that the recipient can be disenrolled within the timeframes specified, the disenrollment is considered approved.	**Documents Submitted:** • WRHCO 351 Disenrollment at the Request of HPN **Description of Process:** During the audit time period, HPN sought to disenroll a member for the first time, pursuant to section 4.3.5.2 of the Medicaid contract #1988. Documents used in this process have been uploaded for review. Policy WRCHO #351 was implemented as a result, in November 2014.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The HPN policy, Medicaid Disenrollment–Handling Member Requests, required that the plan would make a decision on a disenrollment request within 14 days of the receipt of the written request. Health plan staff members estimated that there had only been two out of 500 hundred requests that had not been processed within the specified timeframe. The policy, Disenrollment at the Request of a Medicaid or Nevada Check Up member specified that if HPN or the State (whichever was responsible) failed to make a		

Standard XIV. Enrollment and Disenrollment

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	disenrollment determination so that the recipient could be dis-enrolled within the timeframes specified, the disenrollment would be considered approved. Health plan staff members estimated that there had only been two out of 500 hundred requests that had not been processed within the specified timeframe.		
	Recommendations: None.		
42 CFR 438.56(b)(2) *DHCFP Contract Section 4.11.7.2 (A–E)*	11. Reasons an MCO May Not Request Disenrollment The MCO may not request disenrollment of a member for any of the following reasons: 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.	**Documents Submitted:** • WRHCO 351 Disenrollment at the Request of HPN **Description of Process:** During the audit time period, HPN sought to disenroll a member for the first time, pursuant to section 4.3.5.2 of the Medicaid contract #1988. Documents used in this process have been uploaded for review. Policy WRCHO #351 was implemented as a result, in November 2014.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIV. Enrollment and Disenrollment

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	Findings: The Disenrollment at the Request of HPN policy stated that the health plan could request to disenroll a member who seriously impaired its ability to furnish services to that member or any other member. It listed the reasons that could not be used for a disenrollment request which included, verbatim, the items listed above in (a) through (g).		
	Recommendations: None.		

Results for Standard XIV: Enrollment and Disenrollment							
Total	Met	=	10	X	1.00	=	10.0
	Partially Met	=	1	X	.50	=	0.5
	Not Met	=	0	X	.00	=	0.0
Total Applicable		=	11	**Total Score**		=	10.5

Total Score ÷ Total Applicable	=	95.4%

Summary of Scores for All IQAP Standards

IQAP Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				M	*PM*	*NM*	*NA*	
I	Internal Quality Assurance Program	**54**	54	53	1	0	0	**99.1%**
II	Credentialing and Recredentialing	**16**	15	15	0	0	1	**100.0%**
III	Member Rights and Responsibilities	**14**	14	13	1	0	0	**96.4%**
IV	Member Information	**14**	14	14	0	0	0	**100.0%**
V	Availability and Accessibility of Services	**28**	28	27	1	0	0	**98.2%**
VI	Continuity and Coordination of Care	**16**	16	16	0	0	0	**100.0%**
VII	Grievances and Appeals	**35**	35	31	3	1	0	**92.9%**
VIII	Subcontracts and Delegation	**13**	12	10	2	0	1	**91.7%**
IX	Cultural Competency Program	**16**	16	14	2	0	0	**93.8%**
X	Coverage and Authorization of Services	**23**	23	23	0	0	0	**100.0%**
XI	Provider Dispute and Complaint Resolution	**9**	9	9	0	0	0	**100.0%**
XII	Confidentiality and Record Keeping	**9**	9	8	1	0	0	**94.4%**
XIII	Provider Information	**3**	3	3	0	0	0	**100.0%**
XIV	Enrollment/Disenrollment	**11**	11	10	1	0	0	**95.5%**
	Total Compliance Score	**261**	**259**	**246**	**12**	**0**	**0**	**97.3%**

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

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

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

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

Standard I. Internal Quality Assurance Program

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.8.6.2 (A)	17. Clinical Areas The following are recommended clinical areas of concern to be included in the evaluation: a) Childhood Immunizations (monitoring will be required by DHCFP for recipients); b) Pregnancy (monitoring will be required by DHCFP for recipients); c) Cervical Cancer/Pap Smears (monitoring will be required by the State of Nevada Health Division); d) Comprehensive Well-Child Periodic Health Assessment (will be required by DHCFP for recipients); e) Lead Toxicity (screening required under EPSDT guidelines); f) Pregnancy Prevention and/or Family Planning (monitoring will be required by DHCFP for recipients); g) Hearing and Vision Screening and Services for Medicaid members less than twenty-one (21) years of age (will be required by DHCFP for recipients).	**Documents Submitted:** • 01NVUHC1414 Prenatal Class Mailer • 1278 Jun 2014 NV Check Up Revision (2) PG 15 • 1858 Well Child Self Mailer • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH PG 16 • 2011 Birth Control Options • 2013 QI Program Eval-pg. 80; 83-88; 91-113 • 21NVHP13484 Look Out For Lead Card • 21NVHPN14170 REVISED Well Child Incentive Mailer • 21NVMDCD11732 Healthy Expectations Brochure • 21NVMDCD13483 Prenatal Care Brochure • EPSDT report 2013-2014 **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2013 HPN and SHL QI Program Description and the 2014 HPN and SHL QI Program Description provided evidence of the quality of care studies and other clinical quality improvement activities undertaken by HPN for each year. The QI work plans for each year provided evidence of HPN's tracking of the activities and issues over time. The QI evaluations provided evidence of HPN's evaluation of all of the quality activities that occurred for the Medicaid and Nevada Check Up population, which included the		

Standard I. Internal Quality Assurance Program

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	goals and objectives outlined in the DHCFP State Quality Strategy and the HEDIS and PIP performance measures that are required as part of the external quality review activities. Items a-e in this element were contained in the QI evaluations for both 2013 and 2014. For item f, HPN staff reported that family planning visits were monitored through the HEDIS measure, *Postpartum Care*. The 2014 HEDIS administrative and hybrid measure specifications for *Postpartum Care* did not specifically require contraceptive counseling to be included in the numerator specifications for the measure, *Postpartum Care*. Further, the *Postpartum Care* HEDIS measure only tracked those women who had a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year. The measure did not include women who did not have a live birth within the same period of time. For item g, HPN staff stated that hearing and vision screening services were part of the EPSDT program; however, the QI evaluations for 2013 and 2014 did not include an evaluation of EPSDT services that were provided for the year. HPN staff stated that the EPSDT service evaluations were included in prior years' QI evaluations and the information will be included in the 2015 evaluation.		
	Recommendations: The MCO must ensure that the following are included in its annual quality evaluations: pregnancy prevention and/or family planning and hearing and vision screening and services for Medicaid members less than twenty-one (21) years of age.		
HPN Plan to Correct:	**Plan to Remedy Deficiency:**	**Person Responsible:**	**Timeline/Completion Date:**
DHCFP Response:			

Standard III. Member Rights and Responsibilities

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.8.14.10	11. Treatment of Minors The MCO has written policies regarding the treatment of minors.	**Documents Submitted:** • 1278 Jun 2014 NV Check Up Revision (2) pg 21 • 1278 Jun 2014 revision Nv Check Up span pg 21 • 1936 Jun 2014 revision_smartchoice ENGLISH SPANISH pg 21-22 • Nevada Privacy Policy • Prov Summary Guide Section 8 Medicaid Members Sect 8.8 **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Nevada Privacy Policy included requirements regarding handling of protected health information (PHI) for emancipated and unemancipated minors. The Check Up and SmartChoice handbooks included information relevant to making advance directives for children 18 and over. The on-site review included a discussion with health plan staff members regarding additional policy topics the health plan should consider adopting which could include family planning for individuals of childbearing age who are eligible under the State plan and who desire such services and supplies, treatment of minors in emergency situations, minors who are parents, and minors who are married.		
	Recommendations: HPN should adopt a written policy or polices regarding the treatment of minors.		

HPN Plan to Correct:	**Plan to Remedy Deficiency:**	**Person Responsible:**	**Timeline/Completion Date:**
DHCFP Response:			

Standard V. Availability and Accessibility of Services

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.4.3.2	12. Twenty-five (25) Mile Rule The MCO offers every enrolled recipient a PCP or PCS located within a reasonable distance from the enrolled recipient's place of residence, but in any event, the PCP or PCS may not be more than twenty-five (25) miles from the enrolled recipient's place of residence per NAC 695C.160 without the written request of the recipient.	**Documents Submitted:** • 2013 HPN Access and Availability Policy QI 222.06; 3.3 pg 13 • HPN Network Adequacy sec 4_2nd Qtr 2014 • HPN Network Adequacy sec 4_2nd Qtr 2014_Hosp • HPN Network Adequacy_3rd Q 2013 • HPN Network Adequacy_3rd Q 2013_Hosp • HPN Network Hospital Adequacy_1st Q 2014 • HPN Network Hospital Adequacy_1st Q 2014_Hosp • HPN Network Hospital Adequacy_4thQ 2013 • HPN Network Hospital Adequacy_4thQ 2013_Hosp **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Availability Standards for Geographic Distribution of Practitioners policy provided evidence that HPN required the 25-mile rule for Medicaid Primary Physicians and Dentists. The Medicaid Access Availability Reports for the second quarter of 2014, however, indicated that there were 71 members in Washoe County who did not have access to a PCP within a 25 miles radius.		
	Recommendations: HPN needs to ensure that all members have a PCP that is 25 miles or closer to the member's place of residence unless HPN has a written request from the member to allow assignment to a PCP that is greater than 25 miles from the member's place of residence.		

Standard V. Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
HPN Plan to Correct:	**Plan to Remedy Deficiency:**	**Person Responsible:**	**Timeline/Completion Date:**
DHCFP Response:			

Standard VII. Grievances and Appeals

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.404(c)(4) *DHCFP Contract Section 4.11.3.21*	20. Notice of Actions Requirements The notice of actions must include: a) The enrollee's right to file a grievance if he or she disagrees with that decision; and b) The enrollee's right to receive written resolution notice, and reasonable efforts are to be made to provide oral resolution notice.	**Documents Submitted:** • 2013 HCO 100 UM Policy pg. 40 • Medicaid pre-service denial template page 6,7,10,11 **Description of Process:** N/A	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
	Findings: This federal requirement (42 CFR 438.404(c)(4)) refers to the language that must be contained in an MCO's notice to extend the timeframe to make a decision about a service authorization request, if the MCO required more than 14 calendar days to make a decision. The HPN policies and procedures related to notices of decisions, denials, appeals, or grievances did not contain the requirement to notify enrollees about their right to file a grievance if they disagreed with the MCO's decision to extend the timeframe for rendering a service authorization decision. The policies did contain the requirement that the MCO make authorization decisions within 14 calendar days of receiving the request. The language in the DHCFP/MCO contract for this requirement was listed under notice of action (Section 4.11.3). Notices of decisions, however, occur before a decision to deny, reduce, suspend, or terminate (otherwise known as, "action") would be rendered. DHCFP staff stated that the location of the language in the contract should be moved to Section 4.11.2, Authorization and Notice Timeliness Requirements, to make it more clear in the contract. HPN staff stated that they processed all service authorization requests within 14 calendar days.		
	Recommendations: The MCO must inform the enrollee of his or her right to file a grievance if he or she disagrees with the MCO's decision to extend the timeframe to make a service authorization decision. The notice provided to enrollees must also inform the enrollee that he or she has a right to receive written resolution of the grievance.		

HPN Plan to Correct:	**Plan to Remedy Deficiency:**	**Person Responsible:**	**Timeline/Completion Date:**
DHCFP Response:			

Standard VII. Grievances and Appeals

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.404(c)(5 and 6) *42 CFR 438.406(c)(6)* *42 CFR 438.408(b)(1 and 2)* *42 CFR 438.408(d)(1)* *42 CFR 438.408(d)(2)(i)* *DHCFP Contract Section 4.11.4.1–3*	21. Handling of Grievances and HMO Appeals The MCO is required to dispose of each grievance and resolve each appeal and to provide notice as expeditiously as the enrollee'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 days from the date of receipt of the grievance. b) Standard resolution of appeals: The MCO is allowed no more than 30 days from the date of receipt of the appeal. c) Expedited resolution of appeals: The MCO is allowed up to three working days from the date of receipt of the appeal.	**Documents Submitted:** • 2013 HCO 100 UM Policy-pg. 42-50 • Medicaid Grievances and Appeals Policy Final 6-1-13 • NVCheckUpMemberHandbook-pg. 26 • SmartChoiceNorthernChoiceMemberHandbook-pg. 27 **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The document, 2013 HCO 100 UM Policy, contained the required timeframes for resolving appeals. The policy also contained the requirements for resolving expedited appeals within 72 hours (3 working days). The document, Medicaid Grievances and Appeals Policy Final 6-1-13, included the process for resolving grievances within 90 days of receipt of the grievance. The Nevada Check Up and Medicaid member handbooks provided evidence that the resolution requirements were communicated to members. The on-site review of grievance files provided evidence that the MCO resolved all grievances within the required timeframe of 90 days. The on-site file review of appeals provided evidence that the MCO resolved all standard appeals within the required timeframe of 30 days. The file review of expedited appeals, however, showed that one of the four expedited appeal files reviewed was not resolved within three working days.		
	Recommendations: HPN must ensure that expedited appeals are resolved within the required timeframe, up to three working days from the date of the receipt of the appeal.		

Standard VII. Grievances and Appeals

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
HPN Plan to Correct:	**Plan to Remedy Deficiency:**	**Person Responsible:**	**Timeline/Completion Date:**
DHCFP Response:			
42 CFR 438.408(d)(2)(i) *42 CFR 438.410(a and b)* *42 CFR 438.410(c)(1 and 2)* *DHCFP Contract Section 4.11.4.3–5*	22. Expedited Review Process for Appeals The MCO establishes and maintains an expedited review process for appeals when the MCO determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. a) The MCO ensures that punitive action is not taken against a provider who supports an expedited appeal. b) If the MCO denies a request for an expedited resolution of an appeal, it must transfer the appeal to the standard resolution of appeals and make reasonable efforts to give the enrollee oral notice of the denial and follow up within two calendar days with a written notice. c) The MCO must inform the enrollee of the limited time available to present evidence and allegations of fact or law, in person or in writing, in the case of the expedited resolution. d) These time frames may be extended up to 14 days	**Documents Submitted:** • GPCRRltr 04-25-13 Medicaid 14 day appeal extension • GPCRRltr 04-25-13 Medicaid Expedited Ack Letter • GPCRRltr 04-25-13 Medicaid expedited appeal denial • Medicaid Grievances and Appeals Policy Final 6-1-13 **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VII. Grievances and Appeals

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	if the enrollee requests such an extension or the MCO demonstrates to the satisfaction of the DHCFP that there is a need for additional information and how the extension is in the enrollee's interests. e) If the State grants the MCO's request for an extension, the MCO gives the enrollee written notice of the reason for the delay.		
	Findings: The document, Medicaid Grievances and Appeals Policy Final 6-1-13, included information that met the requirements of items b through e of this element. The Provider Summary Guide provided evidence that the MCO informed providers of the expedited review process for appeals. Neither document, however, contained information that the MCO ensured that punitive action was not taken against a provider who supports an expedited appeal.		
	Recommendations: The MCO must ensure that its process for expedited appeals includes the provision that the MCO does not take punitive action against a provider who supports an expedited appeal.		
HPN Plan to Correct:	**Plan to Remedy Deficiency:**	**Person Responsible:**	**Timeline/Completion Date:**
DHCFP Response:			
42 CFR 438.10(g)(1)(iv-v) *42 CFR 438.406(a)(1 and 2)* *42 CFR 438.406(a)(3)(i)* *42 CFR 438.406(a)(3)(ii)(A-C)* *DHCFP Contract Section 4.11.4.6–9*	23. Notification of Disposition of Grievances and Appeals In handling grievances and appeals, the MCO meets the following requirements: a) The MCO provides enrollees any reasonable assistance in completing forms and taking other procedural steps, including assisting the enrollee and/or the enrollee's representative to arrange for	**Documents Submitted:** • GPCRRltr 04-25-13 Medicaid Ack Letter • GPCRRltr 04-25-13 Medicaid Complaint Ack Letter • Medicaid Grievances and Appeals Policy Final 6-1-13 **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VII. Grievances and Appeals

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	non-emergency transportation services to attend and be available to present evidence at the appeal hearing. This also includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability; b) Acknowledge receipt of each grievance and appeal; c) Ensure that the individuals who make decisions on grievances and appeals were not involved in any previous level of review or decision-making; and d) Ensure that the individuals who make decisions on grievances and appeals are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease if the grievance or appeal involves any of the following: i. An appeal of a denial that is based on medical necessity; ii. A grievance regarding the denial of an expedited resolution of an appeal; or iii. A grievance or appeal that involves clinical issues.		
	Findings: The document, Medicaid Grievances and Appeals Policy Final 6-1-13, described the grievances and appeals notification and handling processes in place by the MCO. The policy included the provision that grievances were acknowledged within 3 calendar days of receipt in company and resolved within 90 calendar days. The policy contained the provision that standard appeals		

Standard VII. Grievances and Appeals

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	were acknowledged within 3 calendar days and resolved within 30 calendar days. For expedited appeals, however, the policy contained language that the appeal was, "acknowledged within 72 working days of receipt within the company." During the on-site interview, HPN staff stated that there was an error in the policy and the language was changed to 72 working hours to acknowledge an expedited appeal, in the 2014 policy. Staff also stated that the policy was revised in September 2014, which was outside the review period for this review. The policy did contain the provisions required by items a, c, and d of this element. The on-site appeal file review showed that 8 of 10 appeals were acknowledged within the required timeframe; 6 of 6 standard appeals were resolved within the required timeframe; 3 of 4 expedited appeals were resolved with the proper notice sent; for the 1 expedited appeal which was not resolved within the required timeframe, no extension notice was sent to the member; all decisions for appeals were made by staff who were not involved in the original decision to deny services; and all appeal decisions were made by staff with the appropriate clinical expertise. The on-site grievance file review showed that 9 of 10 grievances were acknowledged within the required timeframe; all grievances were resolved within the required timeframe; and all grievances were reviewed and decisions were made by staff with appropriate clinical expertise.		
	Recommendations: The MCO must ensure that appeals are acknowledged within the timeframes specified by its policy. For expedited appeals, the MCO must ensure that a notice of extension is sent to members when the MCO requires more time to resolve the expedited appeal and that the expedited appeal is resolved within the required timeframes specified by the MCO's policy. The MCO must ensure that grievances are acknowledged within the timeframes specified by its policy.		
HPN Plan to Correct:	**Plan to Remedy Deficiency:**	**Person Responsible:**	**Timeline/Completion Date:**
DHCFP Response:			

Standard VIII. Subcontracts and Delegation

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.12(a)(2) *DHCFP Contract Section 4.13.3.2*	4. MCO Oversight Requirements The MCO is responsible for oversight of all network subcontracts and is accountable for any responsibilities it delegates to any subcontracted provider (AKA, subcontractor). The MCO evaluates the prospective subcontractor's ability to perform the activities to be delegated.	**Documents Submitted:** • HBI JOC Charter 2014 • HBI Oversight Program Description 2013 • UM COMM 043 MN Request for Peer Review • UM-COM 003 Admin Denial Review Request Inpt-Outpt **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Charter of the Behavioral Healthcare Options/Human Behavior Institute and the Monitoring Performance of a Subcontractor policy provided evidence of meeting the requirements of this element. The Human Behavioral Institute Program Description also delineated the activities involved in HPN's monitoring of the subcontractor. There were no policies found, however, that confirmed the requirement that HPN evaluated a prospective subcontractor's ability to perform the activities to be delegated prior to entering into a subcontractor agreement with a provider.		
	Recommendations: HPN should maintain documentation that demonstrates HPN's evaluation of prospective subcontractor's ability to perform the activities to be delegated prior to entering into a subcontractor agreement with a provider.		
HPN Plan to Correct:	**Plan to Remedy Deficiency:**	**Person Responsible:**	**Timeline/Completion Date:**
DHCFP Response:			
DHCFP Contract Section 4.13.3.5	8. The Subcontract Requirements a) The MCO maintains all agreements and subcontracts relating to the contract in writing. b) The MCO provides copies of all agreements and	**Documents Submitted:** • HPN Medicaid_HBI Contract Eff 6-1-11 pgs 5,6,9,16 **Description of Process:**	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VIII. Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	subcontracts to DHCFP within five (5) days of receiving such request. c) The MCO's agreements and subcontracts contain relevant provisions of the contract appropriate to the subcontracted service or activity, specifically including but not limited to the provisions related to confidentiality, HIPAA requirements, insurance requirements and record retention. d) The MCO has the responsibility to assure that subcontractors are adequately insured to current insurance industry standards.	N/A	
	Findings: The HPN Human Behavioral Institute contract provided evidence of having written agreements with subcontractors. Additional information to meet the requirements of this section also was found in the Human Behavioral Institute contract with HPN and the Medicaid PCP and Consulting Provider agreements. No policies included the requirement, however, that HPN provided copies of all agreements and subcontracts to DHCFP within five (5) days of receiving such request.		
	Recommendations: HPN's documentation must include the requirement that HPN provides copies of all agreements and subcontracts to DHCFP within five (5) days of receiving such request.		
HPN Plan to Correct:	**Plan to Remedy Deficiency:**	**Person Responsible:**	**Timeline/Completion Date:**
DHCFP Response:			

Standard IX. Cultural Competency Program

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Contract Section 4.2.1.16 (A)	3. The MCO CCP identifies a staff member responsible for the CCP. If there is a change in the staff member responsible for the CCP, the MCO notifies the DHCFP.	**Documents Submitted:** • Notification of Change in Quality Improvement Department • Cultural Div and Sens Prog Overview 2014-pg. 32 **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: Page 32 of the Cultural Diversity and Sensitivity Program Overview 2014 listed the chief medical officer as the project lead. The email from HPN to DHCFP on March 7, 2014, however, described of the staffing changes that affected the CCP. The email stated that since Rhet Perret left the QI Department, the new lead for the CCP would be Kim Johnson. During the on-site review, HPN staff stated that the lead should be the chief medical officer, although this was not communicated to DHCFP.		
	Recommendations: The MCO should identify the staff person responsible for the CCP and should communicate the information to the DHCFP.		
HPN Plan to Correct:	**Plan to Remedy Deficiency:**	**Person Responsible:**	**Timeline/Completion Date:**
DHCFP Response:			
DHCFP Contract Section 4.2.1.16 (C.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	**Documents Submitted:** • Cultural Div and Sens Prog Overview 2014-pg. 16-22 **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard IX. Cultural Competency Program

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	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.		
	Findings: During the on-site interview, HPN staff described the training modules listed on LearnSource, which was available to HPN staff online. HPN staff stated that some departments required the training and some departments did not require the training. The Cultural Diversity and Sensitivity Program Overview 2014 included the requirement that all members of the Customer Centric Task Force, which represented the key areas of the health plan, were required to ensure their staff members completed culture and diversity courses offered by HPN. Further, the Cultural Diversity and Sensitivity Program Overview 2014 included the provision that staff who worked with members were required to take at least one of the online training classes offered by the MCO through LearnSource. The LearnSource trainings included: Diversity and Inclusion, Diversity and Inclusion—Making Health Care Work for Everyone, Diversity and Inclusion—The Changing Landscape, and Valuing Diversity and Inclusion II. During the on-site interview, HPN staff stated that there was not a requirement for staff to complete ongoing trainings, for example, annually. The Cultural Diversity and Sensitivity Program Overview 2014 did include the methods used by the MCO to conduct an organizational needs assessment, by way of survey, that was focused on culturally-appropriate staff recruitment and training efforts. The Cultural Diversity and Sensitivity Program Overview 2014 included an analysis of data that described the number of LEP certified employees in 2013 and the comparison in the rate over the previous year. The overview also included the racial and ethnic demographics of the population served by HPN for the Nevada Medicaid and Check Up programs.		
	Recommendations: The MCO must 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. The training should be tailored to the specific training needs of the staff after the assessment of training needs is performed.		
HPN Plan to Correct:	**Plan to Remedy Deficiency:**	**Person Responsible:**	**Timeline/Completion Date:**
DHCFP Response:			

Standard XII. Confidentiality and Recordkeeping

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.224 *DHCFP Contract Section 4.6*	1. Medical Records The MCO has written policies and procedures to maintain the confidentiality of all medical records and pursuant to Standard XII, Section 4.8.16, accessibility and availability or medical records, record keeping, and record review process. Not more than 10 calendar days after submitting a request, the State has access to a member's medical record, whether electronic or paper, and has the right to obtain copies at the MCO's expense.	**Documents Submitted:** • 2013 HIPAA Privacy Policy • Cred-Recred_Policy_CR 300.33 pg 60 • HPN Provider Summary Guide 2014 Section 8; 8.7 Medical Records pg 68 • HPN-SHL-SHO Hospital Template Article III H Records Reports and Billing 4 pg 6 • MEDICAID Consulting Provider Template Article III H Records and Reports 4 pg 5-6 • MEDICAID Primary Care Physician FFS Template Article III J Records and Reports 4 pg 5-6 **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Notice of Privacy Practices policy (Privacy Policy P1), the Clinical Medical Records Review policy (CR 200.00), and the Disclosures to Third Parties policy (Privacy Policy P9) provided evidence of written policies and procedures to maintain the confidentiality of medical records. The 2014 HPN Provider Summary Guide informed practitioners that they had 30 calendar days to produce medical records requested by HPN. The Medicaid PCP FFS Contract Template and the Medicaid Consulting Provider Template included the requirement that providers respond appropriately to all quality referred issues within a reasonable time frame but not to exceed 14 days of receipt. (pg. 7) The templates further stipulated that providers must cooperate with HPN in obtaining and/or allowing access to an enrollee's medical records, upon written request, within thirty (30) calendar days of request (pg. 17). HPN needs to review the inconsistent timeframes established in the policies, summary guide, and contract templates. HPN also needs to establish the requirements with the health plan produces medical records to DHCFP within 10 calendar days of receiving the request for records.		

Standard XII. Confidentiality and Recordkeeping			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Recommendations: HPN must to establish the requirements with the health plan produces medical records to DHCFP within 10 calendar days of receiving the request for records.		
HPN Plan to Correct:	**Plan to Remedy Deficiency:**	**Person Responsible:**	**Timeline/Completion Date:**
DHCFP Response:			

Standard XIV. Enrollment and Disenrollment

Reference	Requirement	Information Submitted as Evidence by the MCO	Score
42 CFR 438.56(c)(2)(i-iii) *42 CFR 438.56(g)* *DHCFP Contract Section 4.3.5.1; 4.3.4; Amendment 3*	2. Open Enrollment and Automatic Enrollment/Re-enrollment During open enrollment, held at least once per year, recipients are free to change MCOs. Recipients who elect to change MCOs after open enrollment or who are automatically enrolled/re-enrolled will have 90 days to request membership in the other MCO. The only exceptions to this policy are recipients who lost their Medicaid or Nevada Check Up eligibility for less than two months: They will not be allowed to change MCO's without cause until the next open enrollment period.	**Documents Submitted:** • MEDICAID DISENROLLMENT--HANDLING MEMBER REQUESTS MS078C • WRHCO 284 Disenrollment at the Request of a Medicaid or Nevada Check Up **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The HPN policy, Medicaid Disenrollment–Handling Member Requests, included the procedures to ensure that during the annual open enrollment period, members could disenroll from the health plan and that member who elected to change health plans after open enrollment or who had been automatically enrolled/re-enrolled, had 90 days to request to switch health plans. The policy and flow-chart training aid within it, did not identify the exception that members who had lost their Medicaid or Nevada Check Up eligibility for less than two months and who were automatically reenrolled, would not be allowed to change MCO's without cause until the next open enrollment period. The policy identified a process for members who lost eligibility for longer than six months, but did not address those who were automatically reenrolled after an eligibility break of less than two months. Additionally, the June 2014 revision of the SmartChoice member handbooks informed members that if they lost eligibility for a short time and got back on Medicaid, they would be an HPN member again, "unless you choose another health plan." Similarly, the June 2014 Nevada Check Up handbook stated that if a child lost coverage for a short time and was reenrolled within the year, they would be an HPN member unless the parent chose another plan for the child. Recipients who lose their Medicaid or Nevada Check Up eligibility for two months or more are allowed a ninety day right to change period, but members with less than a two month break are not allowed the 90-day right to change.		

Standard XIV. Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Recommendations: HPN should ensure that its policy, procedures, and member materials align with contract requirements that members automatically enrolled after a break in eligibility of less than two months may not be allowed to disenroll without cause until the next open enrollment period.		
HPN Plan to Correct:	**Plan to Remedy Deficiency:**	**Person Responsible:**	**Timeline/Completion Date:**
DHCFP Response:			