Division of Health Care Financing and Policy
Nevada Medicaid Managed Care

State Fiscal Year 2017–2018 Internal Quality Assurance Program Compliance Review

for

Health Plan of Nevada

June 2018

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires that states contract with an external quality review organization (EQRO) to conduct an annual evaluation of their 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, Inc. (HSAG), to conduct external quality review (EQR) services for the Nevada Medicaid and Nevada Check Up, Nevada's Child Health Insurance Program (CHIP) managed care program.

The purpose of the state fiscal year (SFY) 2017–2018 Internal Quality Assurance Program (IQAP) Compliance Review was to assess each MCO's compliance with the compliance review standards found in 42 Code of Federal Regulations (CFR) §438 Subparts A–F and the State contract requirements found in the DHCFP Contract 3260. The SFY 2017–2018 IQAP Compliance Review focused on the requirements for provider network management found in Subparts A, C, and D. The review period was July 1, 2017, through December 31, 2017. This report details **Health Plan of Nevada (HPN**'s) compliance with the following:

- State and federal managed care requirements, which were categorized into five contract standards referred to as ***IQAP Standards***.
- Outreach and educational materials associated with the provider manual, referred to as ***Checklists***.
- Operational compliance for credentialing, recredentialing, and delegated subcontractor oversight activities, referred to as ***File Reviews***.

HPN had a composite score of 99.5 percent for all elements evaluated in the SFY 2017–2018 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. Table 1-1 summarizes the overall ratings for **HPN**'s IQAP standards, checklists, and file reviews for the SFY 2017–2018 IQAP Compliance Review.

Table 1-1—SFY 2017–2018 IQAP Compliance Review Results for HPN

Overall Ratings for HPN	
IQAP Standards Score	For the IQAP Standards, **HPN** received a total score of **96.8%**.
Checklist Score	For the Checklist review, **HPN** received a total score of **100%**.
File Review Score	For the File Review, **HPN** received a total score of **100%**.
Composite Score	**HPN** received an overall rating of **99.5%** for all elements reviewed in the SFY 2017–2018 IQAP Compliance Review.

2. Background

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

Mandatory Activity

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

According to the 42 CFR §438.358, which describes the activities related to 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. These standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR §438. To meet this requirement, the DHCFP contracted with HSAG to initiate a new three-year cycle of reviews starting in SFY 2017–2018, to complete a comprehensive review of compliance with State and federal standards within the three-year period. The full review schedule is detailed in Table 2-1.

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

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

Standard	Year 1 SFY 2017 2018	Year 2 SFY 2018 2019	Year 3 SFY 2019 2020
Member Services and Experiences			
1. Member Rights and Responsibilities		✓	
2. Member Information		✓	
3. Continuity and Coordination of Care		✓	
4. Grievances and Appeals		✓	
5. Coverage and Authorization of Services		✓	
Managed Care Operations			
1. Internal Quality Assurance Program			✓
2. Cultural Competency Program			✓
3. Confidentiality and Recordkeeping			✓
4. Enrollment and Disenrollment			✓
5. Program Integrity			✓

Purpose of the Review

The purpose of the SFY 2017–2018 IQAP Compliance Review was to determine **HPN**'s compliance with federal and the State's managed care standards related to provider network management. In addition, HSAG conducted a review of individual files for the areas of credentialing, recredentialing, and delegated subcontractor oversight to evaluate **HPN**'s implementation of the standards. Checklist reviews validated that the MCO apprised providers of the MCO's provider-related policies in the provider manual. The review period was July 1, 2017, through December 31, 2017.

3. Methodology

Compliance Review Process

The IQAP standards were derived from the requirements as set forth in the *Department of Human Services, Division of Health Care Financing and Policy Request for Proposal No. 3260 for Managed Care*, and all attachments and amendments in effect during the review period—July 1, 2017, through December 31, 2017. HSAG followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012[3-1] to create the process, tools, and interview questions used for the SFY 2017–2018 IQAP Compliance Review.

Methods for Data Collection

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and, State regulations and requirements outlined in the contract between the DHCFP and the MCOs. 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 on-site review.
- Providing the detailed agenda and the data collection (compliance review) tool to each MCO to facilitate preparation for HSAG's review.
- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents and other information obtained from the DHCFP, and of documents that 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.

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Mar 9, 2018.

- Generating a list of 10 sample cases plus an oversample of five cases for the credentialing and recredentialing file review.
- Reviewing delegated subcontractors' contracts.

On-site review activities included:

- An opening conference with introductions as well as a review of the agenda and logistics for HSAG's on-site review activities.
- A review of the documents that HSAG requested each MCO to make available on-site.
- A review of the member cases that HSAG requested from each MCO.
- A review of the data systems that 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 3-1 of this report. The results for checklists and file reviews are summarized in Table 3-2 and Table 3-3, respectively, in the pages that follow.

Post-on-site review activities: HSAG reviewers aggregated findings to produce this comprehensive compliance review report. In addition, HSAG created 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 the DHCFP, the MCO must use this template to propose its plan to bring all elements scored *Partially Met* or *Not Met* into compliance with the applicable standard(s). **HPN** must submit its CAP to the DHCFP **within 14 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 and subcontractors.
- The member handbook and other written informational materials.

- Narrative and/or data reports across a broad range of performance and content areas.
- Written plans that guide specific operational areas, which included but were not limited to: utilization management, quality management, care management and coordination, health management and service authorization, credentialing, cultural competency, delegation and contracting, and member education.
- MCO-maintained files for 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 3-1 through Table 3-3 list the standards reviewed, provider manual checklist, and files reviewed to determine compliance with State and federal standards.

Table 3-1—IQAP Standards

IQAP Standard #	IQAP Standard Name	Number of Elements
I	Credentialing and Recredentialing	15
II	Availability and Accessibility of Services	26
III	Subcontracts and Delegation	13
IV	Provider Dispute and Complaint Resolution	7
V	Provider Information	3
	Total Number of IQAP Elements	**64**

Table 3-2—Provider Manual Checklist

Associated IQAP Standard #	Checklist Name	Number of Elements
V	Provider Manual	10
	Total Number of Checklist Elements	**10**

Table 3-3—File Reviews

Associated IQAP Standard #	File Review Name	Number of Elements
I	Initial Credentialing	160
I	Recredentialing	195
III	Delegated Subcontracts	4
	Total Number of File Review Elements	**359**

Data Aggregation and Analysis

IQAP Standards

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which each MCO's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCO during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. The protocol describes the scoring as follows:

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

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

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

Provider Manual Checklist

For the checklist reviewed, HSAG reviewers scored each applicable element within the checklist as either *Yes*, the element was contained within the associated document; or *No*, the element was not

contained within the document. Elements not applicable to the MCO were scored *Not Applicable* and were not included in the denominator of the total score. To obtain a percentage score, HSAG added the total number of elements that received *Yes* scores, then divided by the total number of applicable elements.

File Reviews

HSAG conducted file reviews of the MCO's records for credentialing, recredentialing, and delegated subcontractor oversight to verify that the MCO had put into practice what the MCO had documented in its policy. For credentialing and recredentialing, HSAG 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 the MCO's files. Rather, the file review highlighted instances that practices described in policy were not followed by MCO staff. Based on the results of the file reviews, the MCO must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. For the delegated subcontractor file review, HSAG reviewed the delegated subcontractor files for all delegated subcontractors.

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

Aggregating the Scores

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

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

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

Evaluation Ratings for HPN

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

IQAP Standards

Table 4-1 presents **HPN**'s scores for the IQAP standards. Details regarding **HPN**'s compliance with the five IQAP standards, including the score that **HPN** received for each element within each standard, are found in Appendix A, SFY 2017–2018 IQAP Compliance Review Tool for **HPN**.

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

IQAP Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				M	*PM*	*NM*	*NA*	
I	Credentialing and Recredentialing	15	14	14	0	0	1	100%
II	Availability and Accessibility of Services	26	26	23	2	1	0	92.3%
III	Subcontracts and Delegation	13	12	12	0	0	1	100%
IV	Provider Dispute and Complaint Resolution	7	7	7	0	0	0	100%
V	Provider Information	3	3	3	0	0	0	100%
Total Compliance Score		**64**	**62**	**59**	**2**	**1**	**2**	**96.8%**

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

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

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

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

A review of the IQAP standards shows how well 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 62 applicable elements, **HPN** received *Met* scores for 59 elements, *Partially Met* scores for two elements, and *Not Met* scores for one element. The findings suggest that **HPN** developed the necessary policies, procedures, and plans to operationalize the required elements of its contract and demonstrate compliance with the contract. Further, interviews with **HPN** staff showed that staff members were knowledgeable about the requirements of the contract and the policies and procedures that the MCO employed to meet contractual requirements.

The area with the greatest opportunity for improvement within the IQAP standards was related to Standard II, *Availability and Accessibility of Services*. Specifically, the provider contract, member handbook, and **HPN** policy for access and availability contained different requirements for primary care provider (PCP) appointment availability. **HPN** must ensure that PCP appointment standards are consistent with the degree of urgency described in the MCO contract and that the correct standards are used to monitor provider compliance.

Provider Manual Checklist Review

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

Table 4-2—Checklist Score

Associated IQAP Standard #	Description of File Review	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
V	Provider Manual	10	10	100%
	Checklist Totals	**10**	**10**	**100%**

The results generated by the checklists serve as additional indicators of the MCO's ability to develop the required outreach information and to ensure that the information contains all contractually required elements. Of the 10 elements reviewed for the checklist, **HPN** received *Met* scores for all 10 elements. The findings suggest that **HPN** had strong compliance in each of the areas evaluated by the checklist and that **HPN** developed the necessary manuals, handbooks, and policies according to contract requirements.

File Reviews

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

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

Associated IQAP Standard #	Description of File Review	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
I	Initial Credentialing	10	160	160	100%
I	Recredentialing	10	195	195	100%
III	Delegated Subcontractor	1	4	4	100%
	File Review Totals	**21**	**359**	**359**	**100%**

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 359 total elements reviewed for the file reviews, **HPN** received *Met* scores for all 359 elements. All the areas reviewed scored 100 percent. These results suggest that **HPN** followed the policies it developed to operationalize the required elements of its contract.

Conclusions and Recommendations

Table 5-1 presents overall ratings for **HPN** for IQAP Standards, Checklist, and File Reviews, as well as the overall composite score.

Table 5-1—Overall Rating for HPN

IQAP Standards Score	For the IQAP Standards, **HPN** received a total score of **96.8%**.
Checklist Score	For the Checklist review, **HPN** received a total score of **100%**.
File Review Score	For the File Review, **HPN** received a total score of **100%**.
Composite Score	**HPN** received an overall rating of **99.5%** for all elements reviewed in the SFY 2017–2018 IQAP Compliance Review.

HPN's overall result for the review of the IQAP standards in the SFY 2017–2018 IQAP Compliance Review was 96.8 percent. In addition, **HPN** received a score of 100 percent for the file review, a score of 100 percent for the checklist review, and an overall composite score of 99.5 percent. The overall results demonstrated that **HPN** had strong adherence to State and federal standards required by its contract with the DHCFP. **HPN** developed the necessary policies, procedures, and plans to carry out the required functions of the contract; and the checklist and file review results demonstrated that **HPN** staff appropriately operationalized the elements described in **HPN**'s policies, procedures, and plans.

Compliance With IQAP Standards

Of the five standard areas reviewed, **HPN** achieved 100 percent compliance on four of the five standards, demonstrating performance strengths and adherence to all requirements measured in the areas of *Credentialing and Recredentialing, Subcontracts and Delegation, Provider Dispute and Complaint Resolution,* and *Provider Information.*

The *Availability and Accessibility of Services* standard achieved 92.3 percent for all elements contained in the standard.

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

Compliance With Checklists

HPN achieved 100 percent compliance for the checklist review, which demonstrates **HPN**'s compliance with the requirements for information included in the provider manual.

Compliance With File Reviews

HPN achieved 100 percent compliance on the initial credentialing file review and 100 percent compliance on the recredentialing file review, which indicates **HPN**'s compliance with the credentialing and recredentialing file review standards.

HPN received 100 percent compliance for all required elements related to the delegated subcontractor oversight file review. All files reviewed demonstrated **HPN**'s compliance with the standards detailed in the contract.

Corrective Action Plan

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

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

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

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

Appendix A. Division of Health Care Financing and Policy
Nevada Medicaid Managed Care
State Fiscal Year 2017–2018 Internal Quality Assurance Program
Compliance Review Tool
for Health Plan of Nevada

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.214(a-b) *DHCFP Contract Section 3.16.2.1 (A)*	1. Provider Credentialing The MCO must have written credentialing and recredentialing policies and procedures for determining and assuring that all providers under contract to the MCO, including PCPs and Primary Care Specialists (PCSs), specialists, and other health care professionals, are licensed by the State and qualified to perform the services.	**Documents Submitted:** I_HPN_Cred-Recred_Policy pgs. 3-4, 36, 40-41 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Credentialing and Recredentialing policy described the process the MCO uses to assess and validate providers' qualifications to perform the services under the contract, including the process for verifying that practitioners have current, valid licenses and are authorized to practice in the State.		
	Recommendations: None.		
42 CFR §438.214(d) *DHCFP Contract Section 3.16.2.1 (A)*	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:** I_HPN_Cred-Recred_Policy pgs. 4, 67 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Credentialing and Recredentialing and Prohibited Affiliations policies included statements that the MCO will not employ or contract with providers excluded from participation in federal healthcare programs. The U.S. Department of Treasury Office of Foreign Assets Control (OFAC)/Sanctions Check policies confirmed that employees are also checked monthly against several databases, including the Office of Inspector General and the Nevada Excluded/Sanctioned Providers List. During the on-site review, HPN provided examples of reports which demonstrated ongoing reviews of providers and employees to ensure no exclusions.		
	Recommendations: None.		

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.12(a)(1) *42 CFR §438.214(c)* *DHCFP Contract Section 3.7.2.10*	3. Discrimination Against Providers The MCO: 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) If the MCO declines to include an individual or groups of providers in its network, it must give the affected network provider(s) written notice of the reason for its decision.	**Documents Submitted:** I_HPN_Cred-Recred_Policy pgs. 4, 16-18, 20 I_HPN_Credentialing Letter of Denial **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Credentialing and Recredentialing policy included a statement that the MCO does not discriminate against any provider and provided its processes for monitoring for and preventing discriminatory practices, including periodic audits of provider complaints about discrimination, maintaining a diverse credentialing committee membership, requiring committee members to sign an attestation that they will not make decisions in a discriminatory manner, and conducting regular reviews of all providers denied participation in the network. The MCO also provided written notice to individual or groups of providers of the reason for denying participation in the network, as evidenced by a copy of a letter sent to a facility denied participation during the credentialing process.		
	Recommendations: None.		
DHCFP Contract Section 3.16.2.1 (B)	4. Credentialing Criteria The MCO shall provide credentialing criteria for review and approval by DHCFP's Provider Enrollment unit ninety (90) calendar days prior to the start of the contract and ensure that all network providers meet the criteria.	**Documents Submitted:** I_HPN_Cred-Recred_Policy I_HPN DHCFP Approval of Cred Policy **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Findings: An email dated March 23, 2017, confirmed the MCO's credentialing criteria were submitted to DHCFP for review and approval by DHCFP.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15	5. Credentialing Provisions in IQAP The IQAP must contain 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:** I_HPN SHL QI Program Desc pgs. 7, 14 I_HPN QI Prog Eval 2017_DRAFT **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The 2017 Quality Program Description included documentation pertaining to the MCO's quality of care monitoring processes, which included monitoring of the services provided by practitioners. Additionally, the program description included a statement that the MCO will maintain a credentialing process that complies with NCQA standards and other State and federal regulations.		
	Recommendations: None.		
42 CFR §438.214(b)(1) *DHCFP Contract Section 3.10.15.1*	6. Written Credentialing Policies and Procedures The MCO has written policies and procedures that include a uniform documented process for credentialing, 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 the Nevada Administrative Code (NAC) 679B.0405 which requires the use of Form	**Documents Submitted:** I_HPN_Cred-Recred_Policy pgs. 38-39 I_HPN_NV Initial Standard App 1-13-17 I_HPN_NV ReCredentialing Form 03-20-07 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Nevada Department of Insurance (NDOI)-901 for use in credentialing providers.		
	Findings: The Credentialing and Recredentialing policy demonstrated the MCO's processes for credentialing, recredentialing, and ongoing monitoring of practitioners. This policy also contained the requirement to use the NDOI-901 form when credentialing providers in the State of Nevada.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15.2	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:** I_HPN_Cred-Recred_Policy pg. 5 I_HPN_Cred Comm Minutes – Policy Approval_Redacted **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Credentialing and Recredentialing policy noted the Board of Directors had delegated all operational aspects of the credentialing of providers to the Credentialing Committee. The policy further emphasized that the Credentialing Committee is responsible for the development, review, approval, and implementation of all credentialing policies and procedures. Credentialing Committee minutes from December 2016 further confirmed that credentialing policies are taken to the Credentialing Committee for approval.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15.3	8. Credentialing Entity The MCO designates a credentialing committee, or other peer review body, which makes recommendations regarding credentialing decisions.	**Documents Submitted:** I_HPN_Cred-Recred_Policy pgs. 5-6, 8, 16 I_HPN_Cred Comm Minutes – July_Redacted I_HPN_Cred Comm Minutes – July2_Redacted	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		I_HPN_Cred Comm Minutes – August_Redacted I_HPN_Cred Comm Minutes – August2_Redacted I_HPN_Cred Comm Minutes – September_Redacted I_HPN_Cred Comm Minutes – September2_Redacted I_HPN_Cred Comm Minutes – October_Redacted I_HPN_Cred Comm Minutes – October2_Redacted I_HPN_Cred Comm Minutes – November_Redacted I_HPN_Cred Comm Minutes – November2_Redacted I_HPN_Cred Comm Minutes – November2.1_Redacted I_HPN_Cred Comm Minutes – December_Redacted I_HPN_Cred Comm Minutes – December2_Redacted **Description of Process:** N/A	
	Findings: The Credentialing and Recredentialing policy noted the Board of Directors has delegated to the Credentialing Committee the authority to make credentialing decisions regarding the approval or disapproval of providers in the MCO's network. Credentialing Committee minutes from July through December 2017 further demonstrated that the Credentialing Committee makes recommendations about credentialing decisions.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15.4	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	**Documents Submitted:** I_HPN_Cred-Recred_Policy pg. 10 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	practitioners included in the MCO's literature for recipients.	N/A	
	Findings: The Credentialing and Recredentialing policy provided a definition of all practitioners and institutional providers credentialed and recredentialed by the MCO and falling under its scope of authority and action.		
	Recommendations: None.		
42 CFR §1003.3 *DHCFP Contract Section 3.10.15.6 (D-E)*	10. Recredentialing: Reporting to the State The MCO's provider recredentialing must comply with 42 CFR §1003.3. If the MCO decredentials, terminates or disenrolls a provider the MCO must inform the State within 15 calendar days.	**Documents Submitted:** I_HPN_Cred-Recred_Policy pg. 21 I_HPN_Medicaid Weekly Provider Reporting **Description of Process:** A weekly report (example submitted) of the previous week's provider terminations, credentialing adds/denials, and single case agreements are submitted to DHCFP.	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The HPN Credentialing and Recredentialing policy contained the provision that the MCO would notify the DHCFP within 15 calendar days of the determination to deny a Medicaid provider credentialing or recredentialing due to concerns about provider fraud, integrity, quality, suspected criminal actions, or disciplinary actions related to fraud or abuse.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15.6 (E)	11. Recredentialing: Decredentialing, Terminating, or Disenrolling Providers If the decredentialing, termination, or disenrollment of a provider is due to suspected criminal actions, or disciplinary actions related to fraud or abuse the DHCFP	**Documents Submitted:** N/A **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	notifies Health and Human Services-Office of the Inspector General (HHS-OIG).	Contract Section 3.10.15.6 (E) has been split into two requirements on this tool. The first sentence of (E) is requirement number 10, above. This second sentence of the paragraph, describes a duty of the State. Due to this being a State activity, HPN has no documentation to show that the information provided in the reports referenced in requirement #10 are reported to OIG.	
	Findings: The Credentialing and Recredentialing policy included a statement that the MCO will notify DHCFP within 15 calendar days of the determination to deny a Medicaid provider credentialing or recredentialing due to concerns about provider fraud, integrity, or quality or if the Credentialing Committee decredentialed, terminated, or disenrolled a provider due to suspected criminal actions or disciplinary actions related to fraud or abuse. The HPN Medicaid Weekly Provider Reporting document further supported that DHCFP received names of providers and reasons for termination, and credentialing additions and denials from the MCO.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15.7	12. Delegation of Credentialing Activities If the MCO delegates credentialing and recredentialing, recertification, or reappointment activities: a) There must be a written description of the delegated activities, and the delegate's accountability for these activities; b) There must also be evidence that the delegate accomplished the credentialing activities; and c) The MCO must monitor the effectiveness of the delegate's credentialing and reappointment or recertification process.	**Documents Submitted:** N/A **Description of Process:** HPN does not delegate any credentialing activities.	☐ Met ☐ Partially Met ☐ Not Met ☒ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Findings: HPN confirmed that it does not delegate any credentialing activities.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15.8	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:** I_HPN_Cred-Recred_Policy pg. 29 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Credentialing and Recredentialing policy included a statement that the MCO retains the right of final approval of new practitioners, organizational providers, and sites, and the right of final termination or suspension of individual practitioners or organizational providers for the network. This policy also contained provisions for suspending and terminating provider participation.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15.9	14. Reporting to Appropriate Authorities The MCO must ensure 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:** I_HPN_Cred-Recred_Policy pg. 20 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Credentialing and Recredentialing policy noted that suspensions and terminations resulting from adverse professional review actions are reported to the appropriate government agency and to the National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank (NPDB/HIPDB) through the appropriate channels. During the on-site review, HPN confirmed that the appropriate authorities are notified when applicable.		

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Recommendations: None.		
DHCFP Contract Section 3.10.15.10	15. Provider Dispute Process The MCO must have 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:** I_HPN_Cred-Recred_Policy pgs. 19-21 I_HPN_Practitioner Disciplinary Appeal Process pgs. 3-6 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Credentialing and Recredentialing and Practitioner Disciplinary Appeal Process policies included information regarding the practitioner's appeal process.		
	Recommendations: None.		

Results for Standard I: Credentialing and Recredentialing						
Total	Met	= 14	X	1.00	=	14.0
	Partially Met	= 0	X	.50	=	0.0
	Not Met	= 0	X	.00	=	0.0
	Not Applicable	= 1	X	.00	=	0.0
	Total Applicable	= 14	**Total Rate**		=	14.0
Total Rate ÷ Total Applicable = Total Score						100%

Standard II: 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 3.4.2.7*	1. Network of Providers The MCO must maintain and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all eligible recipients enrolled in the MCO's managed care program.	**Documents Submitted:** II_HPN_NN Provider Directory Dec 2017 II_HPN_SN Provider Directory Dec 2017 II_HPN_PCP FFS Template pgs. 16-17 II_HPN_Consulting Provider Template pgs. 16-17 II_HPN_100-3 Site Visit Policy_1.2017 II_HPN Provider Summary Guide Sec 8.3 pg2 (page 67) II_HPN_100-13 Provider Selection Process Policy II_HPN_Access Avail Policy 2017 pgs 3,8 II_HPN_PCPAfterHrs_Final_Medicaid_7.1.17-12.01.17 II_HPN_Compliance Comm Minutes July 2017 II_HPN_Compliance Comm Minutes August 2017 II_HPN_Compliance Comm Minutes September 2017 II_HPN_Compliance Comm Minutes October 2017 II_HPN_Compliance Comm Minutes December 2017 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Findings: The provider directories for southern and northern Nevada included the list of contracted providers in HPN's managed care catchment areas. The HPN Access and Availability Policy 2017 described the process and structure for developing a network of providers and evaluating the availability and accessibility of providers for all enrolled HPN members. The policy noted that HPN monitored the network by reviewing demographic data annually; reviewing reports to ensure established provider ratios are maintained; performing GeoAccess studies; and reviewing trends in member satisfaction using the annual member survey, complaint analysis, and reports from quality management and provider services. The provider contracts provided evidence that the network providers were supported by written agreements. The Compliance Committee minutes from September 2017 provided evidence that the committee reviewed the results of network monitoring activities performed by HPN staff members to verify that the MCO was compliant with contractually required provider-to-member ratios.		
	Recommendations: None.		
42 CFR §438.207(b)(1-2) *DHCFP Contract Section 3.4.2.7 (A-E)*	2. Establishing and Maintaining a Network of Providers In establishing and maintaining the network, the MCO must consider 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, including a description of the utilization management software or other process used by the plan, taking into consideration the characteristics and health care needs of specific Medicaid and Nevada Check Up populations; d) The numbers and types (in terms of training, experience, and specialization) of providers	**Documents Submitted:** II_HPN_Network Adequacy_Q1 SFY2018 II_HPN_Network Adequacy_Q2 SFY2018 II_HPN_Compliance Comm Minutes July 2017 II_HPN_Compliance Comm Minutes August 2017 II_HPN_Compliance Comm Minutes September 2017 II_HPN_Compliance Comm Minutes October 2017 II_HPN_Compliance Comm Minutes December 2017 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	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 recipients, and whether the location provides physical access for recipients with disabilities.		
	Findings: The HPN Access and Availability Policy 2017 described the process that HPN used to monitor the adequacy of PCPs and high-volume specialty providers to ensure its network was sufficient in the number and types of practitioners. The Compliance Committee minutes from September 2017 provided network reporting information concerning the PCP-to-recipient ratios, the physician specialist-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. Copies of emails from HPN to DHCFP staff members confirmed that HPN sent the quarterly network adequacy reports to DHCFP. HPN staff members confirmed that they submitted the reports quarterly.		
	Recommendations: None.		
42 CFR §438.207(c)(3)(i-ii) *DHCFP Contract Section 3.7.2.11*	3. Reporting Requirements The MCO must submit 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:** II_HPN_Network Adequacy_Q1 SFY2018 II_HPN_Network Adequacy_Q2 SFY2018 II_HPN_Compliance Comm Minutes July 2017 II_HPN_Compliance Comm Minutes August 2017 II_HPN_Compliance Comm Minutes September 2017 II_HPN_Compliance Comm Minutes October 2017 II_HPN_Compliance Comm Minutes December 2017	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Description of Process:	
	Findings: The network adequacy reports for quarters 1 and 2 of SFY 2018 provided evidence of HPN's network monitoring. The Compliance Committee minutes from September 2017 provided network reporting information concerning the PCP-to-recipient ratios, the physician specialist-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. Copies of emails from HPN to DHCFP staff members confirmed that HPN sent the quarterly network adequacy reports to DHCFP. HPN staff members confirmed that they submitted the reports quarterly.		
	Recommendations: None.		
DHCFP Contract Section 3.4.2.8	4. Freedom of Choice of Providers The MCO must allow each recipient to choose his or her health care professional, including a PCP, to the extent possible and appropriate.	**Documents Submitted:** II_HPN_Medicaid Concierge Service MS154 II_HPN Provider Summary Guide Sec 8.9 pg7 (page 72) II_HPN_2017 Member Handbook pgs. 19-20, 63 II_HPN_Welcome Calls Policy pgs. 6-8 II_HPN_WRHCO 279 – PCP Assignment pg. 2 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The 2017 HPN Provider Summary Guide and the 2017 Member Handbook included the requirements of this element. The policy, Medicaid Concierge Services, included the guidelines to assist members in selecting or changing PCPs, accessing out-of-area and out-of-network care, and obtaining appointments with a specialist. The HPN Welcome Calls Policy included the procedures for conducting new member welcome calls, which included a script for staff members to follow while assisting a member in choosing a healthcare professional. HPN staff members stated that as soon as the eligibility file was received from DHCFP, a PCP was assigned		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	if the member had not already selected a PCP. Staff members stated that during the welcome calls, members were notified of the PCP selection and were given the opportunity to select a new PCP at that time.		
	Recommendations: None.		
42 CFR §438.206(b)(2) *DHCFP Contract Section 3.4.2.8 (E)*	5. Direct Access to Women's Health Specialists The MCO must provide female recipients 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 recipient's designated PCP, if that source is not a women's health specialist.	**Documents Submitted:** II_HPN Provider Summary Guide Sec 8.9_pg7 (page 72) II_HPN_2017 Member Handbook pg. 63 II_HPN_WRHCO 279 – PCP Assignment pg. 2 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The 2017 HPN Provider Summary Guide and the 2017 Member Handbook included the statement that women had access to health specialists that provide women's routine and preventive healthcare services in the Members' Rights section of the documents.		
	Recommendations: None.		
42 CFR §438.206(b)(3-4) *DHCFP Contract Section 3.4.2.10*	6. Second Opinions The MCO must provide for a second opinion from a qualified health care professional within the network, or arrange for the recipient to obtain one outside of the network, at no cost to the recipient.	**Documents Submitted:** II_HPN_2017 Member Handbook pgs. 25, 63 II_HPN_WRHCO 354 - Second Opinion II_HPN Provider Summary Guide Sec 8.9 pg7 (page 72) **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Findings: The 2017 HPN Provider Summary Guide and the 2017 Member Handbook included the provision that recipients had the right to a second opinion within or outside the provider network.		
	Recommendations: None.		
42 CFR §438.206(b)(5) *DHCFP Contract Section 3.4.2.11*	7. Payment of Out-of-Network Providers The MCO must coordinate with out-of-network providers with respect to payment.	**Documents Submitted:** II_HPN_100-18 Letters of Agreement Policy, pg 4 II_HPN_WRHCO 132 – Out of Area Services **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The HPN 100-18 Letters of Agreement Policy described the process for coordinating with out-of-network providers with respect to payment.		
	Recommendations: None.		
42 CFR §438.206(c)(1)(i-vi) *DHCFP Contract Section 3.4.2.13*	8. Hours of Operation The MCO must: a) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial recipients or comparable to Medicaid fee-for-service (FFS), if the provider services only Medicaid enrollees pursuant to 42 CFR §438.206. b) Meet and require its providers to meet State standards for timely access to care and services,	**Documents Submitted:** II_HPN Provider Summary Guide Sec 8.6 pg2 (page 68) II_HPN_Access Avail Policy 2017 pgs. 17-19 II_HPN_100-3 Site Visit Policy pg. 4 II_HPN_100-43 Provider Corrective Actions Policy **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	taking into account the urgency of the need for services; c) Make services included in the RFP available twenty-four (24) hours per day, seven (7) days per week, when medically necessary; d) Establish mechanisms to ensure compliance by providers; e) Monitor providers regularly to ensure compliance and take corrective action if there is a failure to comply.		
	Findings: The 2017 HPN Provider Summary Guide and the Access and Availability Policy 2017 contained the provisions noted in this element. The document, HPN 100-3 Site Visit Policy, described the process and requirements for site audits to ensure that providers, provider staff, and facility clinics comply with HPN's requirements. The HPN 100-43 Provider Corrective Actions Policy described the process and procedures for monitoring providers and initiating and requiring corrective action if the provider fails to comply with HPN's contractual and policy requirements related to network standards. Staff members stated that provider services advocates conduct site visits at least annually for all providers. For high-volume providers, HPN staff members stated that they conduct quarterly site visits to track high-volume providers' compliance with contractual requirements. The site visits database provided evidence that the site visits occurred as described by HPN staff members.		
	Recommendations: None.		
42 CFR §438.114(b)(1) *DHCFP Contract Section 3.4.2.14*	9. Emergency Coverage The MCO must provide emergency coverage twenty-four (24) hours per day, seven (7) days per week. The MCO must have written policies and procedures describing how recipients and providers can obtain emergency services after business hours and on weekends. Policies	**Documents Submitted:** II_HPN_Access Avail Policy 2017 pgs 18-19 II_HPN Provider Summary Guide Sec 8.6 pg. 2 (pgs. 68-69) **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	and procedures must include provision of direct contact with qualified clinical staff.	N/A	
	Findings: The 2017 HPN Provider Summary Guide and the 2017 Member Handbook included the provisions related to access to emergency coverage. The HPN Access and Availability Policy 2017 also described the MCO's policy to provide emergency services 24 hours per day, seven days per week and how members may access emergency services after hours and on weekends. HPN staff members stated that the they monitor providers' compliance with after-hours requirements by calling the providers' offices after hours. If a provider did not meet the requirements for after-hours coverage, provider services advocates would educate the provider on the standard and requirements.		
	Recommendations: None.		
DHCFP Contract Section 3.4.2.14	10. Urgent Care The MCO must have written policies and procedures describing how recipients and providers can obtain urgent coverage after business hours and on weekends. Policies and procedures must 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:** II_HPN_Access Avail Policy 2017 pgs. 18-19 II_HPN Provider Summary Guide Sec 8.6 pg. 2 (pgs. 68-69) **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The 2017 HPN Provider Summary Guide outlined the provision that PCPs must have mechanisms in place for after-hours coverage, including referring members to emergency rooms or urgent care centers. The guide also required providers to arrange for a substitute physician and healthcare professionals, who participate with HPN, to provide coverage in the absence of the physician. The HPN Access and Availability Policy 2017 also described the MCO's policy to provide urgent care services after business hours and on weekends.		
	Recommendations: None.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.4.9	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 recipient, the MCO must adequately and timely cover these services out of network for the recipient 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 must also coordinate these services with other services in the MCO benefit package.	**Documents Submitted:** II_HPN_100-18 Letters of Agreement Policy II_HPN_WRHCO 132 – Out of Area Services II_HPN_2017 Member Handbook pg. 63 II_HPN_WRHCO 141 – Coordination of Non-Covered Benefits **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The HPN WRHCO 132 Out-of-Area Services policy and the HPN Access and Availability Policy 2017 provided evidence of meeting the requirements of this element. The HPN 100-18 Letters of Agreement Policy described the process for coordinating with out-of-network providers with respect to payment. HPN staff members stated that they issued single case agreements for out-of-network services for members. HPN staff members stated that they processed no more than two single case agreements per month.		
	Recommendations: None.		
DHCFP Contract Section 3.6.3.2	12. Twenty-five (25) Mile Rule The MCO must offer every enrolled recipient a PCP or Primary Care Site 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	**Documents Submitted:** II_HPN_Network Adequacy_Q1 SFY2018 II_HPN_Network Adequacy_Q2 SFY2018 II_HPN_SN Q3 2017 Geoaccess II_HPN_NN Q3 2017 Geoaccess	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	residence per NAC 695C.160 without the written request of the recipient.	II_HPN_SN Q4 2017 Geoaccess II_HPN_NN Q4 2017 Geoaccess II_HPN_Access Avail Policy 2017 pg. 14 **Description of Process:** N/A	
	Findings: The network adequacy reports for quarters 1 and 2 of SFY 2018 provided evidence of HPN's network monitoring to the 25-mile rule. The Compliance Committee minutes from September 2017 provided network reporting information concerning the 25-mile rule for medical care.		
	Recommendations: None.		
DHCFP Contract Section 3.7.5.1–3.7.5.5	13. Access and Availability The MCO shall: a) Ensure adequate physical and geographic access to covered services for enrolled recipients; b) On a quarterly basis, use geo-access mapping and data-driven analyses to ensure compliance with access standards, and take appropriate corrective action, if necessary, to comply with such access standards; c) Partner actively with DHCFP, community providers and stakeholders to identify and address issues and opportunities to improve health care access and availability for Medicaid and CHIP recipients.	**Documents Submitted:** II_HPN_Access Avail Policy 2017_pg 13 II_HPN_Network Adequacy_Q1 SFY2018 II_HPN_Network Adequacy_Q2 SFY2018 II_HPN_Compliance Comm Minutes July 2017 II_HPN_Compliance Comm Minutes August 2017 II_HPN_Compliance Comm Minutes September 2017 II_HPN_Compliance Comm Minutes October 2017 II_HPN_Compliance Comm Minutes December 2017 II_HPN_WHASN JOC 09-21-2017 II_HPN_WHASN JOC 01-30-2018	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	d) Assure access to health screenings, reproductive services and immunizations through county and state public health clinics. e) Promote care management and early intervention services by completing welcome calls and/or visits to new recipients to ensure orientation with emphasis on access to care, choice of PCP, and availability of an initial health risk screening occurs proactively with each recipient who becomes enrolled. If a screening risk level determines need for further care management, a care management referral will be completed.	II_HPN_Member Advisory Committee 11.08.17 II_HPN_Member Advisory Committee 11.06.07 II_HPN_NBH JOC 9.14.17 II_HPN_NBH JOC 11.14.17 II_HPN_Welcome Calls Policy pgs. 6-8 II_HPN_WHRCO 161 – Health Screening **Description of Process:** Attached are examples of Provider and Member Meeting minutes to illustrate stakeholder partnerships to improve access and availability within our community,	
	Findings: HPN used GeoAccess reports to ensure adequate physical and geographic access to covered services for enrolled recipients as evidenced by the two documents, HPN NN Q3 2017 GeoAccess and HPN NN Q4 2017 GeoAccess. The quarterly network adequacy reports sent to DHCFP recorded the findings of the GeoAccess reports. HPN staff members stated that GeoAccess reports were produced monthly to review the network to assure there were no gaps in coverage. HPN staff stated that all the GeoAccess reports were reviewed by the compliance committee. The minutes from the November 6, 2017, Member Advisory Committee provided evidence of stakeholder involvement in network monitoring and identification of opportunities for improvement related to access to specialists. The HPN Access and Availability Policy 2017 included primary healthcare accessibility standards for preventive services, including routine physical examinations and screenings, and immunizations.		
	Recommendations: None.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.7.5.6 (A)	14. PCP-to-Recipient Ratios The MCO must have at least one full-time equivalent (FTE) primary care provider, considering all lines of business for that provider, for every 1,500 recipients 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:** II_HPN_Access Avail Policy 2017 pg. 12 II_HPN_Network Adequacy_Q1 SFY2018 II_HPN_Network Adequacy_Q2 SFY2018 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Access and Availability Policy 2017 detailed the PCP-to-recipient ratios for PCPs and specialists. The network adequacy reports for quarters 1 and 2 of SFY 2018 provided evidence of HPN's monitoring of network ratios.		
	Recommendations: None.		
42 CFR §438.114(c)(1)(i) *DHCFP Contract Section 3.7.5.7 (A)*	15. Access to Emergency Services 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.	**Documents Submitted:** II_HPN_Access Avail Policy 2017 pgs 18-19 II_HPN Provider Summary Guide Sec 8.6 pg. 2 (pgs. 68-69) II_HPN_2017 Member Handbook pg. 28 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The 2017 HPN Provider Summary Guide and the 2017 Member Handbook included the provisions related to access to emergency services. The HPN Access and Availability Policy 2017 also described the MCO's policy to provide emergency services 24 hours per day, seven days per week and how members may access emergency services from any qualified provider, whether in network or out of network.		
	Recommendations: None.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.7.5.7 (B)	16. PCP Appointments PCP appointments are available as follows: a) Medically necessary, primary care provider appointments are available within two (2) calendar days; b) Same day, urgent care PCP appointments; 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:** II_HPN_Access Avail Policy 2017 pgs. 17-18 II_HPN Provider Summary Guide Sec 8.6 pg. 3 (pages 68-69) **Description of Process:** N/A	☐ Met ☐ Partially Met ☒ Not Met ☐ NA
	Findings: The 2017 HPN Provider Summary Guide, HPN Access and Availability Policy, and the member handbook all contained PCP appointment availability standards; however, the documents differed with respect to the PCP appointment standards, and none of the documents were consistent with the MCO contract language and nomenclature outlined in this element for medically necessary primary care appointments, same-day urgent PCP appointments, and routine care PCP appointments. The 2017 HPN Provider Summary Guide included appointment availability standards for emergent care (same day), urgent care (within two calendar days), and routine PCP appointments (within two weeks). The HPN Access and Availability Policy 2017 included appointment availability standards for preventive care (within 30 calendar days), routine care (within 14 calendar days), urgent care (within 24 hours), and emergent care (same day). The HPN Member Handbook contained PCP appointment standards for emergent care (immediately), urgent care (within 24 hours), routine care (within seven days), and preventive well-child visits (within one month). Although HPN staff members described the process for conducting site visits to monitor providers on appointment availability standards, staff members confirmed that provider services advocates monitored to the standards described in the Provider Services Manual, which did not meet the standards defined for PCP appointments. Further, HPN staff members confirmed that they monitored providers to standards that differed from those communicated to members via the member handbook. HPN staff members confirmed that the descriptions of the standards were inconsistent across the three documents and were also inconsistent with the degree of urgency		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	outlined in the MCO contract for PCP appointments. HPN staff members stated that they would revise the documents to be consistent with the MCO contract nomenclature and definitions described in this element.		
	Recommendations: HPN must ensure that appointment availability standards for PCP appointments are consistent with the MCO contract. HPN must ensure that the appointment availability standards for PCP appointments communicated to providers and members are consistent with the degree of urgency described in the MCO contract.		
DHCFP Contract Section 3.7.5.7 (C)(1-4)	17. Specialist Appointments For specialty referrals to physicians, therapists, behavioral health services, vision services, and other diagnostic and treatment health care providers, the MCO shall provide: a) Same day, emergency appointments within twenty-four (24) hours of referral; b) Urgent 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:** II_HPN_Access Avail Policy 2017 pgs. 17-18 II_HPN Provider Summary Guide Sec 8.6 pg. 3 (pages 68-69) **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The 2017 HPN Provider Summary Guide and HPN Access and Availability Policy 2017 included the appointment availability standards for specialty care appointments, which were consistent with the same-day, urgent, and routine appointment standards in this element.		
	Recommendations: None.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.7.5.7 (D)(1-4)	18. Prenatal Care Appointments Initial prenatal care appointments shall be 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.	**Documents Submitted:** II_HPN_Access Avail Policy 2017 pgs. 17-18 II_HPN Provider Summary Guide Sec 8.6 pg. 3 (pages 68-69) II_HPN_PCP FFS Template pgs. 17-18 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The 2017 HPN Provider Summary Guide and HPN Access and Availability Policy 2017 included the appointment availability standards for prenatal care appointments, which were consistent with the appointment standards in this element.		
	Recommendations: None.		
DHCFP Contract Section 3.7.5.8 (A)	19. 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:** II_HPN_100-3 Site Visit Policy II_HPN_Access Avail Policy 2017 pg. 8 II_HPN Provider Summary Guide Sec 8.6 pg. 3 (pages 68-69) **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		The Director of Provider Services and the Director of Contracting each have distinct responsibilities for oversight and compliance of the appointments standards.	
	Findings: The HPN Access and Availability Policy 2017 detailed the procedure to distribute the accessibility standards to provider networks at the time of initial contracting and subsequently in other provider materials, such as the provider manual, provider summary guide, fax blast communications, website postings, or mailings. The 2017 HPN Provider Summary Guide, which was distributed to providers, contained the appointment standards outlined in the contract. The guide also included the provision that performance against the standards would be measured continually by the Provider Services Department. The HPN 100-3 Site Visit Policy detailed the process for conducting site visits at provider offices to verify compliance with appointment standards. HPN staff members stated that the director of provider services and the director of contracting were responsible for overseeing compliance of appointment standards.		
	Recommendations: None.		
DHCFP Contract Section 3.7.5.8 (B)	20. Monitoring Appointment Standards Concerning the education of its provider network regarding appointment time requirements the MCO shall: a) Monitor the adequacy of its appointment process and compliance; and b) Implement a POC when appointment standards are not met.	**Documents Submitted:** II_HPN_100-3 Site Visit Policy II_HPN_Access Avail Policy 2017 pgs. 15-16, 18-19, 21-23 II_HPN Provider Summary Guide Sec 8.6 pg. 3 (pages 68-69) II_HPN_100-43 Provider Corrective Actions Policy **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Findings: The 2017 HPN Provider Summary Guide included the provision that performance against the standards would be measured continually by the Provider Services Department. The HPN 100-3 Site Visit Policy detailed the process for conducting site visits at provider offices to verify compliance with appointment standards. The HPN 100-43 Provider Corrective Actions Policy described the process and procedures for monitoring providers and initiating and requiring corrective action if the provider fails to comply with HPN's contractual and policy requirements related to appointment standards. The 2017 HPN Provider Summary Guide, HPN Access and Availability Policy, and the member handbook all contained PCP appointment availability standards; however, the documents differed with respect to the PCP appointment standards, and none of the documents were consistent with the MCO contract language and nomenclature outlined in this element for medically necessary primary care appointments, same-day urgent PCP appointments, and routine care PCP appointments. The 2017 HPN Provider Summary Guide included appointment availability standards for emergent care (same day), urgent care (within two calendar days), and routine PCP appointments (within two weeks). The HPN Access and Availability Policy 2017 included appointment availability standards for preventive care (within 30 calendar days), routine care (within 14 calendar days), urgent care (within 24 hours), and emergent care (same day). The HPN Member Handbook contained PCP appointment standards for emergent care (immediately), urgent care (within 24 hours), routine care (within seven days), and preventive well-child visits (within one month). Although HPN staff members described the process for conducting site visits to monitor providers on appointment availability standards, staff members confirmed that provider services advocates monitored to the standards described in the Provider Services Manual, which did not meet the standards defined for PCP appointments. Further, HPN staff members confirmed that they monitored providers to standards that differed from those communicated to members via the member handbook. HPN staff members confirmed that the descriptions of the standards were inconsistent across the three documents and were also inconsistent with the degree of urgency outlined in the MCO contract for PCP appointments. HPN staff stated that they would revise the documents to be consistent with the MCO contract nomenclature and definitions described in this element.		
	Recommendations: HPN must ensure that the appointment standards used to monitor provider compliance are consistent with the degree of urgency described in the MCO contract.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.7.5.9	21. Office Waiting Times The MCO shall establish 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:** II_HPN_Access Avail Policy 2017_pg 18-19, 21-22 II_HPN Provider Summary Guide Sec 8.6 pg. 4 (page 69) II_HPN_PCP FFS Template_pg 19 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The 2017 HPN Provider Summary Guide listed the office waiting times, which were compliant with the requirements noted in this element.		
	Recommendations: None.		
DHCFP Contract Section 3.7.5.13	22. Prohibited Practices The MCO shall take affirmative action so that recipients are provided access to covered medically necessary services without regard to race, national origin, creed, color, gender, gender identity, sexual preference, religion, age, and health status, physical or mental disability, except where medically indicated.	**Documents Submitted:** II_HPN_Access Avail Policy 2017 pg. 2 II_HPN Provider Summary Guide Sec 8.8 pg. 6 (page 71) **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The 2017 HPN Provider Summary Guide and the HPN Access and Availability Policy 2017 included the provisions of this element related to prohibited practices.		
	Recommendations: None.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.7.6.1	23. 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:** II_HPN_Consulting Provider Template II_HPN_PCP FFS Template II_HPN_NN Provider Directory Dec 2017 II_HPN_SN Provider Directory Dec 2017 II_HPN_Network Adequacy_Q1 SFY2018 II_HPN_Network Adequacy_Q2 SFY2018 II_HPN_Cred-Recred Policy II_HPN_Access Avail Policy 2017 pgs. 15-16 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The provider directories for southern and northern Nevada included the list of contracted providers in HPN's managed care catchment areas. HPN staff members stated that the online provider directory was updated weekly and that the PDF directory was updated monthly. The HPN Access and Availability Policy 2017 described the process and structure for developing a network of providers and evaluating the availability and accessibility of providers for all enrolled HPN members. The policy noted that HPN monitored the network by reviewing demographic data annually; reviewing reports to ensure established provider ratios are maintained; performing GeoAccess studies; and reviewing trends in member satisfaction using the annual member survey, complaint analysis, and reports from quality management and provider services. The provider contracts provided evidence that the network providers were supported by written agreements. The Compliance Committee minutes from September 2017 provided evidence that the committee reviewed the results of network monitoring activities performed by HPN staff members. The reports showed that the MCO was compliant with contractually required provider-to-member ratios.		
	Recommendations: None.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.7.6.5	24. Monitoring Providers The MCO must also have written policies and procedures for monitoring its providers, and complete this monitoring on its providers, and for disciplining providers who are found to be out of compliance with the MCO's medical management standards.	**Documents Submitted:** II_HPN_Access Avail Policy 2017 pgs. 15-16 and 21-23 II_HPN_100-3 Site Visit Policy II_HPN Provider Summary Guide Sec 5.10 pgs. 9-14 (Pages 33-38) II_HPN_100-43 Provider Corrective Actions Policy **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The HPN Access and Availability Policy 2017 described the process and structure for developing a network of providers and evaluating the availability and accessibility of providers for all enrolled HPN members. The policy noted that HPN monitored the network by reviewing demographic data annually; reviewing reports to ensure established provider ratios are maintained; performing GeoAccess studies; and reviewing trends in member satisfaction using the annual member survey, complaint analysis, and reports from quality management and provider services. The HPN 100-3 Site Visit Policy described the process and requirements for site audits to ensure that providers, provider staff, and facility clinics comply with HPN's requirements. The HPN 100-43 Provider Corrective Actions Policy described the process and procedures for monitoring providers and initiating and requiring corrective action if the provider fails to comply with HPN's contractual and policy requirements related to medical management standards.		
	Recommendations: None.		
DHCFP Contract Section 3.10.16.7 (A-B)	25. Steps to Assure Accessibility of Services The MCO must take steps to promote accessibility of services offered to recipients. These steps include: a) The points of access to primary care, specialty care and hospital services are identified for recipients;	**Documents Submitted:** II_HPN_2017 Member Handbook pgs. 5-7, 15-16, 23-24, 28-29, 30, 43, 51 II_HPN_Medicaid Concierge Service MS154	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	b) At a minimum, recipients are given information about: i. How to obtain services during regular hours of operations; ii. How to obtain emergency and after-hour care; iii. How to obtain emergency out-of-service area care; iv. How to obtain the names, qualifications and titles of the professionals who provide and are accepting medical patients and/or are responsible for their care; and v. How to access concierge services and if needed case management assistance from the vendor when needed to gain access to care.	II_HPN_NN Provider Directory Dec 2017 II_HPN_SN Provider Directory Dec 2017 Online provider search – Including credentials: http://www.talispoint.com/sgh/external/med/ **Description of Process:** N/A	
	Findings: The provider directories for southern and northern Nevada included the list of contracted providers in HPN's managed care catchment areas. The 2017 Member Handbook provided instruction to members about how to access services during regular business hours, emergency care, emergency care out of network, as well as how to obtain the names and qualifications of professionals accepting patients and how to access concierge services from the MCO. The policy, Medicaid Concierge Services, included the guidelines to assist members in selecting or changing PCPs, accessing out-of-area and out-of-network care, and obtaining appointments with a specialist. The HPN Welcome Calls Policy included the procedures for conducting new member welcome calls, which included a script for staff members to follow while assisting a member in choosing a healthcare professional. HPN staff members stated that customer services staff would mail welcome packets, which include a member handbook, to members within five business days of receiving the eligibility file from DHCFP.		
	Recommendations: None.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.10.17	26. Standards for Availability and Accessibility The MCO must: a) Establish standards for access (e.g., to routine, urgent and emergency care; telephone appointments; advice and recipient service lines) and complies with this RFP. b) Assess performance on these dimensions of access against the established standards.	**Documents Submitted:** II_HPN_Access Avail Policy 2017 pgs. 17-19, 25 II_HPN Provider Summary Guide Sec 5.10 pg 10 (Page34) **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ NA
	Findings: The 2017 HPN Provider Summary Guide, HPN Access and Availability Policy, and the member handbook all contained PCP appointment availability standards; however, the documents differed with respect to the PCP appointment standards, and none of the documents were consistent with the MCO contract language and nomenclature outlined in this element for medically necessary primary care appointments, same-day urgent PCP appointments, and routine care PCP appointments. The 2017 HPN Provider Summary Guide included appointment availability standards for emergent care (same day), urgent care (within two calendar days), and routine PCP appointments (within two weeks). The HPN Access and Availability Policy 2017 included appointment availability standards for preventive care (within 30 calendar days), routine care (within 14 calendar days), urgent care (within 24 hours), and emergent care (same day). The HPN Member Handbook contained PCP appointment standards for emergent care (immediately), urgent care (within 24 hours), routine care (within seven days), and preventive well-child visits (within one month). Although HPN staff members described the process for conducting site visits to monitor providers on appointment availability standards, staff members confirmed that provider services advocates monitored to the standards described in the Provider Services Manual, which did not meet the standards defined for PCP appointments. Further, HPN staff members confirmed that they monitored providers to standards that differed from those communicated to members via the member handbook. HPN staff members confirmed that the descriptions of the standards were inconsistent across the three documents and were also inconsistent with the degree of urgency outlined in the MCO contract for PCP appointments. HPN staff members stated that they would revise the documents to be consistent with the MCO contract nomenclature and definitions described in this element.		
	Recommendations: HPN must ensure that the appointment standards used to monitor provider compliance are consistent with the degree of urgency described in the MCO contract. Further, HPN must assess its performance against contractually required standards.		

Results for Standard II: Availability and Accessibility of Services						
Total	Met	= 23	X	1.00	=	23.0
	Partially Met	= 2	X	.50	=	1.0
	Not Met	= 1	X	.00	=	0.0
	Not Applicable	= 0	X	.00	=	0.0
	Total Applicable	= 26	**Total Rate**		=	24.0
Total Rate ÷ Total Applicable = Total Score						92.3%

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.7.4.1	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:** III_HPN_APAC SOW 6 III_HPN_Alorica_Amd 1 to SOW 6 III_HPN_APAC MSA Executed_Amd 1_06-24-2013 III_HPN_APAC MSA Executed_10-21-2009 III_HPN_Alorica Approval by DHCFP (email) **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: HPN provided the executed, written agreement with Alorica for the overflow call center. An email from DHCFP dated December 19, 2017, confirmed the Alorica contract was approved by the State.		
	Recommendations: None.		
42 CFR §438.6(i)(1) *42 CFR §423.208* *42 CFR §422.210* *DHCFP Contract Section 3.7.6.6*	2. Physician Incentive Plan If the MCO has a physician incentive plan, it must comply with section 1876 of the Social Security Act and the reporting requirements outlined in 42 CFR §423.208 and §422.210, pursuant to 42 CFR §438.6(i)(1).	**Documents Submitted:** N/A – there were no physician incentive plans in place during the audit period **Description of Process:** N/A	☐ Met ☐ Partially Met ☐ Not Met ☒ NA
	Findings: HPN indicated it did not have any physician incentive plans in place during the audit period. Additionally, during the on-site review, HPN staff members confirmed there were no current plans to have a physician incentive plan.		
	Recommendations: None.		

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.214 *42 CFR §438.6* *DHCFP Contract Section 3.15.4.1*	3. Subcontracts with Health Care Professionals The MCO complies with the requirements in 42 CFR §438.214 regarding contracts with health care professionals. The MCO ensures that all subcontracts fulfill the requirements of 42 CFR §438 that are appropriate to the service or activity delegated under the subcontract.	**Documents Submitted:** III_HPN_Cred-Recred_Policy III_HPN_100-11 Provider Summary Guide III_HPN_APAC SOW 6 III_HPN_Consulting Provider Template III_HPN_PCP FFS Template **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: HPN's credentialing program complied with the provider selection requirements found in 42 CFR §438.214.		
	Recommendations: None.		
42 CFR §438.12(a)(2) *DHCFP Contract Section 3.15.4.2*	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:** III_HPN_WRHCO 345 – Monitoring Subcontractor III_HPN_Alorica_QBR_Jun_Oct_17 III_HPN_Alorica_QBR_Oct_Dec_17 III_HPN_PCP FFS Template III_HPN_Consulting Provider Template **Description of Process:** Alorica was contracted for services since 2009, providing the company an opportunity to evaluate their performance before the Medicaid SOW was added in 2014. The	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Medicaid Amendment would not have occurred if Alorica was not performing to their contractual SLAs.	
	Findings: The Delegation of Responsibilities to Subcontractors policy and procedure described HPN's responsibilities for overseeing and evaluating the performance of its subcontractor. A statement within this policy confirmed that HPN remains accountable for meeting the requirements of the contract.		
	Recommendations: None.		
DHCFP Contract Section 3.15.4.3	5. Prior-Approval Requirements by DHCFP All subcontracts for administrative services provided pursuant to this Request For Proposal (RFP), including, but not limited to, utilization review, quality assurance, recipient services, and claims processing, are prior- approved by DHCFP.	**Documents Submitted:** III_HPN_Subcontracts and Disclosure of Ownership (email) III_HPN_Alorica Approval by DHCFP (email) **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: Copies of emails between HPN and DHCFP confirmed that subcontracts were prior-approved by DHCFP.		
	Recommendations: None.		
DHCFP Contract Section 3.15.4.3	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.	**Documents Submitted:** III_HPN_Subcontracts and Disclosure of Ownership (email) III_HPN_Disclosure of Ownership 03.08.17 III_HPN_Alorica Approval by DHCFP (email)	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	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 $25,000 for each incident.	III_HPN_WRHCO 338 – Subcontractor ownership pg1-2 III_HPN_WRHCO 352 – Subcontract Requirements pg2 **Description of Process:**	
	Findings: Copies of emails between HPN and DHCFP confirmed that subcontracts were prior-approved by DHCFP. The Ownership Reporting policy and Subcontract Requirements policy also included the requirements of this element.		
	Recommendations: None.		
DHCFP Contract Section 3.15.4.4	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:** III_HPN_WRHCO 338 – Subcontractor Ownership pgs. 1-2 III_HPN_WRHCO 352 – Subcontract Requirements pg 2 III_HPN_Subcontracts and Disclosure of Ownership (email) III_HPN_Alorica Approval by DHCFP (email) **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: Copies of emails between HPN and DHCFP confirmed that the subcontract with Alorica was prior-approved by DHCFP. The Subcontract Requirements policy also included the requirements of this element.		
	Recommendations: None.		

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.15.4.5	8. 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 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.	**Documents Submitted:** III_HPN_Alorica Amd 1 to SOW 6 III_HPN_APAC SOW 6 III_HPN_APAC MSA Executed_Amd 1_06-24-2013 III_HPN_APAC MSA Executed_10-21-2009 III_HPN_WRHCO 352 – Subcontract Requirements pg 2 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: HPN's Subcontract Requirements policy stated that all subcontracts are in writing and that requests for copies of all agreements and subcontracts by the DHCFP would be provided within five days of receiving such requests. The executed master services agreement between the MCO and Alorica also included the services expected to be performed, and provisions related to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), insurance, confidentiality, and record retention requirements.		
	Recommendations: None.		

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.230(b)(1) *DHCFP Contract Section 3.15.4.6*	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:** III_HPN_WRHCO 345 – Monitoring Subcontractor pg2 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Delegation of Responsibilities to Subcontractors policy and procedure described HPN's responsibilities for overseeing and evaluating the performance of its subcontractor. A statement within this policy confirmed that HPN remains accountable for meeting the requirements of the contract.		
	Recommendations: None.		
42 CFR §438.230(c)(1)(i) *DHCFP Contract Section 3.15.4.7*	10. Written Agreements 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.	**Documents Submitted:** III_HPN_APAC SOW 6 III_HPN_WRHCO 345 – Monitoring Subcontractor pg2 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Delegation of Responsibilities to Subcontractors policy included the requirements of this element. The executed agreement between HPN and the subcontractor included a Statement of Work that detailed the delegated call center activities. The agreement also included the reporting responsibilities, performance targets, and performance guarantees expected of the delegate. The agreement further stipulated HPN's rights to request removal of delegate employees for failure to meet requirements and included a statement that HPN can revoke any functions or activities delegated to the subcontractor.		
	Recommendations: None.		

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.230(a)(1) *42 CFR §438.230(b)(2)* *42 CFR §438.230(c)(1)(iii)* *DHCFP Contract Section 3.15.4.8*	11. Monitoring Performance of the Subcontractor The MCO must monitor the subcontractor's performance on an on-going basis and subject 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:** III_HPN_WRHCO 345 – Monitoring Subcontractor pg2 III_HPN_Alorica_QBR_Jun_Oct_17 III_HPN_Alorica_QBR_Oct_Dec_17 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Delegation of Responsibilities to Subcontractors policy contained information related to HPN's responsibility for overseeing and evaluating its subcontractor. Alorica's quality performance reports, which contained metrics and individual employee audit results, as well as initiatives underway by the delegate, further demonstrated oversight of this delegate's performance. During on the on-site review, HPN confirmed Alorica has not been on a CAP.		
	Recommendations: None.		
DHCFP Contract Section 3.15.4.9	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:** III_HPN_WRHCO 342 – Termination of a Subcontract III_HPN_Notice of Termination of subcontract (email) **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Termination of Subcontract policy included a statement that HPN would notify DHCFP in writing immediately upon notification of any intention of HPN to terminate any subcontract. An email dated August 1, 2017, to		

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	DHCFP confirmed that HPN notified DHCFP of its intent to amend the contracts with two subcontractors to remove all delegated authority.		
	Recommendations: None.		
DHCFP Contract Section 3.15.4.10	13. Ownership of Subcontractor Within 35 calendar days of the date of request, the MCO must provide full and complete information about the ownership of any subcontractor with whom the MCO has had 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:** III_HPN_WRHCO 338 – Subcontractor Ownership pg1-2 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Subcontractor Ownership policy included the requirements of this element.		
	Recommendations: None.		

Results for Standard III: Subcontracts and Delegation						
Total	Met	= 12	X	1.00	=	12.0
	Partially Met	= 0	X	.50	=	0.0
	Not Met	= 0	X	.00	=	0.0
	Not Applicable	= 1	X	.00	=	0.0
	Total Applicable	= 12	**Total Rate**		=	12.0
Total Rate ÷ Total Applicable			**= Total Score**			100%

Standard IV: Provider Dispute and Complaint Resolution			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.10.24	1. Dispute Resolution The MCO must adequately staff a provider services unit to handle provider questions and disputes.	**Documents Submitted:** IV_HPN_NDCPS Org Chart IV_HPN_CRR Org Chart **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: Both the Network Development and Provider Services for Medicaid Organizational Chart and Customer Response and Resolution Department Organizational Chart provided evidence of meeting the requirements of this element. The document, HPN WRHCO 350 Provider Questions and Disputes, detailed the procedures for resolving, tracking, and reporting provider disputes, which were the responsibilities of HPN's provider services, member services, and claims departments.		
	Recommendations: None.		
DHCFP Contract Section 3.10.24.1	2. Resolving Disputes The MCO must resolve 90% of written, telephone or personal contacts within 90 calendar days of the date of receipt with appropriate follow up to provider.	**Documents Submitted:** IV_HPN_WRHCO 350 Provider Questions and Disputes IV_HPN_07.2017 G_A Report IV_HPN_08.2017 G_A Report IV_HPN_09.2017 G_A Report IV_HPN_10.2017 G_A Report IV_HPN_11.2017 G_A Report IV_HPN_12.2017 G_A Report **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard IV: Provider Dispute and Complaint Resolution			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		N/A	
	Findings: The policy, HPN WRHCO 350 Provider Questions and Disputes, detailed the procedures for resolving, tracking, and reporting provider disputes, which were the responsibilities of HPN's provider services, member services, and claims departments. The policy also detailed the goal to resolve 90 percent of written, telephonic, or personal provider contacts within 90 calendar days of receipt with appropriate follow-up to the provider. The MCO Provider Grievance and Appeal reports from July through December 2017 provided evidence that HPN tracked disputes and number of days to resolve disputes received from providers. The reports provided evidence that HPN resolved disputes within 30 days or less. HPN staff members stated that they reviewed aggregate reports which show the number and types of claims reconsiderations requested by providers. The aggregated information allowed staff members to look for trends on how claims were submitted and why they were denied. HPN staff members stated that the provider services department educated providers on common claim submission errors and how providers may submit claims correctly the first time so that the claims do not get denied. HPN staff members stated that claims reconsiderations are handled daily and that, after two resubmissions, the provider may appeal the claim and the appeal would be processed according to the appeals policy.		
	Recommendations: None.		
DHCFP Contract Section 3.10.24.2	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:** IV_HPN_Provider Appeal Log 070117 – 123117 **Description of Process:** There were no logged Provider Grievances during the review period.	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The document, HPN Provider Appeal Log 070117–123117, consisted of a Microsoft Excel spreadsheet that listed the provider appeal/dispute, the nature of the appeal, the date it was filed, dates and actions taken, and final resolution.		
	Recommendations: None.		

Standard IV: Provider Dispute and Complaint Resolution			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.13.8	4. Provider Grievances and Appeals The MCO must establish 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 recipients. 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 anytime 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 system without first obtaining the written approval of the DHCFP.	**Documents Submitted:** IV_HPN_G_A Policy 070117 pgs. 22-23 IV_HPN_DHCFP Approval_G_A Policy Eff 070117 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The policy, HPN WRHCO 350 Provider Questions and Disputes, detailed the procedures for resolving, tracking, and reporting provider disputes. The HPN Grievance and Appeal Policy 070117 provided evidence of HPN's provider grievance and appeal resolution process that was separate from, and not a party to, grievances and appeals submitted by providers on behalf of recipients. The document, HPN DHCFP Approval G A Policy, provided evidence that HPN received email confirmation from DHCFP that the HPN grievance and appeal policy was approved.		
	Recommendations: None.		
DHCFP Contract Section 3.13.8.1	5. Accepting Provider Grievances and Appeals When handling Grievances and Appeals: a) The MCO must accept written or oral grievances and appeals that are submitted directly by the provider as well as those that are	**Documents Submitted:** IV_HPN_G_A Policy 070117 pg. 13 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard IV: Provider Dispute and Complaint Resolution			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	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.	N/A	
	Findings: The HPN Grievance and Appeal Policy 070117 provided evidence of the MCO's policy to accept written or oral grievances and appeals and included the requirement that an oral appeal must be followed by a written, signed appeal. The policy also included the provision that the date of the oral appeal was counted as the initial date of the appeal to establish the earliest possible filing date for the appeal.		
	Recommendations: None.		
DHCFP Contract Section 3.13.8.1	6. Written Record of Provider Grievances and Appeals The MCO must keep 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:** IV_HPN_G_A Policy 070117 pg. 8 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The HPN Grievance and Appeal Policy 070117 provided evidence of HPN's provider grievance and appeal resolution process. The document, HPN Provider Appeal Log 070117–123117, provided evidence of HPN's electronic record of provider grievances and appeals and listed the provider appeal/dispute, the nature of the appeal, the date it was filed, dates and actions taken, and final resolution.		
	Recommendations: None.		

Standard IV: Provider Dispute and Complaint Resolution			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.13.8.1(A-B)	7. Timing of Final Decisions The MCO must issue a final decision, in writing, no later than: a) Ninety (90) calendar days after a grievance is filed; and, b) Thirty (30) calendar days after an appeal is filed.	**Documents Submitted:** IV_HPN_G_A Policy 070117 pgs. 7, 23 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The HPN Grievance and Appeal Policy 070117 included the provision that grievances would be resolved within 90 calendar days of receipt and appeals would be resolved within 30 calendar days of receipt.		
	Recommendations: None.		

Results for Standard IV: Provider Dispute and Complaint Resolution							
Total	Met	=	7	X	1.00	=	7.0
	Partially Met	=	0	X	.50	=	0.0
	Not Met	=	0	X	.00	=	0.0
	Not Applicable	=	0	X	.00	=	0.0
	Total Applicable	=	7	**Total Rate**		=	7.0
Total Rate ÷ Total Applicable = Total Score							100%

Standard V: Provider Information			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.7.8.2	1. Provider Workshops The MCO must conduct, at least annually, provider workshops in the geographic service area to accommodate each provider site. In addition to presenting education and training materials of interest to all providers, the workshops must provide 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 should 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:** V_HPN_100-3 Site Visit Policy **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The HPN 100-3 Site Visit Policy described the process and procedures HPN followed to conduct site visits at provider offices, in lieu of an annual training, as well as provide town hall meetings and provider expos and fairs. The policy described the process for the initial provider site visit and ongoing annual site visits. At the site visit, health plan provider services advocates would deliver applicable educational material that included the Provider Summary Guides, provider directories applicable to the contract affiliation, provider newsletters, and educational pamphlets. The provider newsletters for summer and winter 2017 provided evidence of the ongoing training provided to contracted providers. The on-site demonstration of the site visit database provided evidence that HPN made site visits to provider offices and documented the findings that resulted from the site-visit.		
	Recommendations: None.		

Standard V: Provider Information			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.7.8.3	2. Provider Newsletter The MCO must publish a semi-annual newsletter for network providers. Topics may include practice guidelines, policy updates, quality management strategies, and other topics of provider interest.	**Documents Submitted:** V_HPN_Provider Newsletter Summer 2017 V_HPN_Provider Newsletter Winter 2017 **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The HPN provider newsletters for summer and winter 2017 provided evidence of the ongoing training provided to contracted providers. Examples of newsletter topics included the clinical practice consultant (CPC) program used to share innovative best practices, updating provider demographics, policy and Medicaid benefit updates, understanding patient satisfaction survey results, member incentive programs, and provider incentive programs. HPN staff members confirmed that HPN published newsletters twice per year.		
	Recommendations: None.		
DHCFP Contract Section 3.7.8.4	3. Provider Newsletters on MCO Website The MCO must provide a copy of all newsletters to the DHCFP. Additionally, these newsletters and announcements regarding provider workshops must be published on the MCO's website.	**Documents Submitted:** V_HPN_Provider Newsletter on MCO Website_screenshot V_HPN_DHCFP Acknowledgement_Summer V_HPN_DHCFP Acknowledgement_Winter **Description of Process:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The document, HPN Provider Newsletter on MCO Website screenshot, provided evidence that HPN posted provider newsletters on the provider portal of the HPN website. The DHCFP acknowledgement emails provided evidence that DHCFP received a copy of the spring and winter 2017 newsletters. HPN staff members confirmed that the newsletters were available on the website and that providers did not need to log into the portal to access the newsletters.		
	Recommendations: None.		

Results for Standard V: Provider Information							
Total	Met	=	3	X	1.00	=	3.0
	Partially Met	=	0	X	.50	=	0.0
	Not Met	=	0	X	.00	=	0.0
	Not Applicable	=	0	X	.00	=	0.0
	Total Applicable	=	3	**Total Rate**		=	3.0
Total Rate ÷ Total Applicable = Total Score							100%

Compliance With Standards Review Tool CAP

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.7.5.7 (B)	16. PCP Appointments PCP appointments are available as follows: a) Medically necessary, primary care provider appointments are available within two (2) calendar days; b) Same day, urgent care PCP appointments; 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:** II_HPN_Access Avail Policy 2017 pgs. 17-18 II_HPN Provider Summary Guide Sec 8.6 pg. 3 (pages 68-69) **Description of Process:** N/A	☐ Met ☐ Partially Met ☒ Not Met ☐ NA
	Findings: The 2017 HPN Provider Summary Guide, HPN Access and Availability Policy, and the member handbook all contained PCP appointment availability standards; however, the documents differed with respect to the PCP appointment standards, and none of the documents were consistent with the MCO contract language and nomenclature outlined in this element for medically necessary primary care appointments, same-day urgent PCP appointments, and routine care PCP appointments. The 2017 HPN Provider Summary Guide included appointment availability standards for emergent care (same day), urgent care (within two calendar days), and routine PCP appointments (within two weeks). The HPN Access and Availability Policy 2017 included appointment availability standards for preventive care (within 30 calendar days), routine care (within 14 calendar days), urgent care (within 24 hours), and emergent care (same day). The HPN Member Handbook contained PCP appointment standards for emergent care (immediately), urgent care (within 24 hours), routine care (within seven days), and preventive well-child visits (within one month). Although HPN staff members described the process for conducting site visits to monitor providers on appointment availability standards, staff members confirmed that provider services advocates monitored to the standards described in the Provider Services Manual, which did not meet the standards		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	defined for PCP appointments. Further, HPN staff members confirmed that they monitored providers to standards that differed from those communicated to members via the member handbook. HPN staff members confirmed that the descriptions of the standards were inconsistent across the three documents and were also inconsistent with the degree of urgency outlined in the MCO contract for PCP appointments. HPN staff members stated that they would revise the documents to be consistent with the MCO contract nomenclature and definitions described in this element.		
	Recommendations: HPN must ensure that appointment availability standards for PCP appointments are consistent with the MCO contract. HPN must ensure that the appointment availability standards for PCP appointments communicated to providers and members are consistent with the degree of urgency described in the MCO contract.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.7.5.8 (B)	20. Monitoring Appointment Standards Concerning the education of its provider network regarding appointment time requirements the MCO shall: a) Monitor the adequacy of its appointment process and compliance; and b) Implement a POC when appointment standards are not met.	**Documents Submitted:** II_HPN_100-3 Site Visit Policy II_HPN_Access Avail Policy 2017 pgs. 15-16, 18-19, 21-23 II_HPN Provider Summary Guide Sec 8.6 pg. 3 (pages 68-69) II_HPN_100-43 Provider Corrective Actions Policy **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ NA
	Findings: The 2017 HPN Provider Summary Guide included the provision that performance against the standards would be measured continually by the Provider Services Department. The HPN 100-3 Site Visit Policy detailed the process for conducting site visits at provider offices to verify compliance with appointment standards. The HPN 100-43 Provider Corrective Actions Policy described the process and procedures for monitoring providers and initiating and requiring corrective action if the provider fails to comply with HPN's contractual and policy requirements related to appointment standards. The 2017 HPN Provider Summary Guide, HPN Access and Availability Policy, and the member handbook all contained PCP appointment availability standards; however, the documents differed with respect to the PCP appointment standards, and none of the documents were consistent with the MCO contract language and nomenclature outlined in this element for medically necessary primary care appointments, same-day urgent PCP appointments, and routine care PCP appointments. The 2017 HPN Provider Summary Guide included appointment availability standards for emergent care (same day), urgent care (within two calendar days), and routine PCP appointments (within two weeks). The HPN Access and Availability Policy		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	2017 included appointment availability standards for preventive care (within 30 calendar days), routine care (within 14 calendar days), urgent care (within 24 hours), and emergent care (same day). The HPN Member Handbook contained PCP appointment standards for emergent care (immediately), urgent care (within 24 hours), routine care (within seven days), and preventive well-child visits (within one month). Although HPN staff members described the process for conducting site visits to monitor providers on appointment availability standards, staff members confirmed that provider services advocates monitored to the standards described in the Provider Services Manual, which did not meet the standards defined for PCP appointments. Further, HPN staff members confirmed that they monitored providers to standards that differed from those communicated to members via the member handbook. HPN staff members confirmed that the descriptions of the standards were inconsistent across the three documents and were also inconsistent with the degree of urgency outlined in the MCO contract for PCP appointments. HPN staff stated that they would revise the documents to be consistent with the MCO contract nomenclature and definitions described in this element.		
	Recommendations: HPN must ensure that the appointment standards used to monitor provider compliance are consistent with the degree of urgency described in the MCO contract.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.10.17	26. Standards for Availability and Accessibility The MCO must: a) Establish standards for access (e.g., to routine, urgent and emergency care; telephone appointments; advice and recipient service lines) and complies with this RFP. b) Assess performance on these dimensions of access against the established standards.	**Documents Submitted:** II_HPN_Access Avail Policy 2017 pgs. 17-19, 25 II_HPN Provider Summary Guide Sec 5.10 pg 10 (Page34) **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ NA
	Findings: The 2017 HPN Provider Summary Guide, HPN Access and Availability Policy, and the member handbook all contained PCP appointment availability standards; however, the documents differed with respect to the PCP appointment standards, and none of the documents were consistent with the MCO contract language and nomenclature outlined in this element for medically necessary primary care appointments, same-day urgent PCP appointments, and routine care PCP appointments. The 2017 HPN Provider Summary Guide included appointment availability standards for emergent care (same day), urgent care (within two calendar days), and routine PCP appointments (within two weeks). The HPN Access and Availability Policy 2017 included appointment availability standards for preventive care (within 30 calendar days), routine care (within 14 calendar days), urgent care (within 24 hours), and emergent care (same day). The HPN Member Handbook contained PCP appointment standards for emergent care (immediately), urgent care (within 24 hours), routine care (within seven days), and preventive well-child visits (within one month). Although HPN staff members described the process for conducting site visits to monitor providers on appointment availability standards, staff members confirmed that provider services advocates monitored to the standards described in the Provider Services Manual, which did not meet the standards defined for PCP appointments. Further, HPN staff members confirmed that they monitored providers to standards that differed from those communicated to members via the member handbook. HPN staff members confirmed that the descriptions of the standards were inconsistent across the three documents and were also inconsistent with the degree of urgency outlined in the MCO contract for PCP appointments. HPN staff members stated that they would revise the documents to be consistent with the MCO contract nomenclature and definitions described in this element.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Recommendations: HPN must ensure that the appointment standards used to monitor provider compliance are consistent with the degree of urgency described in the MCO contract. Further, HPN must assess its performance against contractually required standards.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			