Division of Health Care Financing and Policy
Nevada Medicaid Managed Care

Calendar Year 2022 External Quality Review Compliance Review Report

for

LIBERTY Dental Plan of Nevada, Inc.

November 2022

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

In accordance with Title 42 of the Code of Federal Regulations (42 CFR) §438.358 the Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP) or an external quality review organization (EQRO) may perform the mandatory and optional external quality review (EQR) activities, and the data from these activities must be used for the annual EQR technical report described in 42 CFR §438.350 and §438.364. One of the four mandatory activities required by the Centers for Medicare & Medicaid Services (CMS) is:

- A review, conducted within the previous three-year period, to determine the managed care organization's (MCO's), prepaid inpatient health plan's (PIHP's), or prepaid ambulatory health plan's (PAHP's) compliance with the standards set forth in Subpart D of this part (42 CFR §438), the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330.

As DHCFP's EQRO, Health Services Advisory Group, Inc. (HSAG) is contracted to conduct the compliance review activity with each of the contracted managed care entities (MCEs) delivering services to members enrolled in the Nevada Medicaid program. When conducting the compliance review, HSAG adheres to the methodologies and guidelines established in CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019 (CMS EQR Protocol 3).[1-1]

Description of the External Quality Review Compliance Review

DHCFP requires its MCEs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. The calendar year (CY) 2022 compliance review was the second year of the three-year cycle of compliance reviews that commenced in CY 2021. The review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance reviews in Nevada consist of 14 program areas referred to as standards. At DHCFP's request, HSAG conducted a review of the first seven standards in Year One (CY 2021). The remaining seven standards were reviewed in Year Two (CY 2022). In Year Three (CY 2023), a comprehensive review will be conducted on each element scored as *Not Met* during the CY 2021 and

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Aug 3, 2022.

CY 2022 compliance reviews. Table 1-1 outlines the standards reviewed over the three-year review cycle.

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

Standards	Associated Federal Citation[1]	Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
Standard I—Disenrollment: Requirements and Limitations	§438.56	✓		Review of the MCEs' implementation of Year One and Year Two corrective action plans (CAPs)
Standard II—Member Rights and Member Information	§438.100	✓		
Standard III—Emergency and Poststabilization Services	§438.114	✓		
Standard IV—Availability of Services	§438.206	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	✓		
Standard VI—Coordination and Continuity of Care	§438.208	✓		
Standard VII—Coverage and Authorization of Services	§438.210	✓		
Standard VIII—Provider Selection	§438.214		✓	
Standard IX—Confidentiality	§438.224		✓	
Standard X—Grievance and Appeal Systems	§438.228		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230		✓	
Standard XII—Practice Guidelines	§438.236		✓	
Standard XIII—Health Information Systems[2]	§438.242		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330		✓	

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] This standard includes a comprehensive assessment of an MCE's information systems (IS) capabilities.

Summary of Findings

Review of Standards

Table 1-2 presents an overview of the results of the CY 2022 compliance review for **LIBERTY Dental Plan of Nevada, Inc.** (**LIBERTY**). HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement was not applicable to **LIBERTY** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards. Refer to Appendix A for a detailed description of the findings.

Table 1-2—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VIII—Provider Selection	12	10	10	0	2	**100%**
Standard IX—Confidentiality	11	11	11	0	0	**100%**
Standard X—Grievance and Appeal Systems	38	38	35	3	0	**92%**
Standard XI—Subcontractual Relationships and Delegation	7	7	7	0	0	**100%**
Standard XII—Practice Guidelines	8	8	8	0	0	**100%**
Standard XIII—Health Information Systems	12	12	10	2	0	**83%**
Standard XIV—Quality Assessment and Performance Improvement Program	27	24	24	0	3	**100%**
Total	**115**	**110**	**105**	**5**	**5**	**95%**

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

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

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

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

LIBERTY achieved an overall compliance score of 95 percent, indicating adherence to most of the reviewed federal and State requirements. However, opportunities for improvement were identified in the Health Information Systems standard as this program area received a performance score below 90 percent. Detailed findings, including recommendations for program enhancements, are documented in Appendix A.

Corrective Action Process

For any elements scored *Not Met*, **LIBERTY** is required to submit a CAP to bring the element into compliance with the applicable standard(s). The process for submitting the CAP is described in Section 3.

2. Methodology

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MCEs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330. To complete this requirement, HSAG, through its EQRO contract with DHCFP, performed compliance reviews of the MCEs contracted with DHCFP to deliver services to Nevada Medicaid managed care members.

DHCFP requires its MCEs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. The CY 2022 compliance review is the second year of the three-year cycle of compliance reviews that commenced in CY 2021. The review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance reviews in Nevada consist of 14 program areas referred to as standards. At DHCFP's request, HSAG conducted a review of the first seven standards in Year One (CY 2021). The remaining seven standards were reviewed in Year Two (CY 2022). In Year Three (CY 2023), a comprehensive review will be conducted on each element scored as *Not Met* during the CY 2021 and CY 2022 compliance reviews. Table 2-1 outlines the standards reviewed over the three-year review cycle.

Table 2-1—Compliance Review Standards

Standards	Associated Federal Citation[1]	Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
Standard I—Disenrollment: Requirements and Limitations	§438.56	✓		Review of the MCEs' implementation of Year One and Year Two CAPs
Standard II—Member Rights and Member Information	§438.100	✓		
Standard III—Emergency and Poststabilization Services	§438.114	✓		
Standard IV—Availability of Services	§438.206	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	✓		
Standard VI—Coordination and Continuity of Care	§438.208	✓		
Standard VII—Coverage and Authorization of Services	§438.210	✓		
Standard VIII—Provider Selection	§438.214		✓	
Standard IX—Confidentiality	§438.224		✓	
Standard X—Grievance and Appeal Systems	§438.228		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230		✓	

Standards	Associated Federal Citation[1]	Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
Standard XII—Practice Guidelines	§438.236		✓	
Standard XIII—Health Information Systems[2]	§438.242		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330		✓	

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] This standard includes a comprehensive assessment of an MCE's IS capabilities.

This report presents the results of the CY 2022 review period. DHCFP and the individual MCEs use the information and findings from the compliance reviews to:

- Evaluate the quality, timeliness, and accessibility of healthcare services furnished by the MCEs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Technical Methods of Data Collection and Analysis

Prior to beginning the compliance review, HSAG developed data collection tools, referred to as compliance review tools, to document the review. The content of the tools was selected based on applicable federal and State regulations and laws and on the requirements set forth in the contract between DHCFP and the MCE as they related to the scope of the review. The review processes used by HSAG to evaluate the MCE's compliance were consistent with CMS EQR Protocol 3.

For each MCE, HSAG's desk review consisted of the following activities:

Pre-Site Review Activities:

- Collaborated with DHCFP to develop the scope of work, compliance review methodology, and compliance review tools.
- Prepared and forwarded to the MCE a timeline, description of the compliance process, pre-site review information packet, a submission requirements checklist, and a post-site review document tracker.
- Scheduled the site review with the MCE.
- Hosted a pre-site review preparation session with all MCEs.
- Generated a list of 10 sample records for practitioner credentialing, organizational credentialing, grievances, appeals, and three sample records for delegate case file reviews.
- Conducted a desk review of supporting documentation the MCE submitted to HSAG.
- Followed up with the MCE, as needed, based on the results of HSAG's preliminary desk review.

- Developed an agenda for the one-day site review interview sessions and provided the agenda to the MCE to facilitate preparation for HSAG's review.

Site Review Activities:

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed MCE key program staff members.
- Conducted a review of practitioner credentialing, organizational credentialing, grievances, appeals, and delegated entities' records.
- Conducted an IS review of the data systems that the MCE used in its operations, applicable to the standards under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

Post-Site Review Activities:

- Conducted a review of additional documentation submitted by the MCE.
- Documented findings and assigned each element a score of *Met*, *Not Met*, or *NA* (as described in the Data and Aggregation and Analysis section) within the compliance review tool.
- Prepared an MCE-specific report and CAP template for the MCE to develop and submit its remediation plans for each element that received a *Not Met* score.

Data Aggregation and Analysis:

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCE's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCE during the period covered by HSAG's review. This scoring methodology is consistent with CMS EQR Protocol 3. The protocol describes the scoring as follows:

Met indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- Documentation, staff responses, case file reviews, and IS reviews confirmed implementation of the requirement.

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

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.

- Documentation, staff responses, case file reviews, and IS reviews did not demonstrate adequate implementation of the requirement.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any findings of *Not Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

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

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

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

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

- Documented findings describing the MCE's progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCE's performance for each requirement.
- The total percentage-of-compliance score calculated for each of the standards.
- The overall percentage-of-compliance score calculated across the standards.
- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.
- Documented recommendations for program enhancement, when applicable.

Description of Data Obtained

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

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- Records for practitioner credentialing, organizational credentialing, grievances, appeals, and delegated entities.

HSAG obtained additional information for the compliance review through interactions, discussions, and interviews with the MCE's key staff members. Table 2-2 lists the major data sources HSAG used to determine the MCE's performance in complying with requirements and the time period to which the data applied.

Table 2-2—Description of MCE Data Sources and Applicable Time Period

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during or after the site review	January 1, 2022–May 31, 2022
Information obtained through interviews	September 16, 2022
Information obtained from a review of a sample of practitioner and organizational credentialing files	Listing of all practitioners and organizations who completed the credentialing process between January 1, 2022–May 31, 2022
Information obtained from a review of a sample of member grievance files	Listing of all closed member grievances between January 1, 2022–May 31, 2022
Information obtained from a review of a sample of member appeal files	Listing of all closed appeals between January 1, 2022–May 31, 2022
Information obtained from a review of a sample of delegated entity files	Listing of all delegates serving the Nevada Medicaid managed care program between January 1, 2022–May 31, 2022

3. Corrective Action Plan Process

For any program areas requiring corrective action, **LIBERTY** is required to conduct a root cause analysis of the finding and submit a CAP to bring the element into compliance.

The CAP must be submitted to DHCFP and HSAG within 30 days of receipt of the final report. For each element that requires correction, **LIBERTY** must identify the planned interventions to achieve compliance with the requirement(s), the individual(s) responsible, and the timeline. HSAG has prepared a customized template under Appendix B to facilitate **LIBERTY**'s submission and DHCFP's and HSAG's review of corrective actions. The template includes each standard with findings that require a CAP.

DHCFP and HSAG will review **LIBERTY**'s corrective actions to determine the sufficiency of the CAP. If an action plan is determined to be insufficient, **LIBERTY** will be required to revise its CAP until deemed acceptable by HSAG and DHCFP.

To ensure the CAP is fully implemented, **LIBERTY** will be required to submit periodic progress reports on the status of each action plan. A progress report template and instructions for completing and submitting the progress reports will be provided after the approval of **LIBERTY**'s CAP.

Appendix A. Review of the Standards

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

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
General Rules		
1. The DBA implements written policies and procedures for selection and retention of network providers and those policies and procedures, at a minimum, meet the requirements of 42 CFR §438.214. *Additionally*: a. *Prior to becoming a network provider, a provider who is a non-Medicaid provider must be referred to DHCFP for completion of the Medicaid provider enrollment.* b. *The DBA may execute network provider contracts pending the outcome of the screening, enrollment, and revalidation process of up to one hundred twenty (120) calendar days but must terminate a network provider immediately upon notification from DHCFP that the network provider cannot be enrolled, or the expiration of the 120-day period without Medicaid enrollment of the provider, and notify affected members.* 42 CFR §438.214(a) 42 CFR §438.214(b)(2) 42 CFR §438.214(e) Contract 3.6.6.3; 3.6.6.10	**HSAG Recommended Evidence:** • Policies and procedures • Process documentation describing how credentialing/recredentialing information is received, stored, reviewed, tracked, and dated. • Provider enrollment process documentation **Evidence as Submitted by the DBA:** 0. Note to Reviewer - Policy Issue & Approval Dates 1. C1 CR PP - C1 Credentialing Overview and Provider Right: Cite entire policy 2. C3 CR PP - C3 Initial Credentialing Process: Cite entire policy 3. C4 CR PP - C4 Re-Credentialing Process: Cite entire policy 4. Note to Reviewer – Nevada Medicaid Enrollment Verification Process: Cite entire note 5. Nevada Credentialing Application (Initial) NDOI-901: Cite entire form	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: In compliance with 42 CFR §438.214(a) and (b)(2), LIBERTY maintains written policies and procedures (P&Ps) for the selection, retention, credentialing and recredentialing of network providers. Such P&Ps include LIBERTY's *Credentialing Overview*, *Initial Credentialing* and *Recredentialing* P&Ps (Evidence #1 - #3). Per 42 CFR §438.214(e) and (b)(2), these P&Ps reflect Federal and State requirements and ensure that LIBERTY follows a documented process for credentialing and recredentialing of network providers. Consistent with Contract 3.6.6.3, LIBERTY's *Initial Credentialing Process* policy (Evidence #2); *Medicaid Enrollment Verification Process* (Evidence #4); and *Nevada Credentialing Application Form NDOI-907* (which requires a Nevada Medicaid ID number) (Evidence #5), ensure that applicant providers are either enrolled in Nevada Medicaid prior to becoming a network provider or are otherwise referred to DHCFP for Medicaid enrollment.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Although Contract 3.6.6.10 provides for the provisional credentialing of network providers, LIBERTY does not provisionally credential providers in its normal course of business.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element. **Recommendations:** HSAG recommends that the DBA clearly delineate in a policy, procedure, and/or workflow the requirements of sub-element (b) to further demonstrate evidence of compliance. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
2. The DBA must follow a documented process for credentialing and recredentialing of network providers. a. *The DBA identifies those practitioners who fall under its scope of authority and action., including at a minimum, all dentists and other licensed independent practitioners included in the DBA's network.* b. *The DBA complies with Nevada Administrative Code (NAC) 679B0405, which requires the use of Form NDOI-901 for use in credentialing providers.* *The provider credentialing and recredentialing process shall not be administratively burdensome.* c. *The provider receives a timely response regarding the credentialing decision or reason for delay of decision.* 42 CFR §438.214(b)(1-2) 42 CFR §438.214(e) Contract 3.9.15.1 Contract 3.9.15.4	**HSAG Recommended Evidence:** • Policies and procedures • Credentialing form template (link to form is acceptable) • HSAG will also use the results of the File Reviews for Form NDOI-901 Use **Evidence as Submitted by the DBA:** 1. C1 CR PP - C1 Credentialing Overview and Provider Rights: Page 2, Section A #1 and Page 23, Addendum B 2. C3 CR PP - C3 Initial Credentialing Process: Page 4, Process/Procedure 3. C4 CR PP - C4 Re-Credentialing Process: Page 3, Process/Procedure 4. Nevada Credentialing Application (Initial) NDOI-901: Cite entire form 5. Provider Reference Guide NV Medicaid, Page 7, Section 2	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: Per 42 CFR §438.214(b)(1-2), LIBERTY follows a documented process for credentialing and recredentialing network providers. In compliance with 42 CFR §438.214(e), these processes reflect State requirements, including Contract 3.9.15.1 and 3.9.15.4, as outlined below.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
LIBERTY's *Credentialing Overview* policy (Evidence #1) identifies the providers that fall under the scope of authority and action of LIBERTY's credentialing and recredentialing functions, per Contract 3.9.15.4. Applicable practitioners are Dentists (DDS, DMD), Dental Specialists, Licensed Dental Consultants and other dental providers who fall within the scope of credentialing. Per Contract 3.9.15.1: • LIBERTY's *Credentialing Overview*, *Initial Credentialing Process*, and *Re-Credentialing Process* policies (Evidence #1 - #3) ensure that LIBERTY utilizes Nevada's mandated credentialing application form *NDOI-901* (Evidence #4). • LIBERTY ensures its credentialing and recredentialing process is not administratively burdensome by using the Nevada standardized form *NDOI-901* (Evidence #4) and by making network managers available to support providers through the process as transcripts in *Provider Reference Guide* (Evidence #5). • LIBERTY's *Credentialing Overview* policy (Evidence #1) specifies that the timeframe for notifying applicants of credentialing and recredentialing decisions shall not exceed sixty (60) business days from the date of receipt of completed application. Further, the policy establishes that any credentialing application that cannot be completed in the sixty (60) day timeframe will be denied and referred to Provider Relations to address any delays on the part of the provider. Please note, however, during the look-back period LIBERTY processed 100% of credentialing applications in less than sixty (60) days.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
Nondiscrimination		
3. The DBA network provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment, consistent with 42 CFR §438.12. 42 CFR §438.214(c) 42 CFR §438.12 Contract 3.6.2.9	**HSAG Recommended Evidence:** • Policies and procedures **Evidence as Submitted by the DBA:** 1. C2 CR PP - C2 Credentialing Committee: Page 2, Purpose/Scope #4 2. C1 CR PP - C1 Credentialing Overview and Provider Rights: Page 3, Section A #8	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
DBA Description of Process: LIBERTY does not discriminate against providers, per 42 CFR §438.214(c), 42 CFR §438.12 and Contract 3.6.2.9. In compliance with 42 CFR §438.214(c), 42 CFR §438.12 and Contract 3.6.2.9, LIBERTY's *Credentialing Committee* policy (Evidence #1) ensures that credentialing and recredentialing activity does not discriminate against providers who serve high-risk populations or specialize in treatment of costly conditions. Additionally, LIBERTY's *Credentialing Overview and Provider Rights* policy (Evidence #2) prohibits LIBERTY's Credentialing Committee from making decisions based on the types of procedures or patients in which the practitioner specializes.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
4. The DBA may not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. a. If the DBA declines to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision. b. In all contracts with network providers, the DBA must comply with the requirements specified in 42 CFR §438.214. 42 CFR §438.12 (a)(1-2) Contract 3.6.2.9	**HSAG Recommended Evidence:** • Policies and procedures • Provider notice template • Example of one individual and one organizational executed provider contracts **Evidence as Submitted by the DBA:** 1. C1 CR PP - C1 Credentialing Overview and Provider Rights: Page 3, Section A #8 2. C2 CR PP - C2 Credentialing Committee: Purpose/Scope #4 3. NV Provider Agreement 2016.07.26: Page 4, Section 2.2.d.ii-iii 4. Executed Contract-[provider name] 5. Provider Notice Template, Cite entire policy	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY does not discriminate in the participation, reimbursement, or indemnification of any provider who is acting with the scope of their license or certification under applicable State law, solely on the basis of that license or certification, per 42 CFR §438.12 (a)(1-2) and Contract 3.6.2.9.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
In compliance with 42 CFR §438.12 (a)(1-2) and Contract 3.6.2.9, LIBERTY's *Credentialing Overview and Provider Rights* policy (Evidence #1) ensures that the decision to credential and recredential a provider's continued participation in LIBERTY's network is conducted in a non-discriminatory manner by prohibiting decisions based on the types of procedures or patients in which the provider specializes. Further, LIBERTY's *Credentialing Committee* policy (Evidence #2) ensures that credentialing and recredentialing activity is conducted in a non-discriminatory manner by prohibiting decisions based solely on an applicant's serving high-risk populations or specializing in treatment of costly conditions. LIBERTY's *Credentialing Overview and Provider Rights* policy (Evidence #1) ensures that adverse credentialing and recredentialing decisions are communicated to the provider in writing, including the reason for the decision and appeal rights, as applicable, within sixty (60) business days of application. LIBERTY's *Nevada Provider Agreement* (Evidence #3) complies with 42 CFR §438.214 by incorporating by reference the Provider Manual and its citations of LIBERTY's nondiscrimination P&Ps (see sample executed individual provider contract and provider notice template, Evidence #4 - #5). Please note, as a dental benefits administrator, LIBERTY's does not contract with or credential organizational providers (i.e., hospitals and behavioral health facilities); as such, no organizational contracts are available.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
Excluded Providers		
5. The DBA may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. 42 CFR §438.214(d)(1) Contract 3.6.5.13(F)	**HSAG Recommended Evidence:** • Policies and procedures • Three consecutive months of ongoing monitoring reports/documentation **Evidence as Submitted by the DBA:** 1. CM PP – Corporate Sanction Screening Process: Page 2, Policy #2 2. C2 CR PP – C2 Credentialing Committee: Page 8, Section VIII.b 3. Nevada Ongoing Monitoring report April 2022 4. Nevada Ongoing Monitoring report May 2022	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	5. Nevada Ongoing Monitoring report June 2022	
DBA Description of Process: LIBERTY does not employ or contract with providers excluded from participating in Federal health care programs under either section 1128 or section 1128A of the Social Security Act, per 42 CFR §438.214(d)(1) and Contract 3.6.5.13(F). In compliance with 42 CFR §438.214(d)(1) and Contract 3.6.5.13(F), LIBERTY's *Corporate Sanction Screening Process* policy (Evidence #1) prohibits LIBERTY from employing, contracting with or issuing payment to any individual or entity it determines is suspended, debarred or excluded from participation in federal or state health care programs. Further, LIBERTY's *Credentialing Committee* policy (Evidence #2) ensures that during credentialing and recredentialing or during ongoing monthly monitoring, providers found to be excluded from or sanctioned by Medicare or Medicaid are ineligible for participation in LIBERTY's network (see samples of LIBERTY's *Ongoing Monitoring Reports* from April, May and June 2022, Evidence #3 - #5).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
State Requirements		
6. *The governing body, or the group or individual to which the governing body has formally delegated the credentialing function, reviews and approves the credentialing policies and procedures.* a. *The DBA designates a credentialing committee, or other peer review body, which makes recommendations regarding credentialing decisions.* 42 CFR §438.214(e) Contract 3.9.15.2-3.9.15.3	**HSAG Recommended Evidence:** • Policies and procedures • Governing body approval of credentialing policies and procedures • Credentialing committee charter • 3 consecutive examples of credentialing committee meeting minutes **Evidence as Submitted by the DBA:** 1. 2021 Credentialing Committee Charter: Page 2 2. C2 CR PP – C2 Credentialing Committee: Page 2, Purpose/Scope #1 3. Credentialing Meeting Full Presentation 03-10-2022 4. Credentialing Meeting Full Presentation 04-07-2022 -1Q OPTOUT	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	5. Credentialing Meeting Full Presentation 05-05-2022 6. Note to Reviewer – Credentialing Committee Presentation	
DBA Description of Process: In compliance with 42 CFR §438.214€, LIBERTY's Credentialing Committee charter and policies reflect State requirements outlined in Contract 3.9.15.2 and 3.9.15.3, as follows. Per Contract 3.9.15.2, LIBERTY's *Credentialing Committee Charter* (Evidence #1) specifies that LIBERTY's governing body (its Board of Directors) has formally delegated the credentialing function to the Credentialing Committee. Further, LIBERTY's *Credentialing Committee* policy (Evidence #2) specifies that the Credentialing Committee reviews credentialing policies and procedures for approval by LIBERTY's QMI Committee. Per Contract 3.9.15.3, LIBERTY's *Credentialing Committee Charter* (Evidence #1) designates the Credentialing Committee as the peer review body responsible for making recommendations regarding credentialing decisions by reviewing and accepting or rejecting the professional credentials of applicant providers (see LIBERTY's Credentialing Committee minutes, Evidence #3, #4, #5).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
7. *If the DBA has denied credentialing or not extended a provider contract to a provider where the denial is due to the DBA's concerns about provider fraud, integrity, or quality, the DBA reports this to the State's Provider Enrollment Unit within fifteen (15) calendar days.* 42 CFR §438.214(e) Contract 3.9.15.5(N)	**HSAG Recommended Evidence:** • Policies and procedures • Example of timely report to Provider Enrollment Unit **Evidence as Submitted by the DBA:** 1. C6 CR PP – C6 Notification to Authorities and Practitioner Appeal Rights: Page 1, Purpose/Scope 2. Quick Reference Guide State of Nevada FINAL: Page 5	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: In compliance with 42 CFR §438.214(e), LIBERTY's credentialing process reflects State requirements outlined in Contract 3.9.15.5(N), as follows:		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
LIBERTY's *Notification to Authorities and Practitioner Appeal Rights* policy (Evidence #1), outlines LIBERTY's adverse decision process. If LIBERTY has denied credentialing or not extended a provider contract, where the denial is due to concerns about provider fraud, integrity or quality, LIBERTY reports the concern to the State's Provider Enrollment Unit within fifteen (15) days, *Quick Reference Guide* (Evidence #2). There were no applicable adverse decisions within the look-back period, and as such, no reports to DHCFP's Provider Enrollment Unit.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element. Of note, DBA staff members confirmed that they have not denied credentialing or extended a provider contract due to concerns about fraud, integrity, or quality during the time period of review; however, the DBA's quality management department or special investigative unit (SIU) would report any identified concerns to DHCFP.		
Required Actions: None.		
8. *If the DBA delegates credentialing and recredentialing, recertification, or reappointment activities, there must be a written description of the delegated activities, and the delegate's accountability for these activities.* a. *There must be evidence that the delegate accomplished the credentialing activities.* b. *The DBA must monitor the effectiveness of the delegate's credentialing and reappointment or recertification process.* 42 CFR §438.214(e) Contract 3.9.15.7	**HSAG Recommended Evidence:** • Policies and procedures • Delegation agreement template • Two examples of an executed delegation agreement for credentialing • Two examples of evidence to demonstrate credentialing monitoring, including credentialing completion oversight **Evidence as Submitted by the DBA:** 1. CVO Contract – MSA – VP 20210630: Page 7; Page 12, Section J.A and J.F a. CVO_Contract_DOA – VP 20190415 b. CVO_Contract_NV Medicaid Addendum Verifpoint 20171006_Redacted 2. C8 CR PP – C8 Delegation of Credentialing and Credentialing Outsource Delegation: Page 1, Purpose/Scope; Page 2, Policy 3. Example CVO report: Cite entire document 4. 11 2021 – VP VerifPoint Full Cred Delegated Oversight Audit Report: Cite entire document	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
DBA Description of Process: In compliance with 42 CFR §438.214(e), LIBERTY's delegation of primary source verification reflects State requirements outlined in Contract 3.9.15.7, as follows: LIBERTY delegates credentialing, recertification and reappointment primary source verification activities to its Credentials Verification Organization (CVO) and maintains a written description of the delegated activities and the delegate's accountability for such activities (see *CVO Contract*, Evidence #1). Per LIBERTY's *Delegation of Credentialing and Credentialing Outsource Delegation* policy (Evidence #2), LIBERTY collects evidence that the CVO accomplishes delegated activities via ongoing CVO reporting (Evidence #3) and monitors the effectiveness of such activities via oversight audits (initial, annual, and ad hoc, as necessary) (Evidence #4). Separately, please note that LIBERTY retains the sole right to make credentialing and recredentialing decisions about its network providers (see LIBERTY's *Delegation of Credentialing and Credentialing Outsource Delegation* policy, Evidence #2; and *CVO Contract*, Evidence #1).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
File Reviews		
9. The DBA complies with individual practitioner credentialing requirements as specified in the Practitioner Credentialing and Recredentialing File Review Tool. 42 CFR §438.214(e) Contract 3.9.15.5	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing File Reviews **Evidence as Submitted by the DBA:** 1. C3 CR PP – C3 Initial Credentialing Process, Cite entire policy 2. C6 CR PP – C6 Notification to Authorities and Practitioner Appeal Rights: Page 2, Policy 3. Quick Reference Guide State of Nevada FINAL: Page 5	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: In compliance with 42 CFR §438.214(e), LIBERTY's individual provider credentialing requirements reflect State requirements outlined in Contract 3.9.15.5, as follows:		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
LIBERTY's *Initial Credentialing Process* policy (Evidence #1) outlines LIBERTY's documented process for credentialing network providers, in alignment with the requirements in Contract 3.9.15.5 and the Practitioner Credentialing and Recredentialing File Review Tool. LIBERTY's *Notification to Authorities and Practitioner Appeal Rights* policy and *Quick Reference Guide* (Evidence #2 and #3), outline LIBERTY's adverse credentialing decision process, and specify the requirement to notify the appropriate state unit within 15 days, in alignment with the Practitioner Credentialing and Recredentialing File Review Tool.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element. **Recommendations:** The case file review identified one provider whom the DBA confirmed was licensed to practice in the State of Nevada. However, the provider listed three previous out-of-state practice locations, suggesting that the provider had active/inactive licenses in those states although they were not disclosed by the provider on the application. HSAG recommends that the DBA follow up with providers when potentially conflicting information is identified through the provider application and complete primary source verification (PSV) of all active/inactive out-of-state licensures. Additionally, three case files demonstrated that a Drug Enforcement Administration (DEA) registration waiver was approved. For one of those files, an alternative prescriber was identified; however, no verification of the alternative prescriber's DEA registration or State of Nevada Board of Pharmacy (BOP) license was provided. After the site review, a recredentialing report for the alternative prescriber was provided. While the DEA and State of Nevada BOP verifications occurred after the non-prescribing provider was credentialed, the recredentialing report indicated that the alternative prescriber was previously credentialed with the DBA. However, for each credentialing file with an identified alternative prescriber, HSAG recommends that the DBA document in the file that the DBA verified the alternative prescriber's credentials prior to approving the DEA waiver. HSAG will be recommending that DHCFP include verification requirements for alternative prescribers in contract. Further, two files also included an approved DEA waiver but did not include an alternative prescriber; instead, the files indicated that the provider would ensure an alternative prescriber would be made available as needed. HSAG would have expected that the approved DEA waiver with no alternative prescriber identified include a written statement that the prescriber would not prescribe controlled substances and that in the prescriber's professional judgment, the patients receiving care would not require controlled substances. DBA staff members further explained that their DEA waivers were acceptable to the National Committee for Quality Assurance (NCQA). However, HSAG strongly recommends that the DBA ensure that the DEA waivers with no alternative prescriber include this written statement from the provider moving forward. Further, site reviews within the credentialing files were greater than three years old, with one dated 2009. Also, one site review occurred telephonically two days after the provider was approved. Due to the challenges of the pandemic, HSAG did not consider this observation a deficiency. However, moving forward, the DBA must ensure that each provider being credentialed has the results of an on-site survey documented in the case file. DBA staff members also explained that on-site reviews would occur at the group level; therefore, the on-site review for a new provider joining a group practice may have occurred several years prior. However, significant changes in group practices may occur over a period of several years; therefore, HSAG will be recommending that DHCFP include a time frame requirement for site reviews in its contract with the DBA. While the DBA verified sanctions/exclusions, HSAG will be recommending that DHCFP identify the databases which must be queried in contract for consistency across the managed care plans for Nevada Medicaid. HSAG will also be		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
recommending that DHCFP define a time frame standard to complete the initial credentialing process (e.g., 60 or 90 calendar days from receipt of a complete application to the notice of the credentialing decision to the provider) for consistency across the managed care plans for Nevada Medicaid. Implementation of these recommendations will be evaluated during future compliance reviews.		
Required Actions: None.		
10. The DBA complies with individual practitioner recredentialing requirements as specified in the Practitioner Credentialing and Recredentialing File Review Tool. 42 CFR §438.214 Contract 3.9.15.6	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Recredentialing File Reviews **Evidence as Submitted by the DBA:** 1. C4 CR PP - C4 Re-Credentialing Process: Cite entire policy 2. C6 CR PP - C6 Notification to Authorities and Practitioner Appeal Rights: Page 2, Policy 3. Quick Reference Guide State of Nevada FINAL: Page 5	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: In compliance with 42 CFR §438.214(e), LIBERTY's individual provider recredentialing requirements reflect State requirements outlined in Contract 3.9.15.6, as follows: LIBERTY's *Re-Credentialing Process* policy (Evidence #1) outlines LIBERTY's documented process for recredentialing network providers, in alignment with the requirements in Contract 3.9.15.6 and the Practitioner Credentialing and Recredentialing File Review Tool. LIBERTY's recredentialing process follows a thirty-six (36) month timeframe (well within the sixty (60) month contract requirement). LIBERTY's *Notification to Authorities and Practitioner Appeal Rights* policy and *Quick Reference Guide* (Evidence #2 and #3), outline LIBERTY's adverse credentialing decision process, and specify the requirement to notify the appropriate state unit within 15 days, in alignment with the Practitioner Credentialing and Recredentialing File Review Tool.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element. **Recommendations:** The recredentialing report within the case files verified that member grievances, appeals, satisfaction, utilization management, quality improvement, and site audits were considered at the time of recredentialing. DBA staff members explained that various departments who sit on the credentialing committee would be notified of the list of providers due to be reviewed at the upcoming committee. The various departments would then be responsible for bringing any performance concerns to the committee for consideration. HSAG recommends that each program area or department be		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
prepared to provide a live walk-through of the process of reviewing performance concerns during future compliance reviews. Additionally, Form NDOI [Nevada Division of Insurance]-901-R (3/07) was used in lieu of Form NDOI-901 (12/16); therefore, providers were required to attest to the disclosure questions for the past three years as opposed to having any history. After the site review, DBA staff members further clarified that Form NDOI-901-R is the application for reappointment (or recredentialing), and the review period covers the prior three years from the previous credentialing date. As only Form NDOI-901 (12/16) was available via the NDOI website using the Uniform Credentialing Form link, HSAG recommends that the DBA confirm that Form NDOI-901-R (3/07) is still in use and acceptable to use for recredentialing. Implementation of these recommendations will be evaluated during future compliance reviews.		
Required Actions: None.		
11. The DBA complies with organizational credentialing requirements as specified in the Organizational Credentialing and Recredentialing File Review Tool. 42 CFR §438.214	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Organizational Credentialing File Reviews **Evidence as Submitted by the DBA:** N/A	☐ Met ☐ Not Met ☒ NA
DBA Description of Process: Not applicable to LIBERTY. As a dental benefits administrator, LIBERTY's network is comprised of dental providers only. LIBERTY does not contract with or credential organizational providers (i.e., hospitals and behavioral health facilities).		
HSAG Findings: As the DBA does not contract with or credential organizational providers, HSAG has determined that the requirements of this element are not applicable to the DBA.		
Required Actions: None.		
12. The DBA complies with organizational recredentialing requirements as specified in the Organizational Credentialing and Recredentialing File Review Tool. 42 CFR §438.214	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Organizational Recredentialing File Reviews **Evidence as Submitted by the DBA:** N/A	☐ Met ☐ Not Met ☒ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
DBA Description of Process: Not applicable to LIBERTY. As a dental benefits administrator, LIBERTY's network is comprised of dental providers only. LIBERTY does not contract with or credential organizational providers (i.e., hospitals and behavioral health facilities).		
HSAG Findings: As the DBA does not contract with or credential organizational providers, HSAG has determined that the requirements of this element are not applicable to the DBA.		
Required Actions: None.		

Standard VIII—Provider Selection						
Met	=	10	X	1	=	10
Not Met	=	0	X	0	=	0
Not Applicable	=	2				
Total Applicable	=	10	Total Score		=	10
Total Score ÷ Total Applicable					=	100%

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. The DBA must, for medical records and any other health and enrollment information that identifies a particular member, use and disclose such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable. The DBA must: a. *Establish in writing, and enforce, policies and procedures on confidentiality, including confidentiality of dental records.* b. *Ensure patient care offices/sites have implemented mechanisms to guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the DBA.* c. *Hold confidential all information obtained by its personnel about members related to their examination, care, and treatment and shall not divulge it without the member's authorization, unless required or permitted by law.* 42 CFR §438.224 Contract 3.3.6.10; 3.9.16.9(A-C)	**HSAG Recommended Evidence:** • Policies and procedures • Disclosure form(s) or other forms used by the DBA to take action regarding member PHI • Staff and provider training materials • Provider contract templates • Staff and provider monitoring documentation **Evidence as Submitted by the DBA:** 0. Note to Reviewer 1. HA PP - Administrative Requirements - HIPAA Privacy Program – (1) – pgs.1, 2, 3 2. HA PP - Confidentiality & Release of Information (Nevada) (1, 1a, 1b, 1c) – pgs. 1, 2 3. HA PP - Dental Record Reviews & Documentation Standards (1, 1a, 1b)—pgs. 1, 2 4. HA PP - Uses and Disclosure of Protected Health Information - General Rules (1, 1c)—p.1 5. LIBERTY Privacy & Security Program 6. HIPAA Compliance Walkthrough Survey (1a) – *cite to entire document* 7. HIPAA Privacy Training - (1, 1a) – pgs. 6,7,13,17 8. LIBERTY Employee Handbook (1, 1a) – p.44 9. LIBERTY Provider Reference Guide – (1, 1a, 1b, 1c) – pgs.33-34 10. LIBERTY Provider Contract Template (1, 1a, 1b, 1c) – pg.5	☒ Met ☐ Not Met ☐ NA

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	11. HA PP – Secure Use & Transmission of E-PHI - (1, 1a, 1b, 1c) – *cite to entire policy, see especially highlighted areas*	

DBA Description of Process: In compliance with §438.224, LIBERTY's *Administrative Requirements, Confidentiality & Release of Information, Dental Record Reviews* and *Use &Disclosure of PHI* policies, and *Privacy & Security Program* (Evidence #1,2,3,4,5) establish that LIBERTY must only use PHI in accordance with applicable privacy requirements, including ensuring that each member's privacy is protected in the process of coordinating care, per Contract 3.3.6.10. LIBERTY training and monitoring activities reinforce these policies (see: *HIPAA Walkthrough* and *Training*, Evidence 6,7).

Further, LIBERTY complies with Nevada DHCFP confidentiality requirements set forth in Contract 3.9.16. (A-C), as follows:

- **Per Contract 3.9.16 (A),** LIBERTY's *Privacy & Security Program, Employee Handbook, Provider Reference Guide* (Evidence #5,8,9) and related policies formally establish LIBERTY's standards for confidentiality, including confidentiality of dental records, and enforcement of such standards. (see: *Confidentiality & Release of Information*; *Dental Record Reviews; Administrative Requirements*; and *Use & Disclosure of PHI*, Evidence #2, 3, 1, 4).

- **Per Contract 3.9.16 (B),** LIBERTY's *Provider Reference Guide, Provider Contract* and *E-PHI, Confidentiality and Release of Information,* and *Dental Record Review* policies (Evidence #9,10,11,2,3) ensure that patient care offices/sites have implemented mechanisms to guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of LIBERTY.

- ***Per Contract 3.9.16 (C),*** *LIBERTY's Confidentiality & Release of Information, Dental Record Review,* and *Use & Disclosure of PHI policies (*Evidence #2,3,4) ensure that LIBERTY holds confidential all information obtained by its personnel about members related to their examination, care, and treatment, and does not divulge such information without the member's authorization, unless required or permitted by law.

HSAG Findings: HSAG has determined that the DBA met the requirements for this element.

Required Actions: None.

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Uses and Disclosures of PHI		
2. The DBA and its business associates may not use or disclose protected health information (PHI) except as permitted or required by 45 CFR §164.502 or by 45 CFR §160 subpart C. The DBA is permitted to use or disclose PHI as follows: a. To the individual. b. For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR §164.506. c. Incident to a use or disclosure otherwise permitted or required by 45 CFR §164.502, provided that the DBA has complied with the applicable requirements of 45 CFR §§164.502(b), 164.514(d), and 164.530(c). d. Except for uses and disclosures prohibited under 45 CFR §164.502(a)(5)(i), pursuant to and in compliance with a valid authorization under 45 CFR §164.508. e. Pursuant to an agreement under, or as otherwise permitted by 45 CFR §164.510. f. As permitted by and in compliance with 45 CFR §164.512, §164.514(e), (f), or (g). 45 CFR §164.502(a)(1)	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Business associate agreement template • Delegate agreement/contract • HIPAA incident tracking mechanism **Evidence as Submitted by the DBA:** 1. HA PP - Uses and Disclosure of Protected Health Information - General Rules (2a-f) – pgs. 1-2 2. LIBERTY Privacy & Security Program 3. Business Associate Agreement Template (2) – pgs. 1-2 4. HIPAA Privacy Training 5. LIBERTY Incident Management Plan - *cite entire document* 6. 2021 - 2022 Nevada Medicaid Incident Log -*cite entire document* 7. Incident Management System Sample Case – *cite entire document* 8. Incident Response Training – *cite entire document*	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with use and disclosure of protected health information (PHI) requirements, per 45 CFR §164.502 and 45 CFR §160 subpart C. LIBERTY's *Uses and Disclosure of PHI* policy, *Privacy & Security Program,* and *Business Associate Agreement* (Evidence #1, 2, 3) establish when LIBERTY and its business associates are permitted to use or disclose PHI, as reinforced in LIBERTY's *HIPAA Training* (Evidence #4). In addition, LIBERTY's *Incident Management Plan* (Evidence #5) formally outlines a protocol for handling non-permitted disclosures, including tracking such incidents via LIBERTY's *Incident Management System* (see *Incident Log, Sample Case,* and *Training,,* Evidence #6, 7,8).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
3. The DBA, and its business associate as permitted or required by its business associate contract, is required to disclose PHI: a. To an individual, when requested under, and required by 45 CFR §164.524 or §164.528. b. When required by the Secretary to investigate or determine the DBA's compliance with CFR 45 §160 subpart C. 45 CFR §164.502(a)(2-4)	**HSAG Recommended Evidence:** • Policies and procedures • Workflow for processing requests • Training materials • Business associate agreement template **Evidence as Submitted by the DBA:** 1. HA PP - Uses and Disclosure of Protected Health Information - General Rules - Page.2, sections 2a and b (Elements 3a, 3b) 2. HA PP - Right to Access Protected Health Information & Written Authorizations (3a) – p.1 3. HA PP - Accounting of Disclosures of Protected Health Information (3a) – p.1 4. Business Associate Agreement Template – (3a, 2b) - pgs. 3 5. HIPAA Privacy Training (3a) 6. Member Services Job Aid (3a) - rows 1 and 6	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY's *Uses and Disclosure of Protected Health Information, Right to Access,* and *Accounting of Disclosure* policies and *Business Associate Agreement* (Evidence #1, 2, 3, 4), establish when and how LIBERTY and its business associates are required to disclose PHI to an individual or the Secretary, consistent with 45 CFR §164.502(a)(2-4), and as reinforced in LIBERTY's training materials (see: *HIPAA Privacy Training* and *Member Services Job Aid*, Evidence #5, 6).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Minimum Necessary		
4. When using or disclosing PHI or when requesting PHI from another covered entity or business associate, the DBA must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. 45 CFR §164.502(b)	**HSAG Recommended Evidence:** • Policies and procedures • Training materials **Evidence as Submitted by the DBA:** 1. HA PP - Minimum Necessary Use and Disclosure of PHI – pgs. 2-3 2. LIBERTY Privacy & Security Program 3. HIPAA Privacy Training: Page 9	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with HIPAA minimum necessary requirements, per 45 CFR §164.502(b). LIBERTY's *Minimum Necessary* policy and *Privacy & Security Program* (Evidence #1, 2) specify that, when using or disclosing PHI, or when requesting PHI from another covered entity, LIBERTY must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request, as reinforced by LIBERTY's *HIPAA Privacy Training* (Evidence #3).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
5. Minimum necessary does not apply to: a. Disclosures to or requests by a health care provider for treatment. b. Uses or disclosures made to the individual. c. Uses or disclosures made pursuant to an authorization under 45 CFR §164.508. d. Disclosures made to the Secretary regarding compliance and investigations under 45 CFR Part 160. e. Uses or disclosures that are required by law. f. Uses or disclosures that are required for compliance with applicable requirements of 45 CFR.	**HSAG Recommended Evidence:** • Policies and procedures • Training materials **Evidence as Submitted by the DBA:** 1. LIBERTY Privacy & Security Program (5a-f)	☒ Met ☐ Not Met ☐ NA

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
45 CFR §164.502(b)(2)		
DBA Description of Process: In compliance with 45 CFR §164.502(b)(2), LIBERTY's *Privacy & Security Program* establishes when HIPAA's minimum necessary requirement does not apply to uses and disclosures of PHI.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
Uses and Disclosures Requiring Authorizations		
6. Except as otherwise permitted or required by 45 CFR Part 164 Subpart E, a covered entity may not use or disclose PHI without a valid authorization. When a covered entity obtains or receives a valid authorization for its use or disclosure of PHI such use or disclosure must be consistent with such authorization. a. If a covered entity seeks an authorization from an individual for a use or disclosure of PHI, the covered entity must provide the individual with a copy of the signed authorization. 45 CFR §164.508(a)(1) 45 CFR §164.508(b)(1-6) 45 CFR §164.508(c)(1-4)	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Authorization for use and disclosure form **Evidence as Submitted by the DBA:** 1. Right to Access Protected Health Information & Written Authorizations (6 and 6a) – pgs. 1,5,6 2. LIBERTY Privacy & Security Program (6) 3. PHI Authorization to Disclose Form (6) - *cite entire document* 4. HIPAA Forms Training (Element 6) - *cite entire document*	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: In compliance with 45 CFR §164.508(a)(1), LIBERTY's *Authorizations* policy and *Privacy & Security Program* (Evidence #1, 2) establish that LIBERTY may not use or disclose PHI without a valid authorization unless otherwise permitted or required by 45 CFR Part 164 E. LIBERTY's *Authorizations* policy (Evidence #1) also specifies that if LIBERTY seeks an authorization from an individual, it must provide the individual a signed copy. Further, LIBERTY's *Authorization* policy and *Form* (Evidence #1,3) reflect the authorization requirements outlined in §164.508(b)(1-6) and §164.508(c)(1-4), as reinforced by LIIBERTY's *HIPAA Forms Training* (Evidence #4).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Privacy Rights		
7. The DBA complies with the member's right to request privacy protection for PHI and the requirements under 45 CFR §164.522. 45 CFR §164.522	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Process workflow • Tracking documentation • Request form template • Three examples of completed request documentation **Evidence as Submitted by the DBA:** 1. HA PP - Request for Restrictions on Use and Disclosure – p.1 2. LIBERTY Privacy & Security Program 3. Notice of Privacy Practices 4. Member Services Job Aid	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY's *Request for Restrictions* policy and *Privacy & Security Program* (Evidence #1, 2) establish that LIBERTY must comply with an individual's right to request privacy protection in compliance with 45 CFR §164.522. Further, LIBERTY's *Notice of Privacy Practices* and *Member Services Job Aid* (Evidence #3, 4) reinforce that such requests may be submitted in writing to the Privacy Officer, via mail, fax, email, or online, and provide a direct phone number for questions or concerns. LIBERTY did not receive any requests for confidential communications during the look back period.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
8. The DBA complies with the member's right to access PHI and the requirements under 45 CFR §164.524. a. The DBA must act on a request for access no later than 30 days after receipt of the request. b. The DBA must provide the member with access to the PHI in the form and format requested by the member, if it is readily producible in such form and format, or if not, in a readable hard copy form or such other form and format as agreed to by the DBA and member. 45 CFR §164.524	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Process workflow • Tracking documentation • Request form template • Three examples of completed request documentation **Evidence as Submitted by the DBA:** 1. HA PP - Right to Access Protected Health Information & Written Authorizations (8a, 8b), pgs. 1,2,3 2. LIBERTY Privacy & Security Program (Element 8) 3. Notice of Privacy Practices (Element 8) 4. Member Services Job Aid (Element 8)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY's *Right to Access PHI* policy and *Privacy & Security Program* (Evidence #1, 2) establish that LIBERTY must comply with an individual's right to access PHI under 45 CFR §164.524, including acting on a request for access no later than 30 days after receipt of the request, and providing access in the requested form and format (if readily producible). LIBERTY's *Notice of Privacy Practices* and *Member Services Job Aid* (Evidence #3, 4) reinforce that such requests may be submitted in writing to the Privacy Officer, via mail, fax, email, or online, and provide a direct phone number for questions or assistance. LIBERTY did not receive any requests to access PHI during the look back period.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
9. The DBA complies with the member's right to have the DBA amend PHI or a record about the member in a designated record set for as long as the PHI is maintained in the designated record set. The DBA complies with the requirements under 45 CFR §164.526.	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Process workflow • Tracking documentation • Request form template	☒ Met ☐ Not Met ☐ NA

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
a. The DBA must act on the member's request for an amendment no later than 60 days after receipt of such a request. 45 CFR §164.526	• Three examples of completed request documentation **Evidence as Submitted by the DBA:** 1. HA PP - Dental Records Request for Amendment by Member (9) – *cite to entire document* 2. LIBERTY Privacy & Security Program (9, 9a) 3. Notice of Privacy Practices (9) 4. Member Services Job Aid (9)	
DBA Description of Process: LIBERTY's *Dental Records Request for Amendment* policy and *Privacy & Security Program* (Evidence #1, 2) establish that LIBERTY must comply with an individual's right to have LIBERTY amend PHI about the individual consistent with 45 CFR §164.526, including acting on a request no later than 60 days after its receipt. LIBERTY's *Notice of Privacy Practices* and *Member Services Job Aid* (Evidence #3, 4) reinforce that such requests may be submitted in writing to the Privacy Officer, via mail, fax, email, or online, and provide a direct phone number for questions or assistance. LIBERTY did not receive any requests to amend PHI during the look back period.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
10. The DBA complies with the member's right to receive an accounting of disclosures of PHI made by the DBA in the six years prior to the date on which the accounting is requested, in compliance with the requirements under 45 CFR §164.528. a. The DBA must act on the member's request for an accounting, no later than 60 days after receipt of such a request. b. The DBA must document the accounting of disclosures and retain the documentation as required by 45 CFR §164.530(j). 45 CFR §164.528	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Process workflow • Tracking documentation • Request form template • Three examples of completed request documentation **Evidence as Submitted by the DBA:** 1. HA PP - Accounting of Disclosures of Protected Health Information (10a, 10b) – p.1, 2, 3 2. Privacy & Security Program (10)	☒ Met ☐ Not Met ☐ NA

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	3. HA PP - Administrative Requirements - HIPAA Privacy Program (10b) – p.4 4. Notice of Privacy Practices (10) 5. Member Services Job Aid (10)	
DBA Description of Process: LIBERTY's *Accounting of Disclosures* policy and *Privacy & Security Program* (Evidence #1, 2) establish that LIBERTY must comply with an individual's right to receive an accounting of disclosures under 45 CFR §164.528, including acting on a request for an accounting no later than 60 days after receipt of the request, and retaining documentation of the accounting for a minimum of six (6) years per §164.530(j) (as also reflected in LIBERTY's *Administrative Requirements* policy, Evidence #3). LIBERTY's *Notice of Privacy Practices* and *Member Services Job Aid* (Evidence #4, 5) reinforce that such requests may be submitted in writing to the Privacy Officer, via mail, fax, email, or online, and provide a direct phone number for questions or assistance. LIBERTY did not receive any requests for an accounting of disclosures during the look back period.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
Notice of Privacy Practices		
11. The DBA's members have a right to adequate notice of the uses and disclosures of PHI that may be made by the DBA, and of the member's rights and the DBA's legal duties with respect to PHI. a. The DBA must provide a notice that is written in plain language and that contains the elements required by 45 CFR §164.520(b)(1)(i-viii). b. The DBA must make the notice available to its members on request as required by 45 CFR §164.520(c)(1-3). 45 CFR §164.520(a)(1) 45 CFR §164.520(b)(1)(i-viii) 45 CFR §164.520(c)(1-3)	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Authorization for use and disclosure form • Copy of notice of privacy practices **Evidence as Submitted by the DBA:** 1. HA PP - Notice of Privacy Practices (11) – p.1 2. HA PP - Administrative Requirements - HIPAA Privacy Program (11) - 3. Privacy & Security Program – (11, 11a, 11b), p. 3 4. Notice of Privacy Practices (11, 11a) – *cite entire document* 5. DHCFP Approval: HIPAA Privacy Notice Reminder (11a) – *cite entire document*	☒ Met ☐ Not Met ☐ NA

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	6. Note to Reviewer – Online Publication of Privacy Notice (11b) – *cite entire document* 7. Member Handbook (11b) 8. Member Services Job Aid (Element 11c) 9. Privacy & Security Committee Minutes	
DBA Description of Process: Per 45 CFR §164.520, LIBERTY's *Notice of Privacy Practices* and *Administrative Requirements* policies and *Privacy & Security Program* (Evidence #1, 2, 3) specify that, with regard to PHI, LIBERTY must adequately notify individuals of their rights; LIBERTY's duties; and of uses and disclosures that LIBERTY may make. LIBERTY's *Notice of Privacy Practices* (Evidence #4) reflects the plain language and content requirements outlined in §164.520(b)(1)(i-viii) (see also LIBERTY's *Privacy & Security Program,* Evidence #5=3). Further, LIBERTY's *Privacy & Security Program* (Evidence #3) ensures LIBERTY makes its notice available to its members consistent with 45 CFR §164.520(c)(1-3) (see also, *DHCP Approval*, *Online Publication; Member Handbook, Member Services Job Aid; and Privacy & Security Committee Minutes,* Evidence #5, 6,7,8*).*		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element. **Recommendations:** Although the HIPAA [Health Insurance Portability and Accountability Act of 1996] Joint Privacy Notice provided a link for members to access the DBA's Notice of Privacy Practices at any time, including when there is a material change, compliance with the notice requirements under 45 CFR §164.520(b)(1)(v)(C) was therefore scored as *Met*. However, HSAG strongly recommends that the DBA include detailed information about how the DBA will also provide the notice to the member should the notice be updated due to a material change (e.g., provide the revised notice or information about the change and how to obtain the revised notice in its next annual mailing) in support of 45 CFR §164.520(c)(1)(v), which requires the DBA to provide the information directly to the member instead of the member having to seek out the new notice by requesting it from the privacy officer or accessing the website. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard IX—Confidentiality						
Met	=	11	X	1	=	11
Not Met	=	0	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	11	Total Score		=	11
Total Score ÷ Total Applicable					=	100%

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Grievance System General Requirements		
1. *The DBA has a staff person dedicated to the Contract who acts as the Grievances and Appeals Coordinator with the appropriate training, education, and experience to fulfill the requirements of the position.* a. *The DBA shall have sufficient support staff (clerical and professional) available to process grievance and appeals in accordance with the requirements of the Contract.* Contract 3.12.1.6; 3.14.3.2-3.14.3.3	**HSAG Recommended Evidence:** • Job description • Organizational chart • Training materials **Evidence as Submitted by the DBA:** • 00. Note to Reviewer - Policy Issue & Approval Dates • 06. Grievances and Appeals Analyst Job Description (Entire Document) • 10. State Dental Director Job Description (Entire Document) • 07. LDP Appeals and Grievances Organizational Structure (Entire Document) • 08. LDP Grievances and Appeals Clinical Leadership Organization (Entire Document) • 13. Grievances and Appeals Team Lead Job Description (Entire Document) • 14. Supervisor Grievances and Appeals Job Description (Entire Document) • 15. Manager Grievances and Appeals Job Description (Entire Document) • 16. Director Grievances and Appeals Job Description (Entire Document) • 26. AVP Quality Improvement Job Description (Entire Document) • 29. VP Quality Management Job Description (Entire Document • 32. Grievances and Appeals Job Descriptions (Entire Folder)	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
	• 01. GA PP - Grievance Process Policy- NEVADA MEDICAID (Entire Document) • 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (Entire Document)	
DBA Description of Process: LIBERTY complies with the Grievance System staffing requirements in Contract 3.12.1.6, 3.14.3.2-3.14.3.3. LIBERTY's Grievances and Appeals staff dedicated to Nevada includes a Grievances and Appeals Analyst as well a Nevada-licensed State Dental Director (Evidence #6, 7, 8, 10 and 32). These dedicated resources are supported by the LIBERTY Clinical, Quality Management, and Grievances and Appeals leadership and staff (Evidence #7, 8, 13, 14, 15, 16, 26, 29, and 32). As detailed in our Nevada Medicaid Grievance Process and Single Level Appeals Process policies (Evidence #1 and 2), LIBERTY's Grievance System has sufficient staff in the appropriate roles throughout the Grievance System lifecycle. Support staffing needs for Nevada are assessed continuously to ensure we maintain grievances and appeals intake, acknowledgment, investigation, and response timeframes. LIBERTY's Grievances and Appeals staff are cross trained on our policies and procedures to support Nevada if there is a need, providing redundancy to scale for an unexpected influx in case volume or specific expertise (Evidence #32).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
2. The DBA defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination (ABD). Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the DBA to make an authorization decision. 42 CFR §438.400(b) 42 CFR §438.228 Contract 3.12.1.1	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the DBA:** • 01. GA PP - Grievance Process Policy- NEVADA MEDICAID (page 1) • 05. LDP NV Medicaid Member Handbook: Reporting and Solving Problems "How Do I Submit A Grievance" (page 35)	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
DBA Description of Process: LIBERTY complies with the grievance definition requirements of 42 CFR §438.400(b), 42 CFR §438.228, and Contract 3.12.1.1. Our Nevada Medicaid Grievance Process Policy (Evidence #1) uses the exact language required, and our Nevada Medicaid Member Handbook (Evidence #5) reflects the grievance definition in the appropriate language and reading level required.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element. **Recommendations:** The grievance acknowledgement notice and Grievance Process Policy included information that pertained only to appeals (e.g., exhausting the complaint process, informing members of the right to access documents relevant to the member's adverse benefit determination [ABD]). As such, HSAG strongly recommends that the DBA review its member notice templates and policy to ensure that these documents only include information related to the grievance requirements. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
3. A member may file a grievance with the DBA at any time. a. With the written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member. 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(2)(i) 42 CFR §438.228	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Member consent form template • Three examples of grievances submitted by provider or authorized representative with member written consent **Evidence as Submitted by the DBA:** • 01. GA PP – Grievance Process Policy – NEVADA MEDICAID (pages 1 and 3) • 05. LDP NV Medicaid Member Handbook: Reporting and Solving Problems "How Do I Submit A Grievance" (page 35)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the grievance filing, timing, and consent requirements of 42 CFR §438.228, 42 CFR §438.402(c)(1)(ii), and 42 CFR §438.402(c)(2)(i). Our Nevada Medicaid Grievance Process Policy (Evidence #1) applies in its entirety to members, representatives designated by the member including providers, and individuals with the legal authority to act on behalf of members (aka legal guardians, powers of attorney, etc). Whereas our policy reflects the statutory language required, our Nevada Medicaid Member Handbook (Evidence #5) guides the member on how to file a grievance in the appropriate language and reading level required. Please note that LIBERTY has not received any grievances from any provider or authorized representative during the audit period.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
4. The member may file a grievance either orally or in writing. a. *If grievance is filed orally, the DBA is required to document the contact for tracking purposes and to establish the earliest date of receipt.* 42 CFR §438.402(c)(3)(i) 42 CFR §438.228 Contract 3.12.2.7	**HSAG Recommended Evidence:** • Policies and procedures • Oral grievance documentation template • Member materials, such as the member handbook • HSAG will also use the results of the Grievance File Review **Evidence as Submitted by the DBA:** • 01. GA PP – Grievance Process Policy – NEVADA MEDICAID (page 3) • 05. LDP NV Medicaid Member Handbook: Reporting and Solving Problems "How Do I Submit A Grievance" (page 35) • Grievance file selection 02. 00002897253-01_FL034076224	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the grievance filing and tracking requirements of 42 CFR §438.228, 42 CFR §438.402(c)(3)(i), 42 CFR §438.228, and Contract 3.12.2.7. Whereas our Nevada Medicaid Grievance Process Policy (Evidence #1) reflects the required statutory language regarding our grievance staff's receiving, recording, and tracking both oral and written grievances, our Nevada Medicaid Member Handbook (Evidence #5) guides the member on how to file a grievance either orally or in writing in the appropriate language and reading level required. As evidenced by the sample grievance file selection (02. FL034076224), oral grievance submissions are logged and tracked with the original (aka earliest) date and time of receipt.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Handling of Grievances		
5. The DBA must acknowledge receipt of each grievance. 42 CFR §438.406(b)(1) 42 CFR §438.228 Contract 3.12.5.4(B)	**HSAG Recommended Evidence:** • Policies and procedures • Acknowledgement template notice and/or script • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the DBA:** • 01. GA PP – Grievance Process Policy – NEVADA MEDICAID (Entire Document) • 20. Nevada Medicaid Grievance Member Acknowledgement Letter Template (Entire Document) • Grievance File Review 1-10 (Entire Folder)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the grievance receipt and acknowledgment requirements of 42 CFR §438.406(b)(1), 42 CFR §438.228, and Contract 3.12.5.4 (B). As detailed in our Nevada Medicaid Grievance Process Policy (Evidence #1) and our Nevada Medicaid Grievance Member Acknowledgment Letter Template (Evidence #18), LIBERTY issues a written acknowledgement for all grievances received. As demonstrated in all of the case files provided to HSAG for the Grievances File Review, every grievance received is acknowledged as required.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element. **Recommendations:** HSAG recommends that the DBA review the Member Grievance and Appeal Form attached as part of the grievance acknowledgement letter and update it to remove typographical and grammatical issues. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
6. The DBA must ensure that the individuals who make decisions on grievances are individuals: a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual.	**HSAG Recommended Evidence:** • Policies and procedures • Organizational chart • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the DBA:**	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease: i. A grievance regarding denial of expedited resolution of an appeal. ii. A grievance that involves clinical issues. 42 CFR §438.406(b)(2) 42 CFR §438.228 Contract 3.12.5.4(C); 3.12.5.4(D)(2-3)	• 01. GA PP – Grievance Process Policy– NEVADA MEDICAID (Entire Document) • a. 07. LDP Appeals and Grievances Organizational Structure (Entire Document) • a. 08. LDP Grievance and Appeal Clinical Leadership Organization (Entire Document) • b. 01.GA PP – Grievance Process Policy – NEVADA MEDICAID (Entire Document) • b. 08. LDP Grievance and Appeal Clinical Leadership Organization (Entire Document) • b. 10. State Dental Director Job Description (Entire Document) • a, b. Grievance file selection 01. 00001427088-01_FL032556695 (Entire Document) • a, b. Grievance file selection 03. 3615770008-01_FL03395598 (Entire Document)	
DBA Description of Process: LIBERTY complies with the grievance decision-making requirements including the dentist decision-making requirements of 42 §438.406(b)(2), 42 CFR §438.228, and Contract 3.12.5.4(C) and 3.12.5.4(D)(2-3). LIBERTY's grievance processes from intake to resolution -- including the staff who perform each function -- are detailed in our Nevada Medicaid Grievance Process Policy (Evidence #1). The integrity of our grievance review and decision making is demonstrated in our Appeals and Grievances Organizational Structure (Evidence #7) where grievance administrative staff report through LIBERTY's Vice President of Quality Management, and our Grievance and Appeal Clinical Leadership Organization (Evidence #8) where LIBERTY's Nevada Dental Director (Evidence #10) reports through LIBERTY's Chief Clinical Officer and Nevada Plan President. Compliance with the statutory requirements is further evidenced in Grievance File Selections 01 and 03; specifically that these grievances contained clinical components, had multiple levels of review, and each review was conducted by an individual who was not a subordinate of the individual who made the prior decision, and the clinical issues were decided by licensed dentists.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Timely Resolution and Notification of Grievances		
7. The DBA must resolve each grievance and provide notice *as* expeditiously as the member's health condition requires. a. The DBA must resolve the grievance and send *written* notice to the affected parties no later than *ninety (90) calendar days* from the day the DBA receives the grievance. b. The notice must meet the standards described at 42 CFR §438.10 *and include the results of the resolution process and the date it was completed.* 42 CFR §438.408(a) 42 CFR §438.408(b)(1) 42 CFR §438.228 Contract 3.12.5; 3.12.5.1; 3.12.5.6	**HSAG Recommended Evidence:** • Policies and procedures • Grievance resolution notice template • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the DBA:** • 01. GA PP – Grievance Process Policy – NEVADA MEDICAID (Entire Document) • a. 01. GA PP – Grievance Process Policy – NEVADA MEDICAID (pages 2-4) • a. Grievance File Selections 1-10 • b. 01. GA PP – Grievance Process Policy – NEVADA MEDICAID (pages 8-9) • b. Grievance File Selections 1-10 • b. 21. Nevada Medicaid Grievance Resolution Template (Entire Document)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the timely resolution and notification of grievances requirements of 42 CFR §438.408(a), 42 CFR §438.228, and Contract section 3.12.5. While both the statutory requirements and Nevada Medicaid Contract allow up to 90 days for the resolution and notification of grievances, LIBERTY's Nevada Medicaid Grievance Policy and Procedure (Evidence #1) complies with the more stringent NCQA standard requiring we resolve every grievance as quickly as the member's health condition requires and send written notice no later than 30 calendar days after receipt. LIBERTY Grievance Resolution letters meet the notice content and format requirements including the results of the resolution process and the date the resolution was completed (Evidence #21). All 10 of LIBERTY's Grievances Files Review selections confirm LIBERTY resolves all complaints within 30 days and sends the written notice in the format and with the content required.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element. Of note, the DBA demonstrated that it is actively remediating all taglines to ensure compliance with the conspicuous font requirement, in accordance with the DBA's approved corrective action plan (CAP), and provided evidence to demonstrate that materials, including the member handbook, were previously updated to include taglines in conspicuously visible font.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Recommendations: The member handbook, under the Notice of Nondiscrimination section, included specific information indicating that the DBA will provide free aids and services to people with disabilities, and free language services to people whose primary language is not English. With future updates to the member handbook, and as appropriate for other critical member materials, HSAG recommends that this same verbiage be included in Spanish and in conspicuous font to further support compliance with 42 CFR §438.10. Implementation of this recommendation will be evaluated during future compliance reviews. While grievances were resolved within the required time frame, HSAG will be recommending to DHCFP to reduce the current 90-day time frame allowance.		
Required Actions: None.		
8. The DBA may extend the time frame for resolving grievances by up to fourteen (14) calendar days if: a. The member requests the extension; or b. The DBA shows *to the satisfaction of DHCFP* that there is need for additional information and how the delay is in the member's interest. 42 CFR §438.408(c)(1) 42 CFR §438.228 Contract 3.12.5.3(B)	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of grievances with extended time frame • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the DBA:** • 01. GA PP – Grievance Process Policy – NEVADA MEDICAID (pages 6-7) • 20. Nevada Medicaid Member Grievance Acknowledgment Letter Template (Entire Document) • Grievance File Selections 1-10	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the grievance resolution extension requirements of 42 CFR §438.408(c)(1)(i), 42 CFR §438.228, and Contract 3.12.5.3(B). LIBERTY's Nevada Medicaid Grievance Process Policy (Evidence #1) and Nevada Medicaid Member Grievance Acknowledgement Letter (Evidence #20) demonstrate that we inform members of their right to request an extension of up to 14 days to resolve a grievance, and of LIBERTY's right to request an extension of up to 14 days upon approval from DHCFP that such a LIBERTY-requested extension is in the member's best interest. There were no examples within the audit period of any grievance extensions requested by either the member or LIBERTY, nor were there any grievances that took more than 30 calendar days from the date of receipt to resolve and notify the member in writing.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element. Of note, the case file review and DBA staff members confirmed that no grievance resolution time frame extensions were applied during the time period under review.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
9. If the DBA extends the grievance resolution time frame not at the request of the member *(after DHCFP approval for the extension)*, it must complete all of the following: a. Make reasonable efforts to give the member prompt oral notice of the delay. b. Within two (2) calendar days give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision. 42 CFR §438.408(c)(2-3) 42 CFR §438.228 Contract 3.12.5.3(B)	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of grievances with extended time frames (evidence of DHCFP approval to extend the time frame, oral notice of the extension to the member, written notice of the extension to the member must be included) • Grievance extension template letter • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the DBA:** • 01. GA PP – Grievance Process Policy – NEVADA MEDICAID (pages 6-7) • 20. Nevada Medicaid Member Grievance Acknowledgment Letter Template (Entire Document) • Grievance File Selections 1-10	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the grievance resolution and notification extension requirements of 42 CFR §438.408(c)(2-3), 42 CFR §438.228, and Contract 3.12.5.3(B). LIBERTY's Nevada Medicaid Grievance Process Policy (Evidence #1) and Nevada Medicaid Member Grievance Acknowledgement Letter (Evidence #20) demonstrate that we inform members of their right to request an extension of up to 14 days to resolve a grievance, and of LIBERTY's right to request an extension of up to 14 days upon approval from DHCFP that such a LIBERTY-requested extension is in the member's best interest. There were no examples within the audit period of any grievance extensions requested by either the member or LIBERTY, nor were there any grievances that took more than 30 calendar days from the date of receipt to resolve and notify the member in writing. Should LIBERTY ever initiate a grievance extension, per our policy and procedure we would utilize the Grievance Acknowledgment Letter Template and insert the language noting LIBERTY's reasons for believing the extension is in the member's best interest, noting DHCFP's language approving our request, and confirming the member's right to grieve the LIBERTY-initiated, DHCFP-approved extension.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element. Of note, the case file review and DBA staff members confirmed that no grievance resolution time frame extensions were applied during the time period under review.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Appeals General Requirements		
10. The DBA defines an appeal as a review by the DBA of an ABD. 42 CFR §438.400(b) 42 CFR §438.228 Contract 3.12.1.2	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the DBA:** • 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (page 2) • 05. LDP NV Medicaid Member Handbook: Member Rights and Responsibilities (page 13); and Reporting and Solving Problems: Appeals (page 36) • 09. LDP NV Provider Reference Guide Medicaid: Member Rights and Responsibilities (page 22)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the appeal definition requirements of 42 CFR §438.228, 42 CFR §438.400(b), and Contract 3.12.1.2. Our Nevada Medicaid Single Level Appeals Process Policy (Evidence #2) uses the exact statutory language required, as does our Nevada Medicaid Provider Reference Guide (Evidence #9). However, our Nevada Medicaid Member Handbook (Evidence #5) reflects the appeal definition in the appropriate language and reading level required.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
11. The DBA may have only one level of appeal for members. 42 CFR §438.402(b) 42 CFR §438.228	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the DBA:**	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
	• 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (page 4) • 05. LDP NV Medicaid Member Handbook: Member Rights and Responsibilities (page 13); and Reporting and Solving Problems: Appeals (page 38) • 09. LDP NV Provider Reference Guide Medicaid: Member Grievances and Appeals (page 65)	
DBA Description of Process: LIBERTY complies with the single level of member appeal requirements of 42 CFR §438.228 and 42 CFR §438.402(b). Our Nevada Medicaid Single Level Appeals Process Policy (Evidence #2) uses the exact statutory language required, our Nevada Medicaid Provider Reference Guide (Evidence #9) details the requirement for members to exhaust this single level of appeal before requesting a State Fair Hearing, and our Nevada Medicaid Member Handbook (Evidence #5) reflects the appeal process in the appropriate language and reading level required.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
12. The DBA must establish and maintain an expedited review process for appeals, when the DBA determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. a. The DBA must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. 42 CFR §438.410(a-b) 42 CFR §438.228 Contract 3.12.5.3	**HSAG Recommended Evidence:** • Policies and procedures • Provider materials, such as the provider manual **Evidence as Submitted by the DBA:** • 03. GA PP - Expedited Appeals Process Policy - NEVADA MEDICAID (page 12 and Entire Document) • 09. LDP NV Provider Reference Guide Medicaid: Grievances and Appeals (page 66) • a. 03. GA PP – Expedited Appeals Process Policy – NEVADA MEDICAID (page 2) • a. 09. LDP NV Provider Reference Guide Medicaid: Member Rights and Responsibilities: Anti-Discrimination (page 24)	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
DBA Description of Process: LIBERTY complies with the expedited review appeals process requirements and provider non-retaliation requirements of 42 CFR §438.410(a-b), 42 CFR §438.228, and Contract 3.12.5.3. LIBERTY's Nevada Medicaid Expedited Appeals Process Policy (Evidence #3) and Nevada Medicaid Provider Reference Guide (Evidence #9) detail our expedited review process for appeals utilizing the exact statutory criteria. Additionally, LIBERTY maintains a non-retaliation (including not canceling provider contracts) and non-discrimination policy for providers who request expedited resolution or support a member's appeal, which is conveyed in our Nevada Medicaid Expedited Appeals Process Policy (Evidence #3) and in our Nevada Medicaid Provider Reference Guide (Evidence #9). We further ensure the rights of our members and providers through our Quality Management Improvement (QMI) Program, QMI Committee chaired by our State Dental Director, and subcommittees including our Grievance and Appeals Committee.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
13. Following receipt of a notification of an ABD by a DBA, the member has sixty (60) calendar days from the date on the ABD notice in which to file a request for an appeal to the DBA. 42 CFR §438.402(c)(2)(ii) 42 CFR §438.228	**HSAG Recommended Evidence:** • Policies and procedures • Tracking documentation • Member materials, such as the member handbook • ABD notice template • Provider materials, such as the provider manual **Evidence as Submitted by the DBA:** • 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (page 5-6) • 05. LDP NV Medicaid Member Handbook: Reporting and Solving Problems: Appeals (page 36) • 09. LDP NV Provider Reference Guide Medicaid: Member Grievances and Appeals (page 64) • 11. NV Medicaid Notice of Adverse Benefit Determination Sample Redacted (page 3)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the timely appeal filing requirements of 42 CFR §438.402(c)(2)(ii) and 42 CFR §438.228. We detail these requirements in our Nevada Medicaid Single Level Appeals Process Policy (Evidence #2), notify our providers through provider materials		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
including our Nevada Medicaid Provider Reference Guide (Evidence #9), and educate members on how to file an appeal timely in the appropriate language and reading level in our Nevada Medicaid Member Handbook (Evidence #5). Additionally, the Nevada Medicaid Notice of Adverse Benefit Determination (NABD) (Evidence #11) includes a member's right to appeal within 60 calendar days of the date of the notice.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
14. The member may file an appeal orally or in writing. a. With the written consent of the member, a provider or an authorized representative may request an appeal on behalf of the member. b. *If appeal is filed orally, the DBA is required to document the contact for tracking purposes and to establish the earliest date of receipt.* 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(3)(ii) 42 CFR §438.228 Contract 3.12.2.7	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Member consent form template • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the DBA:** • 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (Entire Document) • 05. LDP NV Medicaid Member Handbook: Reporting and Solving Problems: Appeals (page 36) • 09. LDP NV Provider Reference Guide Medicaid: Member Grievances and Appeals (page 65) • 16. NV Medicaid AOR Form (Entire Document) • Appeal File Selection 06. 00000105326-01_FL030989105 • Appeal File Selection OS2. 00001633409-01_FL030989331	☐ Met ☒ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the appeal filing requirements of 42 CFR §438.402(c)(1)(ii), 42 CFR §438.402(c)(3)(ii), 42 CFR §438.228, and Contract 3.12.2.7. We detail those requirements in our Nevada Single Level Appeals Process Policy (Evidence #2), notify and educate our members on how to appeal in the appropriate language and reading level in our Nevada Medicaid Member Handbook (Evidence #5), and notify our providers on the process of appealing on a member's behalf in our Nevada Medicaid Provider Reference Guide (Evidence #9). Additionally, we demonstrate compliance with our policies through the approved Nevada Medicaid AOR Form (Evidence #16), and two representative cases from the Appeal File Selection (06. 00000105326-01_FL030989105) and (OS2. 00001633409-01_FL030989331).		

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: Although the DBA's Written Provider Grievance and Appeal Form indicated, "If you are filing an appeal on behalf of a member, you must include signed authorization from the member," there was no evidence through the case file review that member consent was being obtained. During the site review, DBA staff members explained that they did not have a process to obtain member consent from a provider filing an appeal on behalf of the member when there is an established provider/patient relationship. However, this process did not align with federal requirements, which stipulate that the member's consent must be obtained for a provider to file an appeal on the member's behalf.		
Required Actions: The DBA's process must ensure that written consent is obtained from the member when a provider or an authorized representative requests an appeal on the member's behalf.		
Handling of Appeals		
15. If the DBA denies a request for expedited resolution of an appeal, it must: a. Transfer the appeal to the time frame for standard resolution *of no longer than thirty (30) calendar days from the day the DBA receives the appeal.* b. Follow the requirements in 42 CFR §438.408(c)(2), including: i. Make reasonable efforts to give the member prompt oral notice of the delay. ii. Within two (2) calendar days, give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if the member disagrees with that decision. 42 CFR §438.406(b)(1) 42 CFR §438.410(c) 42 CFR §438.228 Contract 3.12.5.3	**HSAG Recommended Evidence:** • Policies and procedures • Denied request for an expedited appeal time frame letter template • Three examples of a denied request for an expedited appeal resolution (oral and written notice to the member must be included) • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the DBA:** • 03. GA PP - Expedited Appeals Process Policy - NEVADA MEDICAID (pages 4-6, and 8) • a. 03. GA PP - Expedited Appeals Process Policy - NEVADA MEDICAID (pages 4-6, and 8) • a. 17. NV Medicaid Appeal Downgrade Acknowledgement Template	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the processing, timeliness, and notification requirements for denials of expedited appeals in 42 CFR §438.406(b)(1), 42 CFR §438.410(c), 42 CFR §438.228, and Contract 3.12.5.3. We detail the steps our grievance and appeals staff take when a member's request for expedited review of an appeal is denied (following expedited criteria review by a clinician) in our Nevada Medicaid Expedited		

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Requirement	**Supporting Documentation**	**Score**
Appeals Process Policy (Evidence #3). The Nevada Medicaid Appeal Downgrade Acknowledgement Template (Evidence #17) is utilized to provide written notice to the member of the reason for the decision to extend the time frame and to inform the member of the right to file a grievance if the member disagrees with LIBERTY's decision to deny their request for an expedited appeal. LIBERTY did not have any downgraded appeals during the audit period.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element. Of note, the case file review and DBA staff members confirmed there were no requests for expedited appeal resolutions that did not meet expedited criteria during the time period under review.		
Required Actions: None.		
16. The DBA must acknowledge receipt of each appeal. 42 CFR §438.406(b)(1) 42 CFR §438.228 Contract 3.12.5.4(B)	**HSAG Recommended Evidence:** • Policies and procedures • Acknowledgement template notice and/or script • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the DBA:** • 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (pages 6 and 8) • 03.GA PP - Expedited Appeals Process Policy– NEVADA MEDICAID (pages 4, 5, and 8) • 05. LDP NV Medicaid Member Handbook: Reporting and Solving Problems: Appeals (page 37) • 18. NV Medicaid Appeal Member Acknowledgement Letter Template (Entire Document) • 17. NV Medicaid Appeal Downgrade Acknowledgement Letter Template (Entire Document) • Appeal File Review (1-10, Entire Folder)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the appeal receipt acknowledgment requirements of 42 CFR §438.406(b)(1), 42 CFR §438.228, and Contract 3.12.5.4(B). LIBERTY's Nevada Medicaid Single Level Appeals Process Policy (Evidence #2) and Expedited Appeals Process Policy (Evidence #3) detail the procedures, content, and timeliness of verbal acknowledgment for expedited appeals received and written acknowledgment letters for standard appeals (Evidence #17 and #18). Members are informed of how to file both standard and expedited appeals and their right to receive		

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Requirement	**Supporting Documentation**	**Score**
acknowledgment in the appropriate language and reading level in the Nevada Medicaid Member Handbook (Evidence #5). Evidence that LIBERTY complies with our appeals policies is found in the cases selected for Appeal File Review.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
17. The DBA must ensure that the individuals who made decisions on appeals are individuals: a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease: i. An appeal of a denial that is based on lack of medical necessity. ii. An appeal that involves clinical issues. c. Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial ABD. 42 CFR §438.406(b)(2) 42 CFR §438.228 Contract 3.12.5.4(C); 3.12.5.4(D)(1)(3)	**HSAG Recommended Evidence:** • Policies and procedures • Organizational chart • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the DBA:** • 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (page 8) • 03.GA PP - Expedited Appeals Process Policy – NEVADA MEDICAID (page 5) • 05. LDP NV Medicaid Member Handbook: Reporting and Solving Problems: Appeals (page 37) • a.b. 10. State Dental Director Job Description (Entire Document) • a.b. 07. LDP Appeals and Grievances Organizational Structure (Entire Document) • a.b.08. LDP Grievance and Appeal Clinical Leadership Organization (Entire Document) • a.b.c. 05. LDP NV Medicaid Member Handbook Reporting and Solving Problems: Appeals (pages 36-37) • c. Grievance File Selection 01. 00001427088-01_FL032556695	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
DBA Description of Process: LIBERTY complies with the appeal decision-making requirements including the dentist decision-making and member-submitted information requirements of 42 CFR §438.406(b)(2), 42 CFR §438.228, and Contract 3.12.5.4(C) and 3.12.5.4(D)(1)(3). LIBERTY's appeal processes from intake to resolution -- including the staff who perform each function -- are detailed in our Nevada Medicaid Single Level Appeals Process Policy (Evidence #2) and Nevada Medicaid Expedited Appeals Process Policy (Evidence #3) policies. We also communicate appeal processes including their right to submit information as part of the appeal to members in the appropriate language and reading level in our Nevada Medicaid Member Handbook (Evidence #5). The integrity of our appeal review and decision making is demonstrated in our Appeals and Grievances Organizational Structure (Evidence #7) where grievance administrative staff report through LIBERTY's Vice President of Quality Management, and our Grievance and Appeal Clinical Leadership Organization (Evidence #8) where LIBERTY's Nevada Dental Director (Evidence #10) reports through LIBERTY's Chief Clinical Officer and Nevada Plan President. Compliance with the statutory requirements is further evidenced in Grievance File Selection 01. 00001427088-01_FL032556695 that includes member-submitted information as part of the appeal determination.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
18. The DBA must provide that oral inquiries seeking to appeal an ABD are treated as appeals. 42 CFR §438.406(b)(3) 42 CFR §438.228 Contract 3.12.5.5(A)	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the DBA:** • 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (pages 5, 6) • 03.GA PP - Expedited Appeals Process Policy – NEVADA MEDICAID (page 3) • 05. LDP NV Medicaid Member Handbook: Reporting and Solving Problems: Appeals (page 36) • Appeal Sample File 05. 00002023987-01_FL034791872	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the oral appeal filing and processing requirements of 42 CFR §438.406(b)(3), 42 CFR §438.228, and Contract 3.12.5.5(A). Our Nevada Medicaid Single Level Appeal Process Policy (Evidence #2) and Expedited Appeal Process Policy (Evidence #3) policies reflect the required statutory language regarding our appeals staff's receiving, recording, and processing oral appeals. Our Nevada Medicaid		

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Requirement	**Supporting Documentation**	**Score**
Member Handbook (Evidence #5) guides members on how to file an appeal orally in the appropriate language and reading level required. As evidenced by the Appeal Sample File (05. 00002023987-01_FL034791872), oral appeal submissions are processed in compliance with the requirements.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
19. The DBA must provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. a. The DBA must inform the member of the limited time available for this sufficiently in advance of the resolution time frame for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution. 42 CFR §438.406(b)(4) 42 CFR §438.228 Contract 3.12.5.3(A); 3.12.5.5(B)	**HSAG Recommended Evidence:** • Policies and procedures • ABD notice template • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the DBA:** • 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (pages 3, 8, 9, 14) • 03.GA PP - Expedited Appeals Process Policy – NEVADA MEDICAID (pages 2 and 6) • a. 05. LDP NV Medicaid Member Handbook: Reporting and Solving Problems: Appeals (page 37) • a. 11. NV Medicaid Notice of Adverse Benefit Determination Sample Redacted (Entire Document) • a. 18. NV Medicaid Appeal Member Acknowledgement Letter Template (Entire Document)	☐ Met ☒ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the appeal notification and member participation requirements in 42 CFR §438.406(b)(4), 42 CFR §438.228, and Contract 3.12.5.3(A) and 3.12.5.5(B). Our Nevada Medicaid Single Level Appeal Process Policy (Evidence #2) and Expedited Appeals Process Policy (Evidence #3) document the required statutory language including the process for members presenting information for LIBERTY to consider during their appeal and the timing of when we advise members of our process both verbally and in writing. We also provide every member with their right to provide documentation for consideration before an appeal is even filed, including at the time they are enrolled in our plan via the Nevada Medicaid Member Handbook (Evidence #5), and at the time an adverse benefit determination (ABD) is made in the Nevada Medicaid Notice of Adverse Benefit		

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Requirement	**Supporting Documentation**	**Score**
Determination (Evidence #11). Once a member files an appeal, we reiterate their right to provide documentation in the Nevada Medicaid Appeal Member Acknowledgment Letter (Evidence #18). All of the files selected in the Appeal File Review illustrate LIBERTY's compliance with these requirements.		
HSAG Findings: According to findings from the case file review, two of the expedited appeals (cases 9 and 10) did not include evidence that the member was provided a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. For the standard appeals, the acknowledgement letter indicated, "If you would like to add anything to your case, please call us right away." This narrative should clearly indicate that the member also has an opportunity in person and in writing.		
Required Actions: The DBA must provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The DBA must inform the member of the limited time available for this sufficiently in advance of the resolution time frame for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution.		
20. The DBA must provide the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the DBA (or at the direction of the DBA) in connection with the appeal of the ABD. This information must be provided free of charge and sufficiently in advance of the resolution time frame for appeals as specified in 42 CFR §438.408(b) and (c). 42 CFR §438.406(b)(5) 42 CFR §438.228 Contract 3.12.5.5(C)	**HSAG Recommended Evidence:** • Policies and procedures • ABD notice template • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the DBA:** • 02. GA PP – Single Level Appeals Process Policy – NEVAD MEDICAID (Entire Document) • 03. GA PP - Expedited Appeals Process Policy – NEVADA MEDICAID (pages 7-8) • 11. NV Medicaid Notice of Adverse Benefit Determination Sample Redacted (Entire Document) • 18. NV Medicaid Appeal Member Acknowledgement Letter Template (Entire Document) • 05. LDP NV Medicaid Member Handbook: Reporting and Solving Problems: Appeals (pages 37-38)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the provision of the case file requirements including the requirements to provide documents free of charge and timely in 42 CFR §438.406(b)(5), 42 CFR §438.228, and Contract 3.12.5.5(C). Our Nevada Medicaid Single Level Appeals Process Policy (Evidence #2) and Expedited Appeals Process Policy (Evidence #3) document our process for providing the case file including medical records, other		

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Requirement	**Supporting Documentation**	**Score**
documents and records, and any new or additional evidence considered, relied upon, or generated by LIBERTY in connection with the appeal of the Adverse Benefit Determination (ABD). We communicate all appeals rights, including their right to their case file free of charge, to members in the appropriate language and reading level in the Nevada Medicaid Member Handbook (Evidence #5), at the time an adverse benefit determination (ABD) is made in the Nevada Medicaid Notice of Adverse Benefit Determination (Evidence #11), and once they file an appeal, in the Nevada Medicaid Appeal Member Acknowledgment Letter (Evidence #18). All of the files selected in the Appeal File Review illustrate LIBERTY's compliance with these requirements.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
Resolution and Notification of Appeals		
21. The DBA must resolve standard appeals and send *written* notice to the affected parties as expeditiously as the member's health condition requires. a. *The DBA is allowed no more than thirty (30) calendar days from the date of receipt of the appeal.* 42 CFR §438.408(a) 42 CFR §438.408(b)(2) 42 CFR §438.228 Contract 3.12.5; 3.12.5.2	**HSAG Recommended Evidence:** • Policies and procedures • Tracking documentation • Appeal resolution letter template • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the DBA:** • 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (page 3) • 11. NV Medicaid Notice of Adverse Benefit Determination Sample Redacted (Entire Document) • 18. NV Medicaid Appeal Member Acknowledgement Letter Template (Entire Document) • 22. NV Medicaid NOA Exhausted Template (Entire Document) • 23. NV Medicaid NOA Overturn Template (Entire Document) • 24. NV Medicaid NOA Timely Filing Template (Entire Document)	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• 25. NV Medicaid NOA Uphold Template (Entire Document) • 28. Q1 2022 Nevada Appeals Report (page 1) • a. 02. GA PP – Single Level Appeals Process Policy– NEVADA MEDICAID (page 6) • a.05. LDP NV Medicaid Member Handbook: Reporting and Solving Problems: Appeals (page 37) • a. 11. NV Medicaid Notice of Adverse Benefit Determination Sample Redacted (page 3)	
DBA Description of Process: LIBERTY complies with the standard appeal resolution and written notice timeframe requirements in 42 CFR §438.408(a), 42 CFR §438.408(b)(2), 42 CFR §438.228, and Contract 3.12.5 and 3.12.5.2. Our Nevada Medicaid Single Level Appeals Process Policy (Evidence #2) details our standard appeals process and we educate members on these timeframes in the appropriate language and reading level in the Nevada Medicaid Member Handbook (Evidence #5), Nevada Medicaid Notice of Adverse Benefit Determination (Evidence #11), and the Nevada Medicaid Appeal Member Acknowledgement Letter (Evidence #18). We provide written notice for all standard appeal scenarios in approved templates (Evidence #22, 23, 24, 25). As evidenced by our Q1 2022 Nevada Appeals Report (Evidence #28), and all of our Appeals Files, we resolved and provided the written notice on all standard appeals within 30 days.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
22. The DBA must resolve expedited appeals and send *written* notice to the affected parties no later than seventy-two (72) hours after the DBA receives the appeal. 42 CFR §438.408(b)(3) 42 CFR §438.228	**HSAG Recommended Evidence:** • Policies and procedures • Tracking documentation • Appeal resolution letter template • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the DBA:** • 03.GA PP - Expedited Appeals Process Policy – NEVADA MEDICAID (pages 5 and 8)	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• 05. LDP NV Medicaid Member Handbook: Reporting and Solving Problems: Appeals (page 37) • 11. NV Medicaid NABD Sample Redacted (Entire Document) • 22. NV Medicaid NOA Exhausted Template (Entire Document) • 23. NV Medicaid NOA Overturn Template (Entire Document) • 24. NV Medicaid NOA Timely Filing Template (Entire Document) • 25. NV Medicaid NOA Uphold Template (Entire Document) • 28. Q1 2022 Nevada Appeals Report (page 1)	
DBA Description of Process: LIBERTY complies with the expedited appeals resolution and written notice timeframes requirements in 42 CFR §438.408(b)(3) and 42 CFR §438.228. Our Nevada Medicaid Expedited Appeals Process Policy (Evidence #3) details our process to provide both verbal and written resolution notice within 72 hours of receipt of the appeal by any LIBERTY department. We educate members regarding their expedited appeal rights in the appropriate language and reading level in our Nevada Medicaid Member Handbook (Evidence #5) and Nevada Medicaid Notice of Adverse Benefit Determination (Evidence #11). We provide written notice for all expedited appeal scenarios in approved templates (Evidence #22, 23, 24, 25). As evidenced by our Q1 2022 Nevada Appeals Report (Evidence #28), and all of our Appeals Files, we resolve all expedited appeals and send the written notice within 72 hours after receipt of the appeal.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
23. The DBA may extend the standard or expedited appeal resolution time frames by up to fourteen (14) calendar days if: a. The member requests the extension; or b. The DBA shows *to the satisfaction of DHCFP* that there is need for additional information and how the delay is in the member's interest.	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of appeals with extended time frame • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the DBA:** • 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (page 6 and 9)	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
42 CFR §438.408(c)(1) 42 CFR §438.228 Contract 3.12.5.3(B)	• 03. GA PP – Expedited Appeals Process Policy – NEVADA MEDICAID (page 6) • 05. LDP NV Medicaid Member Handbook: Reporting and Solving Problems: Appeals (page 37) • 28. Q1 2022 Nevada Appeals Report (page 1) • a, b. 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (page 6 and 9) • a, b. 03. GA PP – Expedited Appeals Process Policy – NEVADA MEDICAID (page 6) • a, b. 05. LDP NV Medicaid Member Handbook: Reporting and Solving Problems: Appeals (page 37)	
DBA Description of Process: LIBERTY complies with the appeal resolution extension requirements in 42 CFR §438.408(c)(1), 42 CFR §438.228, and Contract 3.12.5.3(B). Our Nevada Medicaid Single Level Appeals and (Evidence #2) and Nevada Medicaid Expedited Appeals Process (Evidence #3) policies both contain the exact statutory language required and we educate members about their appeal rights including the right to an extension up to 14 days in the appropriate language and reading level in the Nevada Medicaid Member Handbook. We did not have any cases during the audit period where a member or LIBERTY in the member's best interests requested an extension. As evidenced by our Q1 2022 Nevada Appeals Report (Evidence #28) and our Appeal File Review cases, all Nevada Medicaid standard resolved within 30 calendar days from the date of receipt and all expedited appeals were resolved within 72 hours of receipt.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
24. If the DBA extends the standard or expedited appeal resolution time frames not at the request of the member *(after DHCFP approval for the extension)*, it must complete all of the following: a. Make reasonable efforts to give the member prompt oral notice of the delay.	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of appeals with extended time frame • Appeal extension template letter • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the DBA:**	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
b. Within two (2) calendar days give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision. c. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 CFR §438.408(c)(2) 42 CFR §438.228 Contract 3.12.5.3(B)	• 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (page 6 and 9) • 03. GA PP – Expedited Appeals Process Policy – NEVADA MEDICAID (page 6) • 05. LDP NV Medicaid Member Handbook: Reporting and Solving Problems: Appeals (page 37) • 28. Q1 2022 Nevada Appeals Report (page 1) • b. 19. NV Medicaid Appeal Extension Notice Template (page 1) • a, b, c. 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (page 6 and 9) • a, b,c. 03. GA PP – Expedited Appeals Process Policy – NEVADA MEDICAID (page 6) • a, b,c. 05. LDP NV Medicaid Member Handbook: Reporting and Solving Problems: Appeals (page 37)	
DBA Description of Process: LIBERTY complies with the extension of appeals resolution timeframe and notice requirements in 42 CFR §438.408(c)(2), 42 CFR §438.228, and Contract 3.12.5.3(B). We detail our process for notifying and resolving member-initiated or LIBERTY-initiated extensions in our Nevada Medicaid Single Level Appeals Process (Evidence #2) and Nevada Medicaid Expedited Appeals Process (Evidence #3) policies. We also educate our members about these extension rights and resolution timeframes in the appropriate language and reading level in our Nevada Medicaid Member Handbook (Evidence #5) and the Nevada Medicaid Appeal Extension Notice (Evidence #19). There were no requests for appeal by the member or by LIBERTY during the audit period and all standard and expedited appeals for our Nevada Medicaid members were resolved and noticed timely and properly, as evidenced by our Q1 2022 Nevada Appeals Report (Evidence #28) and our Appeal Files.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
25. In the case that the DBA fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the DBA's appeals process. The member may initiate a State fair hearing (SFH). 42 CFR §438.408(c)(3) 42 CFR §438.408(f)(1)(i) 42 CFR §438.228	**HSAG Recommended Evidence:** • Policies and procedures • Tracking documentation • Member materials, such as the member handbook • Three examples of an appeal not resolved timely (written notice to the member must be included) • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the DBA:** • 02. GA PP - Single Level Appeals Process Policy- NEVADA MEDICAID (page 3) • 03. Policy GA PP - Expedited Appeals Process Policy- NEVADA MEDICAID (page 5) • 04. GA PP - State Fair Hearing Process Policy- NEVADA MEDICAID (Entire Document) • 11. NV Medicaid Notice of Adverse Benefit Determination Sample Redacted (page 3)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the appeal notice and timing requirements as well as the member State Fair hearing rights requirements in 42 CFR §438.408(c)(3), 42 CFR §438.408(f)(1)(i), and 42 CFR §438.228. Our Nevada Medicaid Single Level Appeals Process (Evidence #2), Nevada Medicaid Expedited Appeals Process (Evidence #3), and Nevada Medicaid State Fair Hearing Process (Evidence #4) policies detail the timeliness and notice requirements for appeals and the fact that if LIBERTY fails to adhere to those requirements, our members may initiate a State Fair Hearing. We also notify members regarding the impact of LIBERTY's failure to adhere to timing and notice requirements on their State Fair Hearing rights in the Nevada Medicaid Notice of Adverse Benefit Determination (Evidence #11). There were no appeals where LIBERTY failed to adhere to the notice and timing requirements during the audit period as evidenced by our Appeal File Review.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
26. For all appeals, the DBA must provide written notice of the resolution in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10. The written notice of the appeal resolution includes: a. The results of the resolution process and the date it was completed. b. For appeals not resolved wholly in favor of the member: i. The right to request a SFH, and how to do so. ii. The right to request and receive benefits while the hearing is pending, and how to make the request. iii. That the member may be held liable for the cost of those benefits if the hearing decision upholds the DBA's ABD related to the appeal. 42 CFR §438.408(d)(2)(i) 42 CFR §438.408(e)(1-2) 42 CFR §438.10 42 CFR §438.228 Contract 3.12.5.6; 3.12.5.6(A-C)	**HSAG Recommended Evidence:** • Policies and procedures • Appeal resolution notice template (upheld and overturned) • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the DBA:** • 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (page 11) • 03. GA PP - Expedited Appeals Process Policy- NEVADA MEDICAID (page 5) • 23. NV Medicaid NOA Overturn Template (Entire Document) • 25. NV Medicaid NOA Uphold Template (Entire Document) • a. 02. GA PP – Single Level Appeals Process Policy– NEVADA MEDICAID (pages 11 and 12) • a. 03. GA PP - Expedited Appeals Process Policy- NEVADA MEDICAID (page 6) • b. 02. GA PP – Single Level Appeals Process Policy– NEVADA MEDICAID (pages 12-14)) • 03. GA PP - Expedited Appeals Process Policy- NEVADA MEDICAID (page 6) • a,b. 23. NV Medicaid NOA Overturn Template (Entire Document) • a, b. 25. NV Medicaid NOA Uphold Template (Entire Document)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the appeals written notice of resolution format, language, and content requirements in 42 CFR §438.408(d)(2)(i), 42 CFR §438.408(e)(1-2), 42 CFR §438.10, 42 CFR §438.228, and Contract 3.12.5.6 and 3.12.5.6(A-C). Our Nevada Medicaid Single Level Appeal (Evidence #2) and Expedited Appeal (Evidence #3) policies detail our appeals resolution process and we provide notice of appeals resolution for standard, expedited, upheld, and overturned appeals in the required template and formats (Evidence #23, 25).		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the DBA met the requirements for this element. Of note, the DBA demonstrated it had been actively remediating all taglines to ensure compliance with the conspicuous font requirement, in accordance with the approved CAP, and provided evidence to demonstrate that materials, including the member handbook, were previously updated to include taglines in conspicuously visible font. Refer to Element 29 for additional findings related to the time frame for members to file for a SFH. **Recommendations:** The member handbook, under the Notice of Nondiscrimination section, included specific information that the DBA will provide free aids and services to people with disabilities, and free language services to people whose primary language is not English. With future updates to the member handbook, and as appropriate for other critical member materials, HSAG recommends that this same verbiage be included in Spanish and in conspicuous font to further support compliance with 42 CFR §438.10. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
27. For notice of an expedited appeal resolution, the DBA must make reasonable efforts to provide oral notice *in addition to the required written notice*. 42 CFR §438.408(d)(2)(ii) 42 CFR §438.228 Contract 3.12.5.7	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of oral notice for an expedited appeal resolution • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the DBA:** • 03. GA PP - Expedited Appeals Process Policy - NEVADA MEDICAID (page 5) • Appeal file selection 10. 00002926851-01_FL036582901	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the oral and written notice for expedited appeal resolution requirements in 42 CFR §438.408(d)(2)(ii), 42 CFR §438.228, and Contract 3.12.5.7. Our Nevada Medicaid Expedited Appeals Process Policy (Evidence #3) uses the exact statutory language required and details our process for capturing the earliest receipt date and time of expedited appeals no matter what department at LIBERY receives the expedited appeal request to meet the 72-hour oral and written notice requirement. One case file from the universe of appeals during the audit period demonstrates our compliance with these expedited appeal requirements (10. 00002926851-01_FL036582901).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
State Fair Hearings		
28. The member may request a SFH only after receiving notice that the DBA is upholding the ABD related to the appeal. 42 CFR §438.408(f)(1)(i) 42 CFR §438.228 Contract 3.12.2.6; 3.12.6.1	**HSAG Recommended Evidence:** • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice **Evidence as Submitted by the DBA:** • 04. GA PP - State Fair Hearing Process - NEVADA MEDICAID (Entire Document) • 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (pages 12 and 13) • 03. GA PP - Expedited Appeals Process Policy- NEVADA MEDICAID (page 6) • 05. LDP NV Medicaid Member Handbook: Reporting and Solving Problems: State Fair Hearings (page 38) • 11. NV Medicaid Notice of ABD Sample Redacted (Entire Document) • 25. NV Medicaid NOA Uphold Template (Entire Document)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the notice and State Fair Hearing requirements in 42 CFR §438.408(f)(1)(i), 42 CFR §438.228, and Contract 3.12.2.6 and 3.12.6.1. Our Nevada Medicaid State Fair Hearing Process (Evidence #4), Single Level Appeals Process(Evidence #2) and Expedited Appeals Process (Evidence #3) policies use the exact statutory language required and we educate our members about the appeal and State Fair Hearing processes including their rights in appropriate language and reading level in the Nevada Medicaid Member Handbook (Evidence #5). LIBERTY complies with the notice requirements as evidenced by the Nevada Medicaid Notice of Adverse Benefit Determination (Evidence #11) and Nevada Medicaid Notice of Appeal Uphold (Evidence #25). LIBERTY did not receive any requests for a State Fair Hearing during the audit period.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
29. *The member must submit a request for a SFH in writing within ninety (90) calendar days from the date of the DBA's notice of resolution of the appeal.* a. *The DBA is required to inform the member of their right to a SFH, how to obtain such a hearing, and representation rules must be explained and provided in writing to the member by the DBA pursuant to 42 CFR 431.200(b); 42 CFR 431.220(a)(6), and 42 CFR 438.408(e)(2)(i).* 42 CFR §438.408(f)(2) 42 CFR §438.228 Contract 3.12.6.2	**HSAG Recommended Evidence:** • Policies and procedures G&A • Appeal resolution notice template G&A • Member materials, such as the member handbook and/or ABD notice G&A • HSAG will also use the results of the Appeal File Review G&A **Evidence as Submitted by the DBA:** • 27. April 7 2020 CMS Letter to DHCFP RE: CMS Waiver 1135 (pages 3-4) • 30. COVID-19 Unwind Nevada Medicaid 1135 Flexibilities Table as of 6.21.22 (Entire Document) • 04. GA PP- State Fair Hearing Process Policy -- NEVADA MEDICAID (pages 1 and 5) • a.05. LDP_NV_Medicaid_Member_Handbook: Reporting and Solving Problems: State Fair Hearings (page 38) • a. 25. NV Medicaid NOA Uphold Template (Entire Document)	☐ Met ☒ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the extended State Fair Hearing submission request timeframes granted Nevada Medicaid from CMS in 2020, as well as the member notification of their State Fair Hearing rights requirements in 42 CFR §438.408(f)(2), 42 CFR §438.228, and Contract 3.12.6.2, under the current CMS waiver 1135 in effect. We detail in our Nevada Medicaid State Fair Hearing Process Policy (Evidence #4) that a member's right to request a state fair hearing has been extended during the COVID-19 Public Health Emergency, in accordance with the current CMS 1135 waiver (Evidence #27, 30). We also notify the member of their State Fair Hearing rights in the required Nevada Medicaid Template (Evidence #25) and in the appropriate language and reading level in the Nevada Medicaid Member Handbook (Evidence #5).		
HSAG Findings: The DBA's member handbook and appeal resolution notices inaccurately indicated that members have 120 days to file for a SFH. Although the DBA indicated that it interpreted DHCFP's coronavirus disease 2019 public health emergency (COVID PHE) waiver to mean that the DBA could extend the SFH time frame to 120 days (i.e., provide an extra 30 days), the waiver allowed DHCFP to modify the time frame to allow an additional		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
120 days to request a SFH from the time frame already allowable under federal rule (i.e., no less than 90 days but no more than 120 days). However, the contract effective January 1, 2022, was updated to indicate that members have 90 days to file for a SFH, and there was no evidence that DHCFP delayed scheduling of SFHs or that the SFH time frame was extended to allow the additional 120 days for members to request a SFH. Upon review of the DHCFP Fair Hearings website, HSAG determined that members were being informed that they must file for a SFH within 90 days. Please refer to https://dhcfp.nv.gov/Resources/PI/Hearings/. As such, the DBA must update its member materials to ensure that members request a SFH within 90 days of the appeal resolution notice to comply with current DHCFP contract requirements.		
Required Actions: The DBA must inform members that they must submit a request for a SFH in writing within 90 calendar days from the date of the DBA's notice of resolution of the appeal, and the DBA is required to inform members of their right to a SFH, how to obtain such a hearing, and representation rules must be explained and provided in writing to the member by the DBA pursuant to 42 CFR 431.200(b), 42 CFR 431.220(a)(6), and 42 CFR 438.408(e)(2)(i).		
Continuation of Benefits		
30. The DBA must continue the member's benefits if all of the following occur: a. The member files the request for an appeal timely (within 60 calendar days from the date on the ABD notice). b. The appeal involves the termination, suspension, or reduction of previously authorized services. c. The services were ordered by an authorized provider. d. The period covered by the original authorization has not expired. e. The member timely files for continuation of benefits. *Timely files* means on or before the later of the following: within ten (10) calendar days of the DBA sending the notice of ABD, or the intended effective date of the DBA's proposed ABD. 42 CFR §438.420 (a-b) 42 CFR §438.228 Contract 3.12.2.3; 3.12.7.1	**HSAG Recommended Evidence:** • Policies and procedures • ABD notice template • Appeal resolution notice template • Three examples of member requests for continuation of member benefits **Evidence as Submitted by the DBA:** • 04. GA PP - State Fair Hearing Process Policy- NEVADA MEDICAID (page 3) • 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (pages 13-14) • 05. LDP NV Medicaid Member Handbook: Reporting and Solving Problems: Appeals (page 36) • 11. NV Medicaid Notice of Adverse Benefit Determination Redacted (Entire Document) • 25. NV Medicaid NOA Uphold Template (Entire Document)	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
DBA Description of Process: LIBERTY complies with continuation of benefits during an appeal requirements in 42 CFR §438.420 (a-b), 42 CFR §438.228, and Contract 3.12.2.3 and 3.12.7.1. As detailed in our Nevada Medicaid Single Level Appeals Process (Evidence #2) and State Fair Hearing Process (Evidence #4) policies, member benefits are continued when the member files the request for an appeal timely, the appeal involves the termination, suspension, or reduction of previously authorized services, the services were ordered by an authorized provider, the period covered by the original authorization has not expired, and the member files for continuation of benefits timely. LIBERTY advises members of their right to continuation of benefits and educates them on how to request them in the appropriate language and reading level in the Nevada Medicaid Member Handbook (Evidence #5), the Nevada Medicaid Notice of Adverse Benefit Determination (Evidence #11), and the Nevada Medicaid Notice of Appeal Uphold letter (Evidence #25). There were no cases involving continuation of benefits or requests by a member to continue benefits during an appeal during the audit period.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
31. If, at the member's request, the DBA continues or reinstates the member's benefits while the appeal or SFH is pending, the benefits must be continued until one of following occurs: a. The member withdraws the appeal or request for SFH. b. The member fails to request a SFH and continuation of benefits within ten (10) calendar days after the DBA sends the notice of an adverse resolution to the member's appeal. c. A SFH office issues a hearing decision adverse to the member. 42 CFR §438.420(c) 42 CFR §438.228 Contract 3.12.2.4; 3.12.7.2	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of documentation related to continuation of member benefits **Evidence as Submitted by the DBA:** • 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (pages 13-14) • 05. LDP NV Medicaid Member Handbook: Reporting and Solving Problems: Appeals (page 36) • a.02 GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (pages 13-14)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the appeal, State Fair Hearing, and continuation of benefits requirements in 42 CFR §438.420(c), 42 CFR §438.228, and Contract 3.12.2.4 and 3.12.7.2. Our Nevada Medicaid Single Level Appeals Process Policy (Evidence #2) details LIBERTY's grievance and appeal system processes to ensure member benefits are continued while an appeal or state fair hearing is still pending upon the member's request. We notify members of their appeal and continuation of benefits rights in the appropriate language and reading level in our Nevada Medicaid		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Member Handbook (Evidence #5). LIBERTY does not have any examples of an appeal case that included continuation of benefits, nor has a request for continuation of benefits been received by any member.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
32. If the final resolution of the appeal or SFH is adverse to the member, that is, upholds the DBA's ABD, the DBA may recover the cost of services furnished to the member while the appeal and SFH was pending, to the extent that they were furnished solely because of the requirements of this section. 42 CFR §438.420(d) 42 CFR §438.228 Contract 3.12.7.3	**HSAG Recommended Evidence:** • Policies and procedures • One example of cost recovery **Evidence as Submitted by the DBA:** • 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (pages 13-14) • 04. GA PP - State Fair Hearing Process - NEVADA MEDICAID (page 3) • 05. LDP NV Medicaid Member Handbook: Reporting and Solving Problems: Appeals (page 36) • 11. NV Medicaid Notice of ABD Sample Redacted (Entire Document) • 25. NV Medicaid NOA Uphold Template (Entire Document)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the cost recovery after appeal and State Fair Hearing requirements in 42 CFR §438.420 (d), 42 CFR §438.228, and Contract 3.12.7.3. Our Nevada Medicaid Single Level Appeals Process (Evidence #2) and Nevada Medicaid State Fair Hearing Process (Evidence #4) policies detail the process of LIBERTY being allowed to recover costs. Members are informed that they can be held liable for the cost of services furnished to them during a pending appeal or State Fair Hearing in the appropriate language and reading level in the Nevada Medicaid Member Handbook (Evidence #5), the initial Notice of Adverse Benefit Determination (Evidence #11) and the Notice of Appeal Uphold (Evidence # 25). There were no cases during the audit period where members requested continuation of benefits and LIBERTY sought to recover costs.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
33. If the DBA or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the DBA must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. 42 CFR §438.424(a) 42 CFR §438.228 Contract 3.12.7.4	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of reinstatement of services (the date of the reversal and date the services were reinstated must be included) **Evidence as Submitted by the DBA:** • 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (pages 13-14) • 03. GA PP – Expedited Appeals Process and Policy – NEVADA MEDICAID (page 6) • 04. GA PP - State Fair Hearing Process - NEVADA MEDICAID (page 5) • Appeal File Selection 08. 00001377890-01_FL030596008	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the appeal, State Fair Hearing, and authorization of services upon reversal requirements, per 42 CFR §438.424(a), 42 CFR §438.228, and Contract 3.12.7.4. As detailed in our Nevada Medicaid Single Level Appeals Process (Evidence #2), Expedited Appeals Process (Evidence #3), and State Fair Hearing Process (Evidence #4) policies, LIBERTY authorizes or provides disputed services promptly based and as required by the member's health condition upon a reversal of an appeal by a LIBERTY reviewer or by a State Fair Hearing Officer. Compliance with these requirements is demonstrated by Appeal File Selection 08. 00001377890-01_FL030596008, wherein a LIBERTY reviewer reversed a member's appeal.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
34. If the DBA or the SFH officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, *the DBA must pay for those services*. 42 CFR §438.424(b) 42 CFR §438.228 Contract 3.12.7.4	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of a SFH reversal with corresponding authorization of services **Evidence as Submitted by the DBA:** • 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (pages 13-14) • 03. GA PP – Expedited Appeals Process and Policy – NEVADA MEDICAID (page 6) • 04. GA PP - State Fair Hearing Process - NEVADA MEDICAID (page 5)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the appeal, State Fair Hearing, and authorization of payment upon reversal requirements in 42 CFR §438.424(b), 42 CFR §438.228, and Contract 3.12.7.4. As detailed in our Nevada Medicaid Single Level Appeals Process (Evidence #2), Expedited Appeals Process (Evidence #3), and State Fair Hearing Process (Evidence #4) policies, in the event a LIBERTY reviewer or State Fair Hearing Officer reverses our initial decision to deny, limit, or delay services that were furnished while the appeal was pending, the services are paid accordingly. There were no cases that were post-service overturned cases within the audit period.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
Grievances, Appeals, and State Fair Hearings		
35. In handling grievances and appeals, the DBA must give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate teletypewriter	**HSAG Recommended Evidence:** • Policies and procedures • Member handbook(s) • One example of assistance to members on filing a grievance or appeal **Evidence as Submitted by the DBA:**	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
(TTY)/telecommunications device for the deaf (TTD) and interpreter capability. a. *The DBA must assist the member and/or the member's representative to arrange for non-emergency transportation services to attend and be available to present evidence at the appeal hearing.* 42 CFR §438.406(a) 42 CFR §438.228 Contract 3.12.5.4(A)	• 01. GA PP – Grievance Process Policy– NEVADA MEDICAID (page 5) • 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (page 5) • a. 05. LDP NV Medicaid Member Handbook: Transportation Services (pages 18-19) • Grievance Sample File 02. 00002897253-01_FL034076224	
DBA Description of Process: LIBERTY complies with the grievance, appeals, and State Fair Hearings member assistance requirements including the arrangement of non-emergency transportation in 42 CFR §438.406(a), 42 CFR §438.228, and Contract 3.12.5.4(A). As we detail in our Nevada Medicaid Grievance Process (Evidence #1) and Single Level Appeals Process (Evidence #2) policies, LIBERTY provides members assistance throughout the grievance, appeal, and State Fair Hearings process. We educate members about the assistance we provide and how to request it in the appropriate language and reading level in our Nevada Medicaid Member Handbook (Evidence #5). We demonstrate compliance with these requirements to assist members in Grievance Sample File 02. 00002897253-01_FL034076224, wherein a member filing a verbal grievance was provided assistance in completing the process.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
36. The DBA must provide information specified in 42 CFR §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. 42 CFR §438.414 42 CFR §438.228 Contract 3.12.1.3; 3.12.1.3(A)	**HSAG Recommended Evidence:** • Policies and procedures • Provider manual • Provider contract • Subcontractor agreement template **Evidence as Submitted by the DBA:** • 01. GA PP – Grievance Process Policy – NEVADA MEDICAID (page 2)	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
	• 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (page 3) • 09. LDP NV Provider Reference Guide Medicaid: Member and Provider Grievance and Appeals (pages 64-66) • 12. LDP NV Medicaid Provider Agreement (pages 4, 5, 7, and 9) • 31. LDP NV Medicaid Subcontractor Addendum (Entire Document)	
DBA Description of Process: LIBERTY complies with the provider and subcontractor notification about our grievance and appeal system requirements, in 42 CFR §438.414, 42 CFR §438.228, and Contract 3.12.1.3 and 3.12.1.3(A). Our Nevada Medicaid Grievance Process (Evidence #1) and Single Level Appeals Process (Evidence #2) policies detail LIBERTY's mechanisms for educating providers and subcontractors (aka delegated vendors) regarding our grievance and appeal system. We demonstrate compliance with these policies by including information about grievance and appeals in the Nevada Medicaid Provider Reference Guide (Evidence #9) that is given to providers during onboarding and is incorporated by reference in our Nevada Medicaid Provider Agreement (Evidence #12). Similarly, all delegated vendors notified and informed regarding LIBERTY's grievance and appeal system during onboarding and in their Subcontractor Addendum (Evidence #31).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
37. The DBA must include as parties to the appeal and SFH: a. The member and his or her representative b. The legal representative of a deceased member's estate c. For SFHs, the DBA. *The DBA will participate in the SFH process, at the DBA's expense, in each circumstance in which a member for whom the DBA has made an ABD requests a SFH. The expectation from the DBA is they have a dental specialist who can explain why the vendor made the adverse decision per the clinical documentation submitted. The DBA is bound by the decision of the Fair Hearing Officer.*	**HSAG Recommended Evidence:** • Policies and procedures • Evidence of SFH participation **Evidence as Submitted by the DBA:** • a, b, c. 03. GA PP - Expedited Appeals Process Policy - NEVADA MEDICAID (Entire Document) • a, b, c. 02. GA PP - Single Level Appeals Process Policy- NEVADA MEDICAID (Entire Document)	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.406(b)(6) 42 CFR §438.408(f)(3) 42 CFR §438.228 Contract 3.12.5.5(D); 3.12.6.3	• a, b, c. 04. Policy GA PP - State Fair Hearing Process Policy - NEVADA MEDICAID (Entire Document)	
DBA Description of Process: LIBERTY complies with the grievance, appeal, and State Fair Hearing requirements in 42 CFR §438.406(b)(6), 42 CFR §438.408(f)(3), 42 CFR §438.228, and Contract 3.12.5.5(D) and 3.12.6.3. Our Nevada Medicaid Single Level Appeals Process (Evidence #2), Expedited Appeals Process (Evidence #3) and State Fair Hearing Process (Evidence #4) policies apply to the member, the member's representative, and in the case of a deceased member, the legal representative of the estate. In addition, our policies detail that during any State Fair Hearing, a licensed dentist would be available to explain the adverse decision and the clinical documentation submitted. There were no State Fair Hearing cases during the audit period.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
Recordkeeping Requirements		
38. Grievance and appeal records must be accurately maintained in a manner accessible to the State and available upon request to CMS, and contain, at a minimum, all of the following information: a. A general description of the reason for the appeal or grievance. b. The date received. c. The date of each review or, if applicable, review meeting. d. Resolution at each level of the appeal or grievance, if applicable. e. Date of resolution at each level, if applicable. f. Name of the member for whom the appeal or grievance was filed. 42 CFR § 438.416(b-c)	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Appeals and Grievances File Reviews **Evidence as Submitted by the DBA:** • 01. GA PP – Grievance Process Policy-NEVADA MEDICAID (Entire Document) • 02. GA PP - Single Level Appeals Process Policy- NEVADA MEDICAID (Entire Document) • 03. GA PP - Expedited Appeals Process Policy- NEVADA MEDICAID (Entire Document) • a, b, c, d, e, f. Appeals and Grievances File Selections	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.228 Contract 3.12.5.8		
DBA Description of Process: LIBERTY complies with the grievance and appeal records and DHCFP access requirements, per 42 CFR § 438.416(b-c), 42 CFR §438.228, and Contract 3.12.5.8. As detailed in our Nevada Medicaid Grievance Process (Evidence #1), Single Level Appeals Process (Evidence #2) and Expedited Appeals Process (Evidence #3) policies, LIBERTY maintains grievance and appeal records with all of the required information and makes those records available to DHCFP through regular reporting and auditing. Our compliance with the data elements required is demonstrated in our Appeals and Grievances Files submitted.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems						
Met	=	35	X	1	=	35
Not Met	=	3	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	38	**Total Score**		=	35
Total Score ÷ Total Applicable					=	92%

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. Notwithstanding any relationship(s) that the DBA may have with any delegate, DBA maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. a. *The DBA must evaluate the prospective subcontractor's ability to perform the activities to be delegated.* b. *The DBA must submit all subcontractors to DHCFP for advance written approval prior to the subcontractor's effective date.* c. *Within thirty-five (35) calendar days of the date of request, the DBA must provide full and complete information about the ownership of any subcontractor with whom the DBA has had a business transaction totaling more than twenty-five thousand dollars ($25,000) during the twelve-month (12-month) period ending on the date of request as required by 42 CFR §455.105.* 42 CFR §438.230(b)(1) Contract 3.14.4.1; 3.14.4.2; 3.14.4.3; 3.14.4.6; 3.14.4.10	**HSAG Recommended Evidence:** • Policies and procedures • Pre-delegation assessment (for delegates implemented within the past fiscal year) • Written approval from DHCFP (for delegates implemented within the past fiscal year) • Example of completed request for ownership information, • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the DBA:** 0. Note to Reviewer - Policy Issue & Approval Dates 1. Delegated Vendor Oversight Program (DVOP): • Page 7, Policy Section 1 for Element 1 • Page 7, Policy Section 2 for Element 1a • Page 7, Policy Section 2(b) for Element 1b • Page 8, Policy Section 2(h) for Element 1c 2. Due Diligence & Oversight Guidelines 3. Subcontractor Checklist Template for Element 1b 4. Credentialing Report – [provider name] dba Canyon Ridge (Pre-delegation Assessment): Cite entire document 5. DHCFP Approval – [provider name] for Element 1b 6. Disclosure of Ownership – Streamline Verify for Element 1c 7. NV Medicaid Addendum template: • Page 2, Section 3(d) for Element 1c • Page 6, Section 11 for Element 1a	☒ Met ☐ Not Met ☐ NA

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
DBA Description of Process: LIBERTY evaluates a prospective subcontractor's ability to perform delegated activities in a quality and compliant manner prior to delegation including, but limited to evaluating the subcontractor's experience, checking references, and reviewing subcontractor's policies and procedures as noted in the *Delegated Vendor Oversight Program* (Evidence #1), *Due Diligence & Oversight Guidelines* (Evidence #2), and required in the *NV Medicaid Addendum* (Evidence #6). Prior to sub-delegating a delegated function to a subcontractor, LIBERTY submits a *Subcontractor Checklist* (Evidence #3) to DHCFP requesting approval of subcontractor as documented in the *Delegated Vendor Oversight Program* (Evidence #1). Upon approval from DHCFP, LIBERTY requires the subcontractor to provide and complete the *Disclosure of Ownership* (Evidence #6) promptly as indicated in the *NV Medicaid Addendum* (Evidence #7). During the past fiscal year, LIBERTY did not add new subcontractors for the NV market. However, LIBERTY is providing an example of the pre-delegation assessment (*Credentialing Report*, Evidence #3) that was completed prior to delegation and *DHCFP Approval* (Evidence #4) for a subcontractor who was onboarded in May 2021.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element. **Recommendations:** While the Delegated Vendor Oversight Program and Nevada Medicaid Program Subcontractor Addendum required the DBA's delegates to report ownership information to the DBA, HSAG recommends that the DBA clearly delineate the requirements of sub-element (c) in a policy, procedure, or workflow to ensure staff awareness that the DBA must report this information to DHCFP within 35 calendar days of a request. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
Contract or Written Arrangement		
2. Each contract or written arrangement with a delegate must specify: a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.	**HSAG Recommended Evidence:** • Delegation agreement/contract template • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the DBA:** 1. Delegated Vendor Oversight Program: Page 7, Policy Section 2 for Element 2a	☒ Met ☐ Not Met ☐ NA

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
b. The delegate agrees to perform the delegated activities and reporting responsibilities specified in compliance with the DBA's contract obligations. c. The contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the DBA determine that the delegate has not performed satisfactorily. 42 CFR §438.230(b)(2) 42 CFR §438.230(c)(1) Contract 3.14.4.7	2. Master Service Agreement template: Page 1, Section 2(a) for Element 2a 3. NV Medicaid Addendum template: Page 3, Section 3(h) for Element 2b & 2c 4. Delegated Oversight Addendum template: Page 1, Section 3 for Element 2c	
DBA Description of Process: LIBERTY's *Delegated Vendor Oversight Program* (Evidence #1) and *Master Service Agreement* (Evidence #2) require that written agreement with subcontractor must specify delegated obligations, service level agreements (SLAs), and related reporting responsibilities. LIBERTY's *NV Medicaid Addendum* (Evidence #3) specifies that subcontractor agrees to perform all delegated activities and reporting responsibilities specified in the agreement and the addendum in compliance with LIBERTY's obligations with the DHCFP's contract. In accordance with 42 CFR §438.230(c)(1)(i), Section 3 of the NV Medicaid Addendum provides that in the event the DHCFP or LIBERTY determines that a subcontractor has not performed satisfactorily, LIBERTY has the right to revoke subcontractor's delegated activities or obligations related to LIBERTY's obligations under the Contract. In addition, the *Delegated Oversight Addendum* (Evidence #4) states that if the subcontractor's performance is unsatisfactory to LIBERTY, the subcontractor needs to submit a performance improvement plan to LIBERTY.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
3. The contract or written arrangement indicates that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions, *including but not limited to the provisions related to confidentiality, HIPAA requirements, insurance requirements, and record retention.* 42 CFR §438.230(c)(2) Contract 3.14.4.5	**HSAG Recommended Evidence:** • Delegation agreement/contract template • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the DBA:** 1. NV Medicaid Addendum template: • Page 4, Section 3(j)(i) • Page 4, Section 3(l) • Page 4, Section 4(a)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: As specified in the *NV Medicaid Addendum*, page 3, section 4(a), (Evidence #1), LIBERTY's subcontractor agrees to comply with all state and federal laws, rules and regulations, and applicable program requirements, regarding the privacy, security, confidentiality, accuracy and/or disclosure of records (including, but not limited to, medical records), personally identifiable information and/or protected health information and enrollment information, including, without limitation, the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively, "HIPAA"). Subcontractor represents and warrants that subcontractor is adequately insured to current insurance industry standards in accordance with Section 3.14.4.5 of the Contract (Evidence #1), and that all records pertaining to LIBERY contract are retained for a minimum of 6 years from the later of the date of Termination of the Contract or the date of payment for the relevant goods or services by the DHCFP (Evidence #1a).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
4. The contract or written arrangement indicates, and the delegate agrees that: a. The State, Centers for Medicare and Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records,	**HSAG Recommended Evidence:** • Delegation agreement/contract template • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the DBA:** 1. NV Medicaid Addendum template: • Page 4, Section 3(j)(i) for Element 4a	☒ Met ☐ Not Met ☐ NA

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
contracts, computer or other electronic systems of the delegate, or of the delegate's subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the DBA's contract with the State. b. The delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members. c. The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. d. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time. 42 CFR §438.230(c)(3)(i-iv)	• Page 4, Section 3(j)(ii) for Element 4b • Page 4, Section 3(j)(iii) for Element 4c • Page 4, Section 3(j)(iv) for Element 4d	
DBA Description of Process: LIBERTY's subcontractor is required to sign the *NV Medicaid Addendum* (Evidence #1) to ensure they agree and comply to specific requirements set by the DHCFP, CMS, the U.S. Department of Health and Human Service Office of Inspector General, and the Comptroller General of the United States including: a. LIBERTY has the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's agents, that pertain to any aspect of services and activities performed, or determination of amounts payable under the contract with LIBERTY. b. The subcontractor will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to LIBERTY's contract c. LIBERTY's right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. d. If DHCFP, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the DHCFP, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time.		

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the DBA met the requirements for this element. **Recommendations:** The Nevada Medicaid Program Subcontractor Addendum included the requirements of this element. It also included a minimum of a six-year time frame for the retention of records which conflicts with the 10-year right to audit requirement. However, the Delegated Oversight Addendum required records to be retained for a period of 10 years following termination or expiration of the agreement or such longer period required by applicable law. Additionally, the addendums included the following language: "All provisions of the Agreement and this Addendum are cumulative. All provisions shall be given effect when possible. If there is inconsistent or contrary language between the Addendum and any other part of the Agreement, the provisions of this Addendum shall prevail except to the extent a provision of the Agreement exceeds the minimum requirements of the Addendum," therefore indicating that the stricter requirement prevails. As such, the DBA received a *Met* score for this element. After the site review, the DBA also indicated that the six-year record retention requirement was required by its contract with DHCFP (Section 9.c). However, HSAG reviewers were unable to locate this citation in the contract applicable during the time period of review. Lastly, of note, the Delegated Oversight Addendum also included only a three-year right to audit requirement. However, DBA staff members clarified that the provision was related to the DBA's right to audit (as opposed to the State, CMS, HHS Inspector General, the Comptroller General, or their designees). HSAG strongly recommends that the DBA conduct a thorough review of its contract and ensure all language is consistent with the federal rule and that the contract does not contain language that contradicts federal rule and/or contract requirements. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
Monitoring and Auditing		
5. *The DBA is responsible for oversight of all subcontracts and is accountable for any responsibilities it delegates to any subcontractor.* a. *The DBA must monitor the subcontractor's performance on an on-going basis.* 42 CFR §438.230 Contract 3.14.4.2; 3.14.4.6; 3.14.4.8	**HSAG Recommended Evidence:** • Delegation agreement/contract template • Three examples of consecutive reporting • Three examples of consecutive delegation oversight committee meeting minutes • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the DBA:** 1. Delegated Oversight Addendum template: Page 1, Section 3 2. Monthly Scorecards - Streamline Verify: Cite entire document 3. Compliance Committee Meeting Minutes Q1 2022 Approved: Page 4, Item f; Page 7, Item f & g	☒ Met ☐ Not Met ☐ NA

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	4. Due Diligence & Oversight Guidelines	

DBA Description of Process:
As indicated in Section 3, page 1 of the *Delegated Oversight Addendum* (Evidence #1), LIBERTY's ongoing monitoring of its subcontractor's performance including, but not limited to reviewing various performance reports, for example, *Monthly Scorecards* (Evidence #2), and conducting virtual meetings with the subcontractor on a regular basis to ensure continued compliance with the *Due Diligence & Oversight Guidelines* (Evidence #4).

LIBERTY reviews applicable reports to ensure service level agreements and expectations are met. If the subcontractor's performance is unsatisfactory to LIBERTY, LIBERTY requires the subcontractor to provide a performance improvement plan to LIBERTY to review and approve. LIBERTY will monitor Subcontractor until the performance is improved at satisfactory level.

LIBERTY's Delegated Vendor Oversight Committee reports to LIBERTY's Compliance Committee. During the lookback, through its Compliance Committee meetings, the Delegated Vendor Oversight Committee reported out the oversight activities. Key updates included monthly exclusion screening, Scorecards, Annual Compliance trainings, transactional audit of 1 subcontractor, and vendor contract review.

The Delegated Vendor Oversight Committee reports regularly to the LIBERTY's Compliance Committee. Applicable, finalized minutes of the Compliance Committee that pertain to the lookback period are provided, please see attached *Compliance Committee Meeting Minutes Q1 2022 Approved*, page 4, item f, and page 7, item f & g (Evidence #3). Additional draft meeting minutes or meeting minutes immediately preceding the lookback period can be provided upon request.

HSAG Findings: HSAG has determined that the DBA met the requirements for this element.
Recommendations: The Regulatory Compliance Committee meeting minutes were heavily redacted and provided minimal information about the DBA's oversight of delegated entities for Nevada Medicaid. As such, HSAG recommends that the DBA ensure that any supporting documentation or reports presented at its committee meetings are also submitted during future compliance reviews. Additionally, for one delegate's monthly scorecard, the delegate received a score of "n/a" for the monthly reporting element. However, the master services agreement indicated that service level standards would be calculated monthly. While an example of a daily monitoring report was provided (although blank as no data were available for the reporting day), and therefore demonstrated mechanisms for conducting oversight, HSAG recommends that the DBA ensure its subcontracts, scorecard, and ongoing monitoring requirements are consistent. Implementation of these recommendations will be evaluated during future compliance reviews.

Required Actions: None.

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**

6. *The DBA conducts a formal review of the subcontractor according to a periodic schedule established by the State, consistent with industry standards, and/or State laws and regulations.*
 	
42 CFR §438.230
Contract 3.14.4.6; 3.14.4.8
	HSAG Recommended Evidence:
	• Delegation agreement/contract template
	• Three examples of formal review results
	• HSAG will use the results from the Delegation File Review
	
	Evidence as Submitted by the DBA:
	1. NV Medicaid Addendum template: Page 6, Section 11
	2. Annual Oversight Audit:
	  • MAP dba LiveMessage America
	  • Streamline Verify
	  • TransPerfect Global Inc.
	3. Due Diligence & Oversight Guidelines
		☒ Met
		☐ Not Met
		☐ NA

DBA Description of Process: LIBERTY performs quality management/operational audit annually as indicated in the *NV Medicaid Addendum*, page 6, Section 11 (Evidence #1). LIBERTY has a formal process of conducting oversight of subcontractor that performs sub-delegated functions on LIBERTY's behalf. The annual audit typically consists of the previous year lookback covering, but not limited to reviewing of the policies & procedures that address HIPAA privacy & security, processes for reporting disclosure incidents, and training of staff on fraud, waste & abuse, etc. The *Annual Oversight Audit* reports (Evidence #2) are completed and provided herein as examples of the audit results to ensure continued compliance with the *Due Diligence & Oversight Guidelines* (Evidence #3).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element. **Recommendations:** HSAG reviewers were initially challenged in determining the DBA's "ongoing monitoring" activities versus its "formal review" of delegates, as for two of the delegates reviewed, the monthly scorecards and the annual reviews appeared to be the same except for an annual compliance attestation. DBA staff members explained that each delegate's oversight and periodic reviews will vary according to each delegate's scope of work (SOW) and risk level. HSAG recommends that the DBA maintain a list of all delegates for Nevada Medicaid that provides a brief summary of their SOW, risk level, schedule/reporting requirements for ongoing monitoring, and schedule/scope of the periodic formal review. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
7. *If the DBA identifies deficiencies or areas for improvement, the DBA and the subcontractor take corrective action.* 42 CFR §438.230 Contract 3.14.4.6; 3.14.4.8	**HSAG Recommended Evidence:** • Delegation agreement/contract template • Three examples of corrective action plans • Committee meeting minutes • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the DBA:** 1. Delegated Vendor Oversight Program: Page 5, Section 4; Page 8, Section 5 2. Delegated Oversight Addendum template: Page 1, Section 3 3. Corrective Action Plan (CAP): • TransPerfect Global Inc. - March 2022 • TransPerfect Global Inc. - May 2022 4. Committee Meeting Minutes Q1 2022 Approved: Page 4, item f; Page 7, Item f & g	☒ Met ☐ Not Met ☐ NA

DBA Description of Process:
LIBERTY's *Delegated Vendor Oversight Program* (Evidence #1) and *Delegated Oversight Addendum* (Evidence #2) require that a corrective action plan (CAP) or a performance improvement plan be developed to address and correct the root cause of any identified systemic deficiency or non-compliance with federal or state law, regulation, sub-regulatory guidelines or contractual requirements, or a deficiency that presents high risk for potential member harm, actual member harm, or potential fines or sanctions. During the lookback period, LIBERTY only issued 2 *CAP*s (Evidence #3) to 1 subcontractor, TransPerfect.

As mentioned in Element 5, LIBERTY's Delegated Vendor Oversight Committee reports to LIBERTY's Compliance Committee. During the lookback, through its Compliance Committee meetings, the Delegated Vendor Oversight Committee reported out the oversight activities including 2 corrective action plans were issued to 1 subcontractor.

The Delegated Vendor Oversight Committee reports regularly to the LIBERTY's Compliance Committee. Applicable, finalized minutes of the Compliance Committee that pertain to the lookback period are provided, please see attached *Compliance Committee Meeting Minutes Q1 2022 Approved*, page 4, item f,

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
and page 7, item f & g (Evidence #4). Additional draft meeting minutes or meeting minutes immediately preceding the lookback period can be provided upon request.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element. Of note, one delegate received partial scores for one element within the monthly scorecards; however, no documentation of follow-up to this finding was provided. DBA staff members clarified that the partial score was specific to another state and not related to Nevada Medicaid.		
Required Actions: None.		

Standard XI—Subcontractual Relationships and Delegation						
Met	=	7	X	1	=	7
Not Met	=	0	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	7	Total Score		=	7
Total Score ÷ Total Applicable					=	100%

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
Adoption of Practice Guidelines		
1. *The DBA's Dental Director oversees the development and revision of the DBA's clinical care standards and practice guidelines and protocols.* Contract 3.14.2.3	**HSAG Recommended Evidence:** • Job description • Committee charter • Committee meeting minutes **Evidence as Submitted by the DBA:** 0. Note to Reviewer - Policy Issue & Approval Dates 1. Dental Director Job Description: Page 1 2. Dental Advisory Committee Charter: Page 2 3. Q1 2022 DAC Minutes: Pages 4 and Page 5 4. 2022 Peer Review Committee Charter: Cite entire document 5. Q1 2022 Peer Review Minutes: Page 1 and 3	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY's Dental Director provides oversight of the development and revision of LIBERTY's clinical criteria standards and practice guidelines, per Contract 3.14.2.3. LIBERTY's *Dental Director Job Description* (Evidence #1) outlines the responsibilities of the Dental Director, including collaboration with key stakeholders to develop clinical criteria guidelines. The clinical criteria standards and practice guidelines and protocols are formally developed, revised and overseen by the Nevada Dental Director in their capacity as co-chair of LIBERTY's Quality Improvement Committees, including LIBERTY's Nevada *Dental Advisory Committee* (DAC); and LIBERTY's *Peer Review Committee*, as evidenced by the DAC and *Peer Review Charters* and *Minutes* (Evidence #2, #3, #4, #5).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
2. The DBA must adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field. a. *The standard/guidelines must address preventive dental services.*	**HSAG Recommended Evidence:** • Policies and procedures • List of adopted practice guidelines • Meeting minutes documenting committee review/approval **Evidence as Submitted by the DBA:**	☒ Met ☐ Not Met ☐ NA

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.236 (b)(1) Contract 3.6.1; 3.6.1.1; 3.9.8.2(F)	1. 1 UM PP - Clinical Criteria for UM Decisions: Page 3 2. Clinical Criteria Guidelines and Practice Parameters 2022: Page 6 3. Q1 2022 Peer Review Committee Minutes: Page 3 4. Note to Reviewer - ADA Snip Clinical Practice Guidelines Resource: Cite entire document	
DBA Description of Process: LIBERTY adopts practice guidelines including those addressing preventive dental services, based on both a consensus of health care professionals, and on valid and reliable clinical evidence, per 42 CFR §438.236 (b)(1) and Contract 3.6.1, 3.6.1.1, and 3.9.8.2(F). LIBERTY's *Clinical Criteria for UM Decisions* policy ensures that LIBERTY considers valid and reliable clinical evidence in developing practice guidelines (Evidence #1). In addition, LIBERTY's *Clinical Criteria, Guidelines and Practice Parameters* (Evidence #2) are developed with input from participating network general dentists and specialists, and address preventative dental services as evidenced by LIBERTY's *Peer Review Committee Minutes* (Evidence #3). In Q1 2022, LIBERTY's Peer Review Committee discussed and updated clinical criteria language (Evidence #4). LIBERTY's Dental Directors participate in dental clinical organizations such as the American Dental Association and have access to clinical journals, clinical criteria updates and collective, evidence-based clinical practice guidelines that are used to inform LIBERTY's *Practice Guidelines* (Evidence #4).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
3. The DBA must adopt practice guidelines that consider the needs of the DBA's members. a. *The standards/guidelines must be developed for the full spectrum of populations enrolled in the plan.* 42 CFR §438.236 (b)(2) Contract 3.9.8.2(G)	**HSAG Recommended Evidence:** • Policies and procedures • List of adopted practice guidelines • Meeting minutes documenting committee review/approval **Evidence as Submitted by the DBA:** 1. Utilization Management Program 2022: Page 5 2. Clinical Criteria Guidelines and Practice Parameters 2022: Cite entire document 3. Provider Reference Guide: Page 12	☒ Met ☐ Not Met ☐ NA

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
	4. LDP NV Medicaid Member Handbook: Page 24 though Page 28	
DBA Description of Process: LIBERTY adopts practice guidelines that are developed for a full spectrum of populations enrolled in the plan per 42 CFR §438.236 (b)(2) and Contract 3.9.8.2(G). LIBERTY establishes value added benefits and/or benefit frequency changes, as appropriate, in consideration of the full spectrum of its member populations (e.g., children/adults, enrollees with special health care needs, pregnant members) (Evidence #3 and #4). LIBERTY's *Utilization Management Programs* assures that clinical guidelines, standards and criteria set by DHCFP are adhered to as appropriate and that decisions are rendered upon evidenced-based criteria and consisted with professional recognized standards of care, including managing complex cases and special needs cases (Evidence #1 and #2).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
4. The DBA must adopt practice guidelines that are adopted in consultation with *contracting dental professionals*. 42 CFR §438.236 (b)(3) Contract 3.6.1; 3.6.1.2	**HSAG Recommended Evidence:** • Policies and procedures • List of adopted practice guidelines • Meeting minutes documenting committee review/approval • Evidence of consultation of network providers **Evidence as Submitted by the DBA:** 1. 2022 Peer Review Committee Charter: Page 3 2. 2022 Peer Review Committee Minutes Annual Approval: Page 1; Page 3 3. Provider Reference Guide: Page 61 4. Q1 2022 Peer Review Committee Minutes: Page 3	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY practice guidelines are adopted in consultation with contracting dental professionals, per 42 CFR §438.236 (b)(3) and Contract 3.6.1 and 3.6.1.2. As outlined in LIBERTY's *Peer Review Committee Charter*, clinical guidelines are reviewed by LIBERTY Directors and contracted dental professionals (Evidence #1). Peer Review Committee quorum consists of external participating providers and is required for any review and approvals (Evidence #2 and #3). LIBERTY has provided an example of the *Q1 2022 Committee Minutes* documenting the review and approval of NV Clinical Criteria Guidelines (Evidence #4).		

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
5. The DBA must adopt practice guidelines that are reviewed and updated periodically as appropriate. 42 CFR §438.236 (b)(4) Contract 3.6.1; 3.6.1.3	**HSAG Recommended Evidence:** • Policies and procedures • List of adopted practice guidelines • Meeting minutes documenting committee review/approval **Evidence as Submitted by the DBA:** 1. UM PP - Clinical Criteria for UM Decisions: Page 3 2. 2022 Peer Review Committee Minutes Annual Approval: 3. Pages 3 4. Q1 2022 DAC Minutes: Pages 4; Page 5 5. Q1 2022 Peer Review Committee Minutes: Page 3	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY adopts practice guidelines that are reviewed and updated periodically as appropriate, per 42 CFR §438.236 (b)(4), and Contract 3.6.1 and 3.6.1.3. LIBERTY's *Clinical Criteria Guidelines for UM Decision* policy and *Peer Review Committee Charter* (Evidence #1 and #2) ensure that reviews and updates to LIBERTY's Clinical Criteria Guidelines and Practice Parameters occur on at least an annual basis and more frequently as determined necessary. LIBERTY has provided an example of meeting minutes documenting annual committee review and periodic review and approval (Evidence #2, #3, #4)		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
Dissemination of Guidelines		
6. The DBA disseminates the guidelines, *including prior authorization policies and procedures*, to: a. All affected providers b. Members and potential members, upon request 42 CFR §438.236 (c) Contract 3.6.2.1	**HSAG Recommended Evidence:** • Policies and procedures • Evidence of dissemination to providers (i.e., provider newsletter, provider manual, provider website) • Evidence of dissemination to members (i.e., member newsletter, member handbook, member website) **Evidence as Submitted by the DBA:** 1. UM PP - Clinical Criteria for UM Decisions: Page 1; Page 4 2. LDP NV Medicaid Member Handbook: Page 23 3. NM PP - Provider Reference Guide: Page 2 4. Provider Reference Guide: Pages 22; Page 36 5. Note to Reviewer - LIBERTY Website Clinical Criteria: Cite entire document	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY disseminates practice guidelines, including prior authorization policies and procedures, to providers, members and potential members upon request per 42 CFR §438.236 (c) and Contact 3.6.2.1. LIBERTY's *Clinical Criteria for UM Decisions* policy (Evidence #1) ensures that practice guidelines are posted on LIBERTY's public website available to members and potential members (Evidence #5) and that the guidelines, including prior authorization policies, may be requested from LIBERTY. Further LIBERTY's practice guidelines are included in its *Provider Reference Guide* (Evidence #4) which is distributed to all newly contracted providers (Evidence #3).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
Application of Guidelines		

7. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.
42 CFR §438.236 (d)
Contract 3.6.2.2
	HSAG Recommended Evidence:
	• Policies and procedures
	• Coverage guidelines/criteria
	• Member educational guidance (i.e., disease management)
	• Member materials (i.e., member handbook, member newsletters)
	• Three examples of coverage denial notice
	
	Evidence as Submitted by the DBA:
	1. 1 UM PP - Clinical Criteria for UM Decisions: Page 5
	2. LDP NV Medicaid Member Handbook: Page 4; Page 15; Page 22
	3. Notice of Denials
	  • Notice of Denials - Sample 1
	  • Notice of Denials - Sample 2
	  • Notice of Denials - Sample 3
	4. Clinical Quality Assurance Audits SOP: Cite entire document
	5. Q1 2022 Peer Review Minutes, page 13
	6. Member Newsletter: Page 5 and 6
		☒ Met
		☐ Not Met
		☐ NA

DBA Description of Process: LIBERTY ensures that decisions for utilization management, member education, coverage of services, and other areas to which LIBERTY's practice guidelines apply, are consistent with the guidelines per 42 CFR §438.236(d) and Contract 3.6.2.2.

LIBERTY's *Clinical Criteria for UM Decision* policy (Evidence #1) ensures that utilization management decisions are based on LIBERTY's clinical guidelines. Further, the policy ensures that consistent application of the guidelines is monitored via LIBERTY's inter-rater reliability process and that any corrective action is monitored by the state Dental Director (Evidence #1). LIBERTY has provided examples of three coverage denial notices consistent with guidelines (Evidence #4). LIBERTY conducts monthly quality assurance reviews (Evidence #5 and #6) of services to ensure the appropriateness and application of practice guidelines within the dental community standards.

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
Consistent with LIBERTY's practice guidelines, LIBERTY's *Nevada Medicaid Member Handbook* (Evidence #2) educates members on a variety of plan topics, such as dental benefits, rights & responsibilities, dental home and prior authorizations. LIBERTY's *Nevada Medicaid Member Newsletter* (Evidence #8) educates members on timely topics such as completing their Oral Health Risk Assessment via phone or QR code; health and dental concerns for a variety of LIBERTY populations (e.g., tribal communities, members with different ages and health conditions); and nutrition.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
8. *Network providers are required to use designated practice guidelines and protocols.* Contract 3.6	**HSAG Recommended Evidence:** • Policies and procedures • Provider materials, such as provider manual • Provider contract template • Utilization review program description **Evidence as Submitted by the DBA:** 1. NV Provider Agreement 2016.07.26 2. Provider Reference Guide: Page 21, Section 7 3. NM PP - Provider Orientation – Cite entire document	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY requires network providers to use designated practice guidelines and protocols per Contract 3.6. LIBERTY's *Provider Agreement* (Evidence #1) requires providers to comply with LIBERTY's policies and procedures and *Provider Reference Guide*, including LIBERTY's practice guidelines (Evidence #2). Providers are informed of practice guidelines and protocols during LIBERTY provider orientations (Evidence #3).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element. **Recommendations:** Although the provider contract contains a general statement about the provider agreeing to adhere to all policies, procedures and guidelines identified in the provider manual, LIBERTY should consider enhancing template language to make clear the expectation for providers' use of clinical practice guidelines (CPGs) to deliver dental care. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard XII—Practice Guidelines						
Met	=	8	X	1	=	8
Not Met	=	0	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	8	Total Score		=	8
Total Score ÷ Total Applicable					=	100%

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. The DBA must operate a management information system (MIS) capable of maintaining, providing, documenting, and retaining information sufficient to substantiate and report the DBA's compliance with the contract requirements. 42 CFR §438.242(a) Contract 3.13.1	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Systems integration mapping documentation • Most current Information Systems Capabilities Assessment (ISCA) • Technical manual(s) • HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the DBA:** 0. Note to Reviewer - Policy Issue & Approval Dates 1. IT PP Health Information System: Cite entire policy 2. LIBERTY Management Information System Diagram: Cite entire diagram 3. Core Administrative System graphic: Cite entire diagram	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY's *Health Information Systems* policy (Evidence #1) establishes that LIBERTY must operate a management information system (MIS) capable of maintaining, providing, documenting, and retaining information sufficient to substantiate and report on LIBERTY's compliance with contractual requirements, per 42 CFR §438.242(a) and Contract 3.13.1. LIBERTY's MIS supports all DHCFP-required functional areas (e.g., claims, EDI interfaces, eligibility, disenrollment, finance, fulfilment, grievance and appeals, provider network, and utilization management), as depicted in the referenced system diagrams (Evidence #2, #3).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
2. The DBA must maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of Medicaid managed care requirements. The systems must provide information on areas including, but not limited to: a. Utilization b. Claims c. Grievances and appeals d. Disenrollments for other than loss of Medicaid eligibility 42 CFR §438.242(a) Contract 3.9.5	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Systems integration mapping documentation • Most current Information Systems Capabilities Assessment (ISCA) • Technical manual(s) • HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the DBA:** 1. IT PP Health Information System: Cite entire policy 2. LIBERTY Management Information System Diagram: Cite entire diagram 3. Reporting Workflow: Cite entire diagram 4. Note to Reviewer - Disenrollment Tracking: Cite entire document	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY's *Health Information Systems* policy (Evidence #1) establishes that LIBERTY must maintain an MIS that can collect, analyze, integrate, and report data, and that can achieve the objectives of Medicaid managed care requirements, per 42 CFR §438.242(a) and Contract 3.9.5. LIBERTY's MIS and its group of integrated databases support DHCFP-required functional areas and serve as the central repository for related information and reporting, including utilization, claims, grievances and appeals and disenrollment data (see referenced system diagrams and reporting workflows, Evidence #2, #3, #4).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Basic Elements of a Health Information System		
3. The DBA must comply with section 6504(a) of the Affordable Care Act, and ensure its claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act (electronic claims submission). 42 CFR §438.242(b)(1)	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Claims data collection and processing guidelines • HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the DBA:** 1. IT PP Health Information System: Cite entire policy 2. IT PP HSP Application EDI Data Processing, APPENDIX A-NEVADA MEDICAID: Page 1 3. 837 Encounter Outbound Transmission Process: Page 1 4. Claims Data Entry Requirements: Pages 4 - 8; Pages 10 - 25 5. Electronic Attachments (system screenshots): Page 1 6. SOP EDI Data Processing: Page 2 I, II, III	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY's *Health Information Systems* policy (Evidence #1) establishes LIBERTY's compliance with the requirements set forth in 42 CFR §438.242(b)(1). Consistent with 1903(r)(1)(F), LIBERTY's MIS collects the data elements necessary to enable mechanized claims processing, as reflected in the referenced process documents (Evidence #2, #3). Further, LIBERTY job aids and systems (Evidence #4, #5) demonstrate that LIBERTY collects data elements for both paper and electronic claims necessary to comply with Nevada DHCFP submission requirements (Evidence #6).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
4. The DBA must collect data on member and provider characteristics as specified by DHCFP and on all services furnished to members through an encounter data system or other method as may be specified by DHCFP. 42 CFR §438.242(b)(2) Contract 3.9.5.1	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Claims data collection and processing guidelines • Encounter data collection and submission guidelines • HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the DBA:** 1. EE PP - Timely Uploading and Reconciliation of Electronic Eligibility Files: Page 1 and 2 2. C3 CR PP - C3 Initial Credentialling Process: Pages 1, 3, 4 and 16 3. SOP EDI Data Processing: Page 2 I, II, III 4. IT PP HSP Application EDI Data Processing APPENDIX A-NEVADA MEDICAID: Page 1 5. 837 Encounter Outbound Transmission Process: Page 1 6. NM PP Maintaining Provider Directories: Pages 2 - 6	☒ Met ☐ Not Met ☐ NA

DBA Description of Process: LIBERTY complies with 42 CFR §438.242(b)(2) and Contract 3.9.5.1, as follows:

Member data collection requirements: LIBERTY's *Timely Uploading and Reconciliation of Electronic Eligibility Files* policy (Evidence #1) ensures that necessary member data is collected on all members and updated timely, including data necessary to support encounter reporting.

Provider data requirements: LIBERTY's *Initial Credentialing Process* policy (Evidence #2) establishes a documented process for onboarding network providers, including collecting provider demographics such as name, location, tax ID, NPI and taxonomy, etc, that are required to process encounters. This data is stored and maintained within LIBERTY's health information system (see *Maintaining Provider Directories*, Evidence #6).

Data collection for all services furnished: LIBERTY's *EDI data processing policies* (Evidence #3, #4, #5), ensures that all services furnished to members through an encounter data system are collected as specified by DHCFP.

HSAG Findings: HSAG has determined that the DBA met the requirements for this element.

Required Actions: None.

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
5. The DBA must ensure that data received from providers is accurate and complete by: a. Verifying the accuracy and timeliness of reported data, including data from network providers the DBA is compensating on the basis of capitation payments. b. Screening the data for completeness, logic, and consistency. c. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts. 42 CFR §438.242(b)(3) Contract 3.9.5.2-3.9.5.3	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Claims submission requirements document • Claims data collection and processing guidelines • Claim validation processes • Claim timeliness reports • HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the DBA:** 1. Claims Data Entry Requirements: Page 4 - 8; Page 10 - 25 for Element 5a, 5b, and 5c 2. Electronic Attachments: Page 1 for Element 5a, 5b, and 5c 3. SOP EDI Data Processing: Page 2 I, II, III for Element 5a, 5b, and 5c 4. IT PP HSP Application EDI Data Processing, APPENDIX A-NEVADA Medicaid: Page 1 and 2 for Element 5a, 5b, and 5c 5. 837 Encounter Outbound Transmission Process: Page 1 for Element 5a, 5b, and 5c 6. Claims Payment Timeliness: Cite entire report	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with 42 CFR §438.242(b)(3) and Contract 3.9.5.2-3.9.5.3 to ensure data received from providers is accurate and complete. LIBERTY's policies, job aids and systems ensure that data from capitated and non-capitated providers is submitted in standardized formats and screened for accuracy, timeliness, completeness and consistency (see Evidence #1 - #6).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
6. The DBA must make all collected data available to the State and upon request to CMS. 42 CFR § 438.242(b)(4) Contract 3.9.5.4	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Encounter data submission requirements/reports • Encounter data acceptance/rejection reports **Evidence as Submitted by the DBA:** 1. IT PP Health Information System: Cite entire policy 2. SOP EDI Data Processing: Page 2 I, II, III **See above** 3. IT PP HSP Application EDI Data Processing, APPENDIX A-NEVADA MEDICAID: Page 1 4. 837 Encounter Outbound Transmission Process: Page 1 5. Encounter Data Acceptance/Rejection Reports: Cite entire document	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY's *Health Information Systems* policy (Evidence #1) requires LIBERTY to make all collected data available to the State and upon request to CMS, per 42 CFR §438.242(b)(4) and Contract 3.9.5.4 (see also LIBERTY's EDI and encounter data reporting processes, and encounter data acceptance/rejection reports, Evidence #2, #3, #4, #5).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
Member Eligibility Database		
7. *The DBA's enrollment system is capable of linking records for the same enrolled member that are associated with different Medicaid and/or Nevada Check Up identification numbers (e.g., members who are re-enrolled and assigned new numbers).* Contract 3.13.3.1	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the DBA:** 1. EE PP - Linking Multiple Coverages to a Member: Page 1	☒ Met ☐ Not Met ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
DBA Description of Process: Per Contract 3.13.3.1, LIBERTY's *Linking Multiple Coverages to a Member* policy (Evidence #1) ensures all identifiers associated with an individual are unified into a single record, and that reporting capabilities include all member numbers and associated transactions.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
Application Programming Interface		
8. The DBA must implement an Application Programming Interface (API) as specified in 42 CFR §431.60 (member access to and exchange of data) as if such requirements applied directly to the DBA. Information must be made accessible to its current members or the members' personal representatives through the API as follows: a. Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and member cost-sharing pertaining to such claims, no later than one (1) business day after a claim is processed; b. Encounter data no later than one (1) business day after receiving the data from providers compensated on the basis of capitation payments; c. All other encounter data, including adjudicated claims and encounter data from any subcontractors; d. Clinical data, including laboratory results, no later than one (1) business day after the data is received by the DBA. 42 CFR §438.242(b)(5) 42 CFR §431.60 Contract 3.13.7	**HSAG Recommended Evidence: Tom & Rishi** • Policies, procedures, and workflows • API project plan(s) • API documentation • HSAG will use the results from the API demonstration **Evidence as Submitted by the DBA:** 1. I-Connect Services 10.08.0: Cite entire document 2. Member Portal: Cite entire document 3. Online Portal Guide: Cite entire document	☐ Met ☒ Not Met ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
DBA Description of Process: In compliance with 42 CFR §438.242(b)(5), 42 CFR §431.60 and Contract 3.13.7, LIBERTY makes claims, encounters and other clinical data available to its members and providers. LIBERTY's member and provider portals give real time access to claims, utilization, cost share and other relevant information (see Evidence #1, #2, #3)		
HSAG Findings: The DBA did not implement the API as specified in 42 CFR §431.60 (member access to and exchange of data) during the time period under review. DBA staff members explained that the API is due to be implemented in October 2022.		
Required Actions: The DBA must implement an API as specified in 42 CFR §431.60 and in accordance with CMS' implementation guidelines.		
9. The DBA must maintain a publicly accessible standards-based API described in 42 CFR §431.70 (access to published provider directory information), which must include all information specified in 42 CFR §438.10(h)(1) and (2). 42 CFR §438.242(b)(6) 42 CFR §431.70 42 CFR §438.10(h)(1-2) Contract 3.13.7.2-3.13.7.4	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Link to web-based provider directory(ies) • HSAG will use the results from the web-based provider directory demonstration **Evidence as Submitted by the DBA:** 1. LIBERTY Management Information System Diagram: Cite entire document 2. I-Connect Services 10.08.0: Cite entire document 3. Nevada Medicaid Provider Directory Link	☐ Met ☒ Not Met ☐ NA
DBA Description of Process: In compliance with 42 CFR §438.242(b)(6), 42 CFR §431.70, 42 CFR §438.10(h)(1-2), Contract 3.13.7.2-3.13.7.4, LIBERTY makes provider data available publicly. LIBERTY's online provider directory provides real time access to provider demographics and network status (See Evidence #1, #2, #3).		
HSAG Findings: The DBA did not implement a publicly accessible standards-based API described in 42 CFR §431.70 (access to published provider directory information) during the time period under review. DBA staff members explained that the API is due to be implemented in October 2022.		
Required Actions: The DBA must implement a publicly accessible standards-based API described in 42 CFR §431.70 and in accordance with CMS' implementation guidelines.		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Member Encounter Data		
10. The DBA must collect and maintain sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members. a. *The encounter data reporting system is designed to assure aggregated, unduplicated service counts provided across service categories, provider types, and treatment facilities.* b. *The DBA uses a standardized methodology capable of supporting CMS reporting categories for collecting service event data and costs associated with each category of service.* 42 CFR §438.242(c)(1) Contract 3.13.4.1	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Encounter data collection requirements • HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the DBA:** 1. EE PP - Timely Uploading and Reconciliation of Electronic Eligibility Files: Page 1 and 2 for Element 10b 2. C3 CR PP – C3 Initial Credentialling Process: Page 1, 3, 4 for Element 10b 3. SOP EDI Data Processing: Page 2 I, II, III for Element 10b 4. IT PP HSP Application EDI Data Processing, APPENDIX A-NEVADA MEDICAID: Page 1 for Element 10b 5. 837 Encounter Outbound Transmission Process: Page 1 for Element 10b 6. SOP Processing Units: Page 5 and 7-15 for Element 10a 7. NM PP Maintaining Provider Directories: Pages 2 - 6 for Element 10b	☒ Met ☐ Not Met ☐ NA

DBA Description of Process: LIBERTY maintains an encounter data reporting system requirements per 42 CFR §438.242.(c)(1) and contract 3.13.4.1. LIBERTY's *Timely Uploading and Reconciliation of Electronic Eligibility Files* (Evidence #1) ensures LIBERTY to collect and maintain sufficient member data, including data for encounter reporting.

LIBERTY's *Initial Credentialing Process* policy (Evidence #2) establishes a documented process for onboarding network providers, including collecting provider demographics such as name, location, tax ID, NPI and taxonomy, etc, that are required to process encounters. This data is stored and maintained within LIBERTY's health information system (see *Maintaining Provider Directories*, Evidence #6). LIBERTY's *SOP Processing Units* (Evidence #6) ensures that LIBERTY collects and maintains sufficient member encounter data to identify the provider who delivered any item(s) or service(s) to members.

LIBERTY's *SOP EDI Data Processing* (Evidence #3), *and 837 Encounter Outbound Transmission Process* (Evidence #5) ensures LIBERTY's encounter data reporting system designed to assure aggregated, unduplicated service counts provided across service categories, provider types, and treatment facilities.

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Requirement	**Supporting Documentation**	**Score**
IT PP HSP Application EDI Data Processing APPENDIX A- NEVADA MEDICAID (Evidence #4) ensures LIBERTY uses a standardized methodology capable of supporting CMS reporting categories for collecting service event data and costs associated with each category of service, per Contract 3.13.4.1.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
11. The DBA must submit member encounter data to the State *within 90 calendar days of receipt of the encounter and in the American Dental Association (ADA) Claims Form format or an alternative format if prior approved by the DHCFP* based on program administration, oversight, and program integrity needs. a. The member encounter data must include all State-specific requirements for encounter data submissions, including allowed amount and paid amount, that the State is required to report to CMS under 42 CFR §438.818. b. The member encounter data must be submitted to the State in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate. 42 CFR §438.242(c)(2-4) Contract 3.13.4.2; 3.13.5; 3.16.1	**HSAG Recommended Evidence: Wendy** • Policies, procedures, and workflows • Encounter data submission requirements • Three concurrent submission compliance reports (acceptance/rejection reports) **Evidence as Submitted by the DBA:** 1. IT PP Health Information System: Cite entire policy for Element 11a and 11b 2. IT PP HSP Application EDI Data Processing, APPENDIX A-NEVADA MEDICAID: Page 1 Element 11a and 11b 3. SOP EDI Data Processing: Page 2 I, II, III Element 11a and 11b 4. 837 Encounter Outbound Transmission Process: Page 1 Element 11a and 11b 5. Encounter Submission Reports: Cite entire document for Element 11a and 11b	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with 42 CFR §438.242.(c)(2-4) and Contract 3.13.4.2; 3.13.5; 3.16.1. LIBERTY's *Health Information System* and *HSP Application EDI Data Processing* policies (Evidence #1, #2) ensures LIBERTY encounter data processing procedures follow federal and State requirements. LIBERTY's *SOP EDI Data Processing* (Evidence #3) and *837 Encounter Outbound Transmission Process* and *Encounter Submission Reports* (Evidence #4, #5) ensure LIBERTY complies with the requirement to submit encounter data within 90 days of receipt, in the ASC X12N 837 format (including allowed amount and paid amount).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element. **Recommendations:** The DBA is required by its contract with DHCFP to pay 99 percent of all clean claims within 90 calendar days of the date of receipt and also submit encounter data to DHCFP within 90 calendar days of receipt of the claim. Therefore, if the DBA paid/denied a clean claim on day 90, the		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
encounter data would need to be submitted to DHCFP that same day to be compliant with the 90-calendar-day time frame for encounter data submissions. Depending on when the encounter data were submitted to DHCFP, the DBA theoretically could be out of compliance with the 90-calendar-day time frame for encounter data submission but still be compliant with the 90-calendar-day time frame for paying/denying clean claims. As such, HSAG recommends that the DBA consult with DHCFP to obtain clarification on the expectations for submitting encounter data to DHCFP within 90 calendar days of receipt of the claim when the contract also allows the DBA 90 calendar days to pay/deny a clean claim within 90 calendar days of receipt of the claim. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
Claims Payment		
12. *The DBA has written policies and procedures for processing claims submitted for payment from any source and monitors its compliance with these procedures.* Contract 3.11.4	**HSAG Recommended Evidence: Machelle** • Policies, procedures, and workflows • HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the DBA:** 1. Claims Data Entry Requirements: Page 4 - 8; Page 10 – 25 **See above** 2. CL PP - Claims Process: Page 2 3. CL PP - Coordination of Benefits, Appendix B NEVADA Medicaid: Page 1, 2, and 3 4. EO PP - Internal Claims Audit (Payment Accuracy): Page 1 and 2	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with Contract 3.11.4 by maintaining documented policies and procedures for claims processing and monitoring. LIBERTY's *Claims Data Entry Requirements* (Evidence #1), *CL PP - Claims Process* (Evidence #2), *CL PP - Coordination of Benefits Appendix B NEVADA Medicaid* (Evidence #3) ensure that claims submitted for payment from any source are processed, and *EO PP Internal Claims Audit (Payment Accuracy)* (Evidence #4) ensures claims are monitored for compliance with this requirement.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard XIII—Health Information Systems						
Met	=	10	X	1	=	10
Not Met	=	2	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	12	Total Score		=	10
Total Score ÷ Total Applicable					=	83%

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
General Rules		
1. The DBA must establish and implement an ongoing comprehensive quality assessment and performance improvement (QAPI) program (*referred to as the Internal Quality Assurance Program [IQAP] in Nevada*) for the services it furnishes to its members. a. *The QAPI program consists of systematic activities, undertaken by the DBA, to monitor and evaluate the care delivered to members according to predetermined, objective standards, and effect improvements as needed.* 42 CFR §438.330(a)(1) Contract 3.9	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan **Evidence as Submitted by the DBA:** • 1. 2022 Quality Management and Improvement (QMI) Program Description (Entire Document) • 2. 2022 Nevada Quality Management and Improvement Work Plan (Entire Document)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the QAPI Program requirements of 42 CFR §438.330(a)(1) and contract 3.9. LIBERTY's 2022 Quality Management and Improvement (QMI) Program Description (Evidence #1) details LIBERTY's ongoing comprehensive quality assessment and performance improvement program for services we furnish to our members. LIBERTY's QMI Program consists of systemic activities to monitor and evaluate the care delivered to members according to predetermined, objective standards. LIBERTY's QMI Committee develops an annual Work Plan (Evidence #2) which includes a timetable for implementation and/or completion of activities and objectives. The Work Plan includes metrics that will be tracked and monitored on a quarterly and/or annual basis.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Basic Elements of QAPI Programs		
2. The *written description contains a detailed set of quality assurance (QA) objectives, which are developed annually and include a timetable for implementation and accomplishment.* Contract 3.9.6.2	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan **Evidence as Submitted by the DBA:** • 1. 2022 Quality Management and Improvement (QMI) Program Description (pages 4-6) • 2. 2022 Nevada Quality Management and Improvement Work Plan (Entire Document)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the QAPI Program written description requirement in Contract 3.9.6.2. LIBERTY's 2022 Quality Management and Improvement (QMI) Program Description (Evidence #1), contains a detailed set of quality assurance objectives which are developed and reviewed annually. The 2022 Nevada Quality Management and Improvement Work Plan (Evidence #2) includes a timetable for implementation and accomplishments of activities and objectives. These metrics are tracked and monitored on a quarterly and/or annual basis.		
HSAG Findings: HSAG has determined that DBA met the requirements for this element.		
Required Actions: None.		
3. *The scope of the QAPI program is comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service.* a. *The scope includes availability, accessibility, coordination, and continuity of care.* Contract 3.9.6.3(A)	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan **Evidence as Submitted by the DBA:** • 1. 2022 Quality Management and Improvement (QMI) Program Description (page 7, pages 10-11) • 2. 2022 Nevada Quality Management and Improvement Work Plan (Entire Document)	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• 10. Quality Management and Improvement (QMI) Committee Structure (Entire Document)	
DBA Description of Process: LIBERTY complies with the QAPI Program scope requirement in Contract 3.9.6.3(A) The 2022 Quality Management and Improvement (QMI) Program Description (Evidence #1) is comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service. The 2022 Nevada Quality Management and Improvement Work Plan (Evidence #2) ensures monitoring includes the availability, accessibility, coordination, and continuity of care by clinical and non-clinical professionals. The Quality Management and Improvement (QMI) Committee Structure (Evidence #10) includes dedicated sub-committees on both clinical care and non-clinical aspects of service.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
4. *The QAPI program description provides for continuous performance of the activities, including tracking of issues over time.* Contract 3.9.6.5	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan **Evidence as Submitted by the DBA:** • 1. 2022 Quality Management and Improvement (QMI) Program Description (Entire Document) • 2. 2022 Nevada Quality Management and Improvement Work Plan (Entire Document)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the QAPI Program description requirement in contract 3.9.6.5. The 2022 Quality Management and Improvement (QMI) Program Description (Evidence #1) provides for continuance performance of quality assurance activities. These activities are tracked over time through the 2022 Nevada Quality Management and Improvement Work Plan (Evidence #2). The Work Plan includes metrics that are tracked and monitored on a quarterly and/or annual basis.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element. **Recommendations:** The QMI Program Description included a general statement that "tracking of issues that encompasses clinical and nonclinical functions" occurs. HSAG recommends that the QMI Program Description be enhanced to detail what types of issues are tracked and what analyses are conducted to ensure continued quality improvement. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
5. The QAPI program must include mechanisms to assess both underutilization and overutilization of services *and to follow up appropriately*. a. *If fraud and abuse is suspected, a referral is made to the vendor's Program Integrity Unit (PIU) and the DHCFP Surveillance and Utilization Review (SUR) Unit for appropriate action.* 42 CFR §438.330(b)(3) Contract 3.9.8.1(D)	**HSAG Recommended Evidence:** • QAPI program description QM • Evidence demonstrating assessment of underutilization and overutilization of services (e.g., committee meeting minutes, reports) • Evidence of underutilization and overutilization of services follow-up actions **Evidence as Submitted by the DBA:** • 3. 2022 Utilization Management Program Description (page 4 and 9) • 40. Q1 2022 Utilization Management Committee Meeting Minutes Redacted (page 11) • 4. Special Investigations Unit Fraud Referrals Policy and Procedure - State of Nevada Medicaid (page 2)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the QAPI Program utilization and fraud and abuse referral requirements in 42 CFR §438.330(b)(3) and contract 3.9.8.1(D). LIBERTY's Utilization Management Program Description (Evidence #3) and LIBERTY's Q1 2022 Utilization Management Committee Meeting Minutes Redacted (Evidence #40) detail LIBERTY's efforts to review and assess utilization data and identification of service patterns and/or trends of over and under-utilization requiring appropriate follow up. In addition to appropriate follow up with providers, including reeducation, the UM Committee refers to LIBERTY's Special Investigation Unit (SIU) if fraud or abuse is suspected and the DHCFP Surveillance and Utilization Review (SUR) Unit for appropriate action, as detailed in LIBERTY's Special Investigations Unit Fraud Referrals Policy and Procedure - State of Nevada Medicaid (Evidence 4). During the audit period, there were no referrals from the UM Committee to the SIU or SUR for suspected fraud or abuse.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
6. The QAPI program must include mechanisms to assess the quality and appropriateness of care and services provided to members, including members identified as having special health care needs. a. *The QAPI program methodology provides for review of the entire range of care provided by the vendor, including services provided to Children with Special Health Care Needs (CSHCN), by assuring that all demographic groups, care settings and types of services (e.g., preventive, primary, specialty care, and ancillary) are included in the scope of the review.* 42 CFR §438.330(b)(4) Contract 3.9.6.3(B)	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan • Assessment tools • Clinical guidance/criteria • Metrics/performance measures to assess special health care needs • Documentation to support continuous quality improvement **Evidence as Submitted by the DBA:** • 1. 2022 Quality Management and Improvement (QMI) Program Description (page 4) • 5. 2022 Case Management and Care Coordination Program Description (Entire Document) • 6. CM-PP Coordination of Dental Services Policy and Procedure - State of Nevada Medicaid (page 3) • 22. Special Patient Care Advisory Committee Charter (Entire Document)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the QAPI Program assessment of care and services for members with special health care needs requirement of 42 CFR §438.330(b)(4) and Contract 3.9.6.3(B). LIBERTY's Quality Management and Information Program Description (Evidence #1) includes mechanisms to assess the quality and appropriateness of care and services provided to members, including members identified as having special health care needs. Our QMI Program also includes the Special Patient Care Advisory Committee (Evidence #22), the purpose of which is to develop care strategies and determinations for enrollees with special needs regarding their dental care. LIBERTY's care management policies (Evidence #6) ensure that Children with Special Health Care Needs (CSHCN) receive appropriate and equal access to dental services by assuring that all demographic groups, care settings, and types of services offered including preventive, primary, specialty care, and ancillary care. LIBERTY's focus on members identified as having special health care needs, including CSHCNs, have expanded and are detailed in our 2022 Case Management and Care Coordination Program Description (Evidence #5).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
7. For DBAs providing long-term services and supports (LTSS), the QAPI program must include mechanisms to assess the quality and appropriateness of care furnished to members using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable. 42 CFR §438.330(b)(5)(i)	**HSAG Recommended Evidence:** • QAPI program description • Assessment tools • Clinical guidance/criteria • Metrics/performance measures to assess LTSS • Audit tools and results **Evidence as Submitted by the DBA:**	☐ Met ☐ Not Met ☒ NA
DBA Description of Process:		
HSAG Findings: HSAG has determined that this element is *Not Applicable* to the DBA.		
Required Actions: None.		
8. For DBAs providing LTSS, the QAPI program must include participation in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per 42 CFR §441.302 and §441.730(a) that are based, at a minimum, on the requirements for home and community-based waiver programs per 42 CFR §441.302(h). 42 CFR §438.330(b)(5)(ii)	**HSAG Recommended Evidence:** • QAPI program description • Critical incident policies and procedures • Critical incident reports • Committee meeting minutes • Provider remediation plan template(s) **Evidence as Submitted by the DBA:**	☐ Met ☐ Not Met ☒ NA
DBA Description of Process:		
HSAG Findings: HSAG has determined that this element is *Not Applicable* to the DBA.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Adequate Resources		
9. *The QAPI program has sufficient material resources and staff with the necessary education, experience, or training to effectively carry out its specified activities.* Contract 3.9.12	**HSAG Recommended Evidence:** • QAPI program description • Quality staffing structure/organizational chart • Job descriptions • Training materials **Evidence as Submitted by the DBA:** • 1. 2022 Quality Management and Improvement (QMI) Program Description: Quality Management Program Resources (pages 13-16) • 9. LIBERTY Dental Plan Nevada Quality Management Leadership Organizational Structure (Entire Document) • 38. State Dental Director Job Description (Entire Document) • 33. Vice President of Quality Management Job Description (Entire Document)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the QAPI Program resources and staff requirement of Contract 3.9.12. LIBERTY's 2022 Quality Management and Improvement (QMI) Program Description: Quality Management Program Resources (Evidence #1) details our national and Nevada-based executive, clinical, and administrative resources and staff and their qualifications to effectively conduct all QAPI program activities. The LIBERTY Dental Plan Nevada Quality Management Leadership Organizational Structure (Evidence #9) demonstrates the national and Nevada-based executive and clinical leadership oversight of our QMI program. LIBERTY's QMI leadership includes our Nevada Dental Director (Evidence #38) and Vice President of Quality Management. (Evidence #33).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
10. *There is a designated senior executive who is responsible for QAPI program implementation.* a. *The DBA's dental director has involvement in quality assurance activities.* Contract 3.9.11	**HSAG Recommended Evidence:** • QAPI program description • Quality staffing structure/organizational chart • Dental director job description **Evidence as Submitted by the DBA:** • 1. 2022 Quality Management and Improvement (QMI) Program Description (pages 13-14) • 8. QM PP - Quality Management and Improvement Program and Committee Policy and Procedure (Entire Document) • 7. QM PP - Dental Director Oversight (Entire Document) • 9. LIBERTY Dental Plan Nevada Quality Management Leadership Organizational Structure (Entire Document) • 38. State Dental Director Job Description (Entire Document) • 33. Vice President of Quality Management Job Description (Entire Document)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the QAPI Program senior executive and dental director requirement in Contract 3.9.11. LIBERTY maintains a Quality Management and Improvement (QMI) Program that provides a formal process to systemically monitor and objectively evaluate the quality, efficiency, and effectiveness of activities through established Sub-Committees and Work Groups, under the direction of the Nevada Dental Director (Evidence #1 and 8). LIBERTY Nevada's QMI Committee is chaired by the Nevada Dental Director who reports QMI Program activities quarterly to LIBERTY's BOD (Evidence #7, 38). Collaborating with the Dental Director and QMI committee on a daily basis is LIBERTY's Vice President, Quality Management, and other senior executives and staff (Evidence #1, 9, AND 33).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
Quality Assurance Committee		
11. *The QAPI program delineates an identifiable structure responsible for performing quality assurance functions within the DBA.* a. *The structure/committee meets on a regular basis with a specified frequency, no less than quarterly to oversee IQAP activities.* b. *This frequency must be sufficient to demonstrate that the structure/committee is following up on all findings and required actions.* c. *The role, structure and function of the structure/committee must be specified.* d. *There must be records documenting the structure and committee's activities, findings, recommendations and actions.* Contract 3.9.10; 3.9.10.1-3.9.19.3	**HSAG Recommended Evidence:** • QAPI program description • Quality committee structure • All committee charters under the structure • Three consecutive committee meeting minutes for each committee under the structure **Evidence as Submitted by the DBA:** • 1. 2022 Quality Management and Improvement (QMI) Program Description (page 8) • 42. QMI Committee and sub-committee Charters (Entire Folder) • a. 8. QM PP – Quality Management and Improvement Program and Committee Policy and Procedure (page 1) • a. 11. Q1 2022 Quality Management Improvement Committee (QMI) Meeting Minutes (Entire Document) • b. 28. 2021 NV Medicaid QMI Annual Program Evaluation (pages 1-2) • c. 10. QMI Committee Structure (Entire Document) • c. 8. QM PP – Quality Management and Improvement Program and Committee Policy and Procedure (page 1) • d. 28. 2021 NV Medicaid QMI Annual Program Evaluation (pages 1-2) • d. 41. 2022 Q1 Quality Management and Improvement Program Committee and sub-Committee Meeting Minutes (Entire Folder)	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
DBA Description of Process: LIBERTY complies with the QAPI Program structure and quality assurance functions requirements in Contract 3.9.10, and 3.9.10.1-3.9.19.3. LIBERTY's quality management governance details our execution and oversight of QMI activities through clearly defined roles and assignments of tasks to appropriately qualified individuals (Evidence #1, 8, 10). LIBERTY's Board of Directors (BOD) has ultimate responsibility and oversight for the quality of care and service delivered to our members and is responsible for the overall leadership and oversight of the QMI Program (Evidence #1, 8, 10, 28). The BOD has established the QMI Committee and its designated sub-committees to carry out all designated QMO Program functions (Evidence #1, 8, 10, 28, 41, 42). The QMI Committee(s) meet on a quarterly basis (Evidence #8, 11, 28), the QMI Chair presents and discusses these quarterly activities to the BOD quarterly as well as an overall evaluation of the QMI Program annually (Evidence 28). As detailed in the 2021 NV Medicaid QMI Annual Program Evaluation, LIBERTY's QMI Committee and sub-committees monitored and assessed all planned activities and interventions in the QMI Work Plan with 100% tasks completed (Evidence #28). Due to the limited audit period, the 2021 Program Evaluation is being submitted as the 2022 Program Evaluation will not be available until Q1 2023; and only Q1 2022 QMI Committee and sub-Committee Meeting Minutes are available for the audit period.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
12. *There is active participation in the QAPI committee from DBA providers, who are representative of the composition of the DBA's providers.* Contract 3.9.10.5	**HSAG Recommended Evidence:** • QAPI program description • Quality committee structure • All committee charters under the structure, with a list of providers who serve on the QAPI committee(s) • Three consecutive committee meeting minutes for each committee under the structure **Evidence as Submitted by the DBA:** • 1. 2022 Quality Management and Improvement (QMI) Program Description (pages 9-10) • 8. QM PP – Quality Management and Improvement Program and Committee Policy and Procedure (page 2) • 10. QMI Committee Structure (Entire Document)	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• 42. QMI Committee Charters (QMI, Peer Review, Dental Advisory Committee Charters) • 12. Nevada Committee Provider Participant List • 11. Q1 2022 Quality Management Improvement Committee (QMI) Meeting Minutes (page 3) • 21. Q1 2022 Peer Review Sub-Committee Meeting Minutes (Entire Document (page 1) • 29. Q1 2022 Dental Advisory Committee Sub-Committee Meeting Minutes (page 1)	
DBA Description of Process: LIBERTY complies with the active participation in our QAPI Committees by representative providers requirement in Contract 3.9.10.5. The QMI Program is a coordinated and collaborative effort that involves senior leadership, inter-departmental coordination, administrative staff, and dentists working together as a team to improve our organizational performance (Evidence #1). There is active participation by network providers in LIBERTY's QMI Committee, Peer Review sub-committee, and Dental Advisory Committee (Evidence #1, 10, 11, 12, 21, 29, 42). Due to the limited audit period, minutes from the Q1 2022 QMI Committee and sub-Committees are available (Evidence #11, 21, 29).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
Performance Measurement		
13. The QAPI program must include the collection and submission of performance measurement data. The DBA must annually: a. Measure and report to DHCFP on its performance, using the standard measures required by DHCFP; b. Submit to DHCFP data, specified by DHCFP, which enables DHCFP to calculate the DBA's performance using the standard measures identified by DHCFP; or c. Perform a combination of the activities described in sub-elements (a) and (b).	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan • Performance measures reports • Evidence of submission of performance measurement reports to DHCFP **Evidence as Submitted by the DBA:** • 1. 2022 Quality Management and Improvement (QMI) Program Description (Entire Document)	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
42 CFR §438.330(b)(2) 42 CFR §438.330(C) Contract 3.9.3.1; 3.9.3.2	• 2. NV Medicaid Work Plan (Entire Document) • a. 14. CMS416ReportDentalAnnual_Medicaid_2021.11.23 (Entire Document) • a. 13. CMS416ReportDentalAnnual_CheckUp_2021.11.23 (Entire Document) • b. 15. CMS416ReportDental_Medicaid_2021.11.23 (Entire Document) • b. 16. CMS416ReportDental_CheckUp_2021.11.23 (Entire Document)	
DBA Description of Process: LIBERTY complies with the performance measurement requirements of 42 CFR §438.330(b)(2), 42 CFR §438.330(C), Contract 3.9.3.1 and 3.9.3.2. LIBERTY measures its QMI Program performance using the standard measures required by DHCFP (Evidence #1 and 2). Performance measure data is submitted to DHCFP on an annual basis. Fiscal year 2022 performance measures are scheduled to be submitted to DHCFP in November 2022. Due to the limited audit period, the evidence provided are reports from fiscal year 2021 (Evidence # 13, 14, 15 and 16).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
Performance Improvement Projects		
14. The QAPI program must include performance improvement projects (PIPs). a. The DBA must conduct PIPs that focus on both clinical and nonclinical areas. b. *The DBA must annually conduct two PIPs.* *i. Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, high-volume services, high-risk services, and continuity and coordination of care*	**HSAG Recommended Evidence:** • Policies and procedures • QAPI program description • QAPI work plan • Policies and procedures • PIP documentation for all active PIPs **Evidence as Submitted by the DBA:**	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
ii. Nonclinical PIPs include projects focusing on availability, accessibility, and cultural competency of services, interpersonal aspects of care, and appeals, grievances, and other complaints. 42 CFR §438.330(b)(1) 42 CFR §438.330(d)(1) Contract 3.9.1; 3.9.7.4	• 1. 2022 Quality Management and Improvement (QMI) Program Description: Performance Improvement Projects (pages 12-13) • a. 19. QM PP – Conducting Performance Improvement Projects and Quality Improvement Projects Policy (page 1) • a, b. 20 LIBERTY_NV2021-22 PIP Validation Report (page 10, 14, Entire Document) • b. i. 17. Total Eligibles Receiving a Sealant on a Permanent Molar Tooth, LIBERTY NV PIP Modules 1-4 (Entire Document) • b. ii. 18. Total Eligibles Who Received Preventive Dental Services, LIBERTY NV PIP Modules 1-4 (Entire Document)	
DBA Description of Process: LIBERTY complies with the QAPI Program Performance Improvement Projects requirements in 42 CFR §438.330(b)(1), 42 CFR §438.330(d)(1), and Contract 3.9.1, and 3.9.7.4. LIBERTY actively conducts and monitors PIPs addressing clinical and non-clinical issues as part of its QMI Program (Evidence #1 and 19). DHCFP confirmed in the LIBERTY NV2021-PP PIP Validation Report (Evidence #20), that LIBERTY successfully conducted two annual PIPs in Nevada (one clinical, one non-clinical) in compliance with both federal and contract requirements. (Due to the truncated audit period, evidence is from PIPS concluded December 31, 2021. Planning for the next 18-month PIP cycle begins with DHCFP after the look-back period of 5/31/22). LIBERTY's clinical PIP, Total Eligibles Receiving A Sealant on a Permanent Molar Tooth (Evidence #17) focused on prevention and LIBERTY's non-clinical PIP, Total Eligibles Who Received Preventive Dental Services (Evidence #18), focused on accessibility of services.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
15. *The DBA must have written guidelines for its PIPs and related activities. The guidelines include:* a. *Specification of dental services delivery areas to be monitored.*	**HSAG Recommended Evidence:** • Policies and procedures • Written guidelines • QAPI program description • QAPI work plan	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
b. *Efforts to monitor and evaluate, at a minimum, care and services in certain priority areas of concern selected by DHCFP, and identified through the DHCFP Quality Strategy.* Contract 3.9.7; 3.9.7.1; 3.9.7.2	**Evidence as Submitted by the DBA:** • 1. 2022 Quality Management and Improvement (QMI) Program Description: Performance Improvement Projects (pages 12-13) • 19. QM PP -- Conducting Performance Improvement Projects and Quality Improvement Projects Policy and Procedure (Entire Document) • 2. 2022 NV Medicaid Work Plan (Entire Document) • 36. September 23, 2019 Email from DHCFP to LDP NV Selected PIP Topics (Entire Document) • a, b. 20 LIBERTY_NV2021-22 PIP Validation Report (page 6, Entire Document)	
DBA Description of Process: LIBERTY complies with the Performance Improvement Projects written guidelines requirements in Contract 3.97, 3.9.7.1, and 3.9.7.2. LIBERTY's PIP guidelines are detailed in our QMI Program Description (Evidence #1) and our Conducting Performance Improvement Projects and Quality Improvement Projects Policy and Procedure (Evidence #19). These written guidelines detail our structured, planned, systematic QMI program to promote continuous quality improvement in clinical and non-clinical processes and outcomes, and our process developing and implementing PIPs to enhance the quality of care and eliminate oral health disparities for our members. LIBERTY partners with DHCFP to develop and implement PIPs according to DHCFP's quality strategy (Evidence #2, 36). Due to the limited audit timeframe and the timing of the 18-month PIP cycle in Nevada, the validation report submitted is from 2021 (Evidence #20).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
16. Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and must include the following elements: a. Measurement of performance using objective quality indicators.	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan • Policies and procedures • PIP documentation for all active PIPs	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
b. Implementation of interventions to achieve improvement in the access to and quality of care. c. Evaluation of the effectiveness of the interventions based on the performance measures required by the State. d. Planning and initiation of activities for increasing or sustaining improvement. 42 CFR §438.330(d)(2) Contract 3.9.1; 3.9.1.1-3.9.1.4; 3.9.7.5; 3.9.7.6	**Evidence as Submitted by the DBA:** • 1. 2022 Quality Management and Improvement (QMI) Program Description: Performance Improvement Projects (pages 12-13) • 2. 2022 NV Medicaid Work Plan (Entire Document) • 19. QM PP -- Conducting Performance Improvement Projects and Quality Improvement Projects Policy and Procedure (Entire Document) • 17. PIP_Improving Sealant Rate_04152022 (a. page 2, b. page 3, c. pages 8-9, d page 10) • 18. PIP_Preventative Dental Services_04152022 (a. page 2, b. page 3, c. pages 8-9, d. page 10) • 20. LIBERTY_NV2021-22 PIP Validation Report (Entire Document)	
DBA Description of Process: LIBERTY complies with the Performance Improvement Project design requirements in 42 CFR 438.330(d)(2), and Contract 3.9.1, 3.9.1.1-3.9.1.4, 3.9.7.5, and 3.9.7.6. As detailed in our PIP written guidelines (Evidence #1 and 19), we use a structured, planned, systematic QMI program to promote continuous quality improvement in clinical and non-clinical processes and outcomes and in developing and implementing PIPs to enhance the quality of care and eliminate oral health disparities for our members. The Plan, Do, Study, Act (PDSA)and SMART Aim goal methodologies are utilized to ensure the PIPs are objectively measured, interventions are monitored to evaluate the effectiveness, and overall PIP performance is documented to help sustain improvement. LIBERTY partners with DHCFP and HSAG to develop and implement PIPs according to DHCFP's quality strategy utilizing HSAG's Module 1-4 roadmap. DHCFP confirmed in the LIBERTY NV2021-22 PIP Validation Report (Evidence #20), that LIBERTY successfully conducted two annual PIPs in Nevada (one clinical, one non-clinical) in compliance with both federal and contract requirements.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
17. The DBA must report the status and results of each PIP to DHCFP as requested, but not less than once per year. a. *Each PIP must be completed in a reasonable time period so as to generally allow information on the success of PIPs to be available to DHCFP for its annual review of the DBA's QAPI program.* 42 CFR §438.330(d)(3) Contract 3.9.2	**HSAG Recommended Evidence:** • Evidence of annual submission, including the documentation that was submitted, of all PIPs to DHCFP **Evidence as Submitted by the DBA:** • 20. LIBERTY_NV2021-22 PIP Validation Report (Entire Document) • 37. PIPs Module 4 Submission 4-15-22 - LIBERTY Dental Plan (Entire Document)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the Performance Improvement Project reporting requirements in 42 CFR 438.330(d)(3) and Contract 3.9.2. LIBERTY's collaborative approach with DHCFP and HSAG involved interval submission status updates and reviews of each PIP module to HSAG for validation and feedback throughout each PIP lifecycle. LIBERTY engaged and applied any feedback and all recommendations by HSAG to both active PIP topics. DHCFP confirmed in the LIBERTY NV2021-22 PIP Validation Report (Evidence #20), that LIBERTY successfully conducted two annual PIPs in Nevada (one clinical, one non-clinical) in compliance with both federal and contract requirements. LIBERTY submitted its Module 4 final report for its Improving Sealant Rates and Improving Preventative Dental Services PIPs on April 15th 2022 to DHCFP/HSAG for final review and validation (Evidence #37).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
Critical Incident Management System		
18. The QAPI program must include participation in efforts by DHCFP to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per 42 CFR §441.302 and §441.730(a) that are based, at a minimum, on the requirements for home and community-based waiver programs per 42 CFR §441.302(h).	**HSAG Recommended Evidence:** • QAPI program description • Critical incident policies and procedures • Critical incident reports • Committee meeting minutes • Provider remediation plan template(s)	☐ Met ☐ Not Met ☒ NA

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Requirement	**Supporting Documentation**	**Score**
42 CFR §438.330(b)(5)(ii)	**Evidence as Submitted by the DBA:**	
DBA Description of Process:		
HSAG Findings: HSAG has determined that this element is *Not Applicable* to the DBA.		
Required Actions: None.		
Provider Participation in the QAPI		
19. *Participating dentists and other providers must be kept informed about the written QAPI program through provider newsletters and updates to the provider manual.* Contract 3.9.13.1	**HSAG Recommended Evidence:** • Provider newsletters and website screenshots demonstrating providers are informed of quality initiatives • Provider manual	☒ Met ☐ Not Met ☐ NA
	Evidence as Submitted by the DBA: • 32. Provider Reference Guide NV Medicaid (pages 59 -66) • 31. Q2 2022 LIBERTY Quarterly Provider News (Entire Document) • 39. Q1 2022 Q1 NV DAC QMI Program Evaluation Summary (Entire Document) • 41. LDP NV Provider Portal Screenshot (Entire Document)	
DBA Description of Process: LIBERTY complies with the provider awareness of our QMI Program requirement in Contract 3.9.13.1. LIBERTY maintains on our secure Provider Portal a continuously updated Provider Reference Guide (PRG) that details our QMI Program (Evidence #32). We also send all network providers an electronic copy and maintain on our provider portal LIBERTY's provider newsletter, and the Q2 2022 edition included information about our Grievance and Appeal System (Evidence #31). LIBERTY also posts on its secure Provider Portal a summary of our 2021 NV Medicaid QMI Annual Program Evaluation (Evidence #41). The 2021 NV Medicaid QMI Annual Program Evaluation summary was also reviewed with our Dental Advisory Committee (DAC) during the Q1 2022 Meeting (Evidence #39).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
Implementation of Corrective Actions		
20. *The DBA's QAPI program must include written procedures for taking corrective action, as determined under the QAPI program, whenever inappropriate or substandard services are furnished, or services that should have been furnished were not. Corrective action procedures must include:* a. *Specification of the types of problems requiring corrective action.* b. *Specification of the person(s) or body responsible for making the final determinations regarding quality problems.* c. *Specific actions to be taken; provision of feedback to appropriate health professionals, providers, and staff.* d. *The schedule and accountability for implementing corrective actions.* e. *The approach to modifying the corrective action if improvements do not occur.* f. *Procedures for terminating the affiliation with the dental provider.* Contract 3.9.8.3.4; 3.9.8.5(A-F)	**HSAG Recommended Evidence:** • QAPI program description • Policies and procedures • All active provider POCs during the time period under review **Evidence as Submitted by the DBA:** • 1. 2022 Quality Management and Improvement (QMI) Program Description (page 5) • 24. QM PP - Corrective Action Quality Improvement and Follow-Up (Entire Document) • 35. Peer Review Committee Charter (Entire Document)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the implementation of corrective actions policies and procedures as part of our QMI Program requirement in Contract 3.9.8.3.4 and 3.9.8.5(A-F). As detailed in our QMI Program Description (Evidence #1), one of our key program objectives is identifying, documenting, evaluating, and resolving known or suspected quality of care issues through corrective action plans when necessary. As detailed in our Corrective Action Quality Improvement and Follow-Up Policy and Procedure (Evidence #24), LIBERTY's QMI Committee is ultimately responsible for ongoing monitoring of the QMI Program and all of its activities including but not limited to assessing results from Onsite Facility reviews, Dental Chart audits, identification of Potential Quality Issues (PQI) and other activities. The Peer Review Committee Charter (Evidence #35) details this sub-committee's responsibility to review PQI and to provide the QMI Committee issued CAPs after carefully reviewing the available documentation and facts. The CAP describes the particular issue to be corrected and a schedule and accountability for implementing corrective actions. The QMI Committee monitors the CAPs effectiveness against the expectations communicated to the provider. In addition to corrective action plans, LIBERTY's Dental Director may		

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Requirement	**Supporting Documentation**	**Score**
determine if a provider warrants disciplinary action up and including termination (Evidence #24). There were no active provider POCs during the audit period.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
21. *The DBA monitors and evaluates the plans of correction to assure required changes have been made.* a. *Changes in practice patterns must be monitored.* b. *The DBA timely follows-up on identified issues to ensure actions for improvement have been effective.* Contract 3.9.8.6(A-B)	**HSAG Recommended Evidence:** • QAPI program description • Policies and procedures • Evidence of monitoring of all active provider POCs during the time period under review **Evidence as Submitted by the DBA:** • 1. 2022 Quality Management and Improvement (QMI) Program Description (page 9) • 26. Utilization Management Committee Charter (Entire Document) • 3. 2022 Utilization Management Program (page 6) • 40. Q1 2022 Utilization Management Committee Meeting Minutes (Draft Redacted) (pages 11-12) • 25. DCM PP - Dental Care Management Process Policy (Entire Document)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the corrective action monitoring and evaluation requirements of Contract 3.9.8.6(A-B). LIBERTY monitors and evaluates treatment and practice patterns in our Utilization Management (UM) Committee (Evidence #1, 3, 26, and 40). LIBERTY's Dental Care Management (DCM) process (Evidence #25) involves both clinical and non-clinical professional staff using analytical tools to establish benchmarks and identify utilization patterns (both over-and under-utilization). We analyze utilization at the office/provider levels, procedure code ratios (such as crowns/fillings) and by specific market with similar population (such as Medicaid, etc.). Our DCM program allows LIBERTY to improve network quality by identifying providers with performance patterns outside expected standards and provide appropriate remediation. Our Nevada Dental Director help providers bridge the gap between data on their performance and implementation of practices to improve their performance. Providers that fall below the		

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Requirement	**Supporting Documentation**	**Score**
guidelines or are found to be consistent outliers in their utilization, may be counseled, put on corrective action, referred to Peer Review Committee, or terminated. There were no active provider POCs during the audit period.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
Accountability to the Governing Body		
22. *The governing body has approved the overall QAPI and the annual QAPI.* Contract 3.9.9.1	**HSAG Recommended Evidence:** • Governing body meeting minutes with annual QAPI program approval **Evidence as Submitted by the DBA:** • 27.Q1 2022 LDP NV BOD Minutes Redacted (page 1) • 28. 2021 NV Medicaid QMI Annual Program Evaluation (Entire Document) • 11. Q1 2022 QMI Committee Meeting Minutes (Entire Document)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the Board of Directors (BOD) oversight of our QMI Program requirement in Contract 3.9.9.1. Liberty's BOD received the 2021 NV Medicaid QMI Annual Program Evaluation (dated March 31, 2022) and approved it by unanimous consent in Q2 2022 (Evidence #27, 28). In addition, the BOD's designated QMI Committee also accepted and approved the 2021 NV Medicaid QMI Annual Program Evaluation during its Q1 2022 Committee Meeting (Evidence #11). Due to the shortened audit period and the timing of the 2022 QMI Annual Program Evaluation not being available until Q1 2023, the 2021 QMI Annual Program Evaluation is being submitted as evidence along with the Minutes of both the BOD and the QMI Committee for Q1 2022.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
23. *The governing body has formally designated an entity or entities within the DBA to provide oversight of the QAPI program and is accountable to the governing body or has formally decided to provide such oversight as a committee of the whole.* Contract 3.9.9.2	**HSAG Recommended Evidence:** • QAPI program description **Evidence as Submitted by the DBA:** • 1. 2022 Quality Management and Improvement (QMI) Program Description: Committee Structure (page 8) • 23. 2022 Quality Management and Improvement Committee Charter (Entire Document) • 8. QM PP - Quality Management and Improvement Program and Committee Policy (Entire Document)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the designation by the Board of Directors of the QMI Program to the Quality Management and Improvement (QMI) Committee requirement in Contract 3.9.9.2. As evidenced in LIBERTY's QMI Program Description (Evidence #1) and QMI Charter (Evidence #23), LIBERTY's BOD retains ultimate responsibility and oversight for the QMI Program but has formally designated overall operations of the QMI Program and evaluation of the effectiveness of the Program and its Annual Workplan to the Quality Management and Improvement (QMI) Committee (Evidence #8).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
24. *The governing body routinely receives written reports from the QAPI program describing actions taken, progress in meeting quality assurance objectives, and improvements made.* Contract 3.9.9.3	**HSAG Recommended Evidence:** • Three consecutive written reports reviewed by the governing body • Three consecutive governing body meeting minutes **Evidence as Submitted by the DBA:** • 1. 2022 Quality Management and Improvement (QMI) Program Description (page 6) • 27. Q1 2022 LDP NV BOD Meeting Minutes (pages 1-12)	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• 11. Q1 2022 QMI Committee Meeting Minutes (Entire Document)	
DBA Description of Process: LIBERTY complies with the QMI Program written reports oversight requirement of Contract 3.9.9.3. As detailed in the Program Description (Evidence #1), LIBERTY's Board of Directors (BOD) and its designated Quality Management and Improvement (QMI) Committee receive written reports detailing the QMI Program quarterly, in addition to the annual QMI Program Evaluation. Due to the shortened audit period, Q1 2022 BOD and QMI Committee Meeting Minutes are included as evidence of compliance (Evidence #27, 11).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element. **Recommendations:** Although the DBA demonstrated that it would provide the Board of Directors (BOD) quarterly QAPI updates, minimal details pertaining to most discussion items were documented in the meeting minutes. While HSAG acknowledges that there may not have been any items that required discussion in some instances, HSAG strongly recommends that the DBA facilitate discussion and dialogue from members of the BOD for QAPI activities. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
25. *The governing body formally reviews on a periodic basis, but no less frequently than annually, a written report on the QAPI program.* a. *This annual quality program evaluation report is submitted to DHCFP in the second calendar quarter and at minimum must include studies undertaken; results; subsequent actions and aggregate data on utilization and quality of services rendered; and an assessment of the QAPI's continuity, effectiveness, and current acceptability.* Contract 3.9.9.5	**HSAG Recommended Evidence:** • Governing body meeting minutes with annual QAPI program approval • Annual written report reviewed by the governing body • Evidence the annual QAPI program evaluation was submitted to DHCFP **Evidence as Submitted by the DBA:** • 1. 2022 Quality Management and Improvement (QMI) Program Description (page 8) • 27. Q1 2022 LDP NV BOD Minutes (page 1) • 28. 2021 NV Medicaid QMI Annual Program Evaluation (Entire Document) • 11. Q1 2022 QMI Committee Meeting Minutes (Entire Document)	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• a. 30. 2021 QMI Evaluation DHCFP Submission (Entire Document)	
DBA Description of Process: LIBERTY complies with the Board of Directors and Quality Management Committee oversight as well as the QMI Program annual submission to DHCFP requirements in Contract 3.9.9.5. The governing body, Board of Directors (BOD) reviews on a quarterly basis (Evidence #1, 27) a written report on the QAPI Program. In addition, the BOD reviewed the 2021 Nevada Medicaid QMI Annual Program Evaluation (Evidence #28) during its Q1 2022 BOD Meeting (Evidence #27) Annually, the quality program evaluation report is submitted to DHCFP and the 2021 Nevada Medicaid QMI Annual Program Evaluation (Evidence #28) was submitted to DHCFP on March 21, 2022 (Evidence # 30).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
26. *Upon receipt of regular written reports delineating actions taken and improvements made, the governing body takes action when appropriate, and directs that the operational QAPI program be modified on an ongoing basis to accommodate review findings and issues of concern with the DBA.* a. *This activity is documented in the minutes of the meetings of the governing board in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to quality assurance.* Contract 3.9.9.6	**HSAG Recommended Evidence:** • Three consecutive written reports reviewed by the governing body • Three consecutive governing body meeting minutes **Evidence as Submitted by the DBA:** • 1. 2022 Quality Management and Improvement (QMI) Program Description (page 8) • 23. 2022 Quality Management and Improvement Committee Charter (pages 1, 4) • a. 27. 1Q 2022 LDP NV Board Minutes Redacted (pages 1-13)	☒ Met ☐ Not Met ☐ NA
DBA Description of Process: LIBERTY complies with the governing body oversight and continuous quality improvement requirement 26, contract 3.9.9.6. LIBERTY's Board of Directors (BOD) has ultimate responsibility and oversight for the quality of care and service delivered to our members. They are responsible for the overall leadership and oversight of the Quality Management and Improvement (QMI) Program (Evidence #1). The BOD has established the Quality Management and Improvement Committee, which reports to the BOD not only detailed metrics quarterly but also an overall evaluation of the QMI Program including progress on areas of needed improvement annually (Evidence #23). On a quarterly basis, the BOD discusses the QMI Program including QMI Committee and sub-committee reports, metrics, and areas of improvement requested by the BOD from the previous quarter		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
with the LIBERTY NV Dental Director through his presentation at the BOD's Quarterly Meeting (Evidence #27). Due to the limited audit period, BOD minutes and QMI reports are limited to the Q1 2022 Meeting.		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element.		
Required Actions: None.		
QAPI Program Reviews, Analysis, and Evaluation		
27. *At the end of each calendar year (second calendar quarter), the DBA must submit a written report on the QAPI program to DHCFP, which addresses:* a. The performance on the measures on which it is required to report. b. The outcomes and trended results of each PIP. c. *Quality assurance studies and other activities completed.* d. *Trending of clinical and service indicators and other performance data, including aggregate data on utilization and quality of services rendered.* e. *Demonstrated improvements in quality.* f. *Areas of deficiency and recommendations for corrective action.* g. *Evaluation of the overall effectiveness of the QAPI program, including an assessment of the QAPI program's continuity, effectiveness, and current acceptability.* h. *Evidence that quality assurance activities have contributed to significant improvements in the care delivered to members.* 42 CFR §438.330(e) Contract 3.9.8.7(A-C)	**HSAG Recommended Evidence:** • QAPI program evaluation • Evidence of QAPI program evaluation annual submission to the State **Evidence as Submitted by the DBA:** • 28. 2021 NV Medicaid QMI Annual Program Evaluation a. Page 2 b. Page 4 c. Page 23 d. Page 16 e. Page 24 f. Page 4 g. Page 1 h. Page 5 • 30. 2021 QMI Evaluation DHCFP Submission (Entire Document)	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
DBA Description of Process: LIBERTY complies with the QAPI Program review requirements of 42 CFR §438.330(e) and Contract 3.9.8.7(A-C). On an annual basis, at the end of each calendar year, LIBERTY completes a written evaluation of the Nevada Medicaid QMI Program (Evidence #28). The Evaluation is reviewed, discussed, and approved by the Board of Directors and the QMI Committee, and then submitted to DHCFP in Q2 2022 (Evidence #30). The written evaluation includes: performance measures on Work Plan activities, PIP outcomes and trended results, quality assurance Work Plan activities completed, data trends on clinical and service indicators, demonstrated improvements in quality, areas of improvement and recommendations, evaluation of the overall effectiveness of our QMI Program, and evidence that our quality assurance activities have contributed to significant improvements in the care delivered to our Nevada members (Evidence #28).		
HSAG Findings: HSAG has determined that the DBA met the requirements for this element. **Recommendations:** While the 2021 Nevada Medicaid QMI Annual Program Evaluation included general information pertaining to the DBA's assessment of the QAPI program's continuity and effectiveness, HSAG strongly recommends that the DBA enhance the information included in the annual QAPI evaluation to provide specific detail pertaining to the overall assessment of the QAPI program's effectiveness (e.g., how the DBA came to this conclusion) and any revisions necessary to support future program improvements. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program						
Met	=	24	X	1	=	24
Not Met	=	0	X	0	=	0
Not Applicable	=	3				
Total Applicable	=	24	**Total Score**		=	24
Total Score ÷ Total Applicable					=	100%

Appendix B. Compliance Review Corrective Action Plan

SFY 2021–22 Compliance With Standards Review Tool CAP Template

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA[B-1]**	**Score**
Appeals General Requirements			
42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(3)(ii) 42 CFR §438.228 Contract 3.12.2.7	14. The member may file an appeal orally or in writing. a. With the written consent of the member, a provider or an authorized representative may request an appeal on behalf of the member. b. *If appeal is filed orally, the DBA is required to document the contact for tracking purposes and to establish the earliest date of receipt.*	**Evidence as Submitted by the DBA:** • 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (Entire Document) • 05. LDP NV Medicaid Member Handbook: Reporting and Solving Problems: Appeals (page 36) • 09. LDP NV Provider Reference Guide Medicaid: Member Grievances and Appeals (page 65) • 16. NV Medicaid AOR Form (Entire Document) • Appeal File Selection 06. 00000105326-01_FL030989105 • Appeal File Selection OS2. 00001633409-01_FL030989331	☐ Met ☒ Not Met ☐ NA

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

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA[B-1]**	**Score**
	DBA Description of Process: LIBERTY complies with the appeal filing requirements of 42 CFR §438.402(c)(1)(ii), 42 CFR §438.402(c)(3)(ii), 42 CFR §438.228, and Contract 3.12.2.7. We detail those requirements in our Nevada Single Level Appeals Process Policy (Evidence #2), notify and educate our members on how to appeal in the appropriate language and reading level in our Nevada Medicaid Member Handbook (Evidence #5), and notify our providers on the process of appealing on a member's behalf in our Nevada Medicaid Provider Reference Guide (Evidence #9). Additionally, we demonstrate compliance with our policies through the approved Nevada Medicaid AOR Form (Evidence #16), and two representative cases from the Appeal File Selection (06. 00000105326-01_FL030989105) and (OS2. 00001633409-01_FL030989331).		
	HSAG Findings: Although the DBA's Written Provider Grievance and Appeal Form indicated, "If you are filing an appeal on behalf of a member, you must include signed authorization from the member," there was no evidence through the case file review that member consent was being obtained. During the site review, DBA staff members explained that they did not have a process to obtain member consent from a provider filing an appeal on behalf of the member when there is an established provider/patient relationship. However, this process did not align with federal requirements, which stipulate that the member's consent must be obtained for a provider to file an appeal on the member's behalf.		
	Required Actions: The DBA's process must ensure that written consent is obtained from the member when a provider or an authorized representative requests an appeal on the member's behalf.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
Handling of Appeals			
42 CFR §438.406(b)(4) 42 CFR §438.228 Contract 3.12.5.3(A); 3.12.5.5(B)	19. The DBA must provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. a. The DBA must inform the member of the limited time available for this sufficiently in advance of the resolution time frame for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution.	**Evidence as Submitted by the DBA:** • 02. GA PP – Single Level Appeals Process Policy – NEVADA MEDICAID (pages 3, 8, 9, 14) • 03.GA PP - Expedited Appeals Process Policy – NEVADA MEDICAID (pages 2 and 6) • a. 05. LDP NV Medicaid Member Handbook: Reporting and Solving Problems: Appeals (page 37) • a. 11. NV Medicaid Notice of Adverse Benefit Determination Sample Redacted (Entire Document) • a. 18. NV Medicaid Appeal Member Acknowledgement Letter Template (Entire Document)	☐ Met ☒ Not Met ☐ NA
	DBA Description of Process: LIBERTY complies with the appeal notification and member participation requirements in 42 CFR §438.406(b)(4), 42 CFR §438.228, and Contract 3.12.5.3(A) and 3.12.5.5(B). Our Nevada Medicaid Single Level Appeal Process Policy (Evidence #2) and Expedited Appeals Process Policy (Evidence #3) document the required statutory language including the process for members presenting information for LIBERTY to consider during their appeal and the timing of when we advise members of our process both verbally and in writing. We also provide every member with their right to provide documentation for consideration before an appeal is even filed, including at the time they are enrolled in our plan via the Nevada Medicaid Member Handbook (Evidence #5), and at the time an adverse benefit determination (ABD) is made in the Nevada Medicaid Notice of Adverse Benefit Determination (Evidence #11). Once a member files an appeal, we reiterate their right to provide documentation in the Nevada Medicaid Appeal Member Acknowledgment Letter (Evidence #18). All of the files selected in the Appeal File Review illustrate LIBERTY's compliance with these requirements.		

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	HSAG Findings: According to findings from the case file review, two of the expedited appeals (cases 9 and 10) did not include evidence that the member was provided a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. For the standard appeals, the acknowledgement letter indicated, "If you would like to add anything to your case, please call us right away." This narrative should clearly indicate that the member also has an opportunity in person and in writing.		
	Required Actions: The DBA must provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The DBA must inform the member of the limited time available for this sufficiently in advance of the resolution time frame for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
State Fair Hearings			
42 CFR §438.408(f)(2) 42 CFR §438.228 Contract 3.12.6.2	29. *The member must submit a request for a SFH in writing within ninety (90) calendar days from the date of the DBA's notice of resolution of the appeal.* a. *The DBA is required to inform the member of their right to a SFH, how to obtain such a hearing, and representation rules must be explained and provided in writing to the member by the DBA pursuant to 42 CFR 431.200(b); 42 CFR 431.220(a)(6), and 42 CFR 438.408(e)(2)(i).*	**Evidence as Submitted by the DBA:** • 27. April 7 2020 CMS Letter to DHCFP RE: CMS Waiver 1135 (pages 3-4) • 30. COVID-19 Unwind Nevada Medicaid 1135 Flexibilities Table as of 6.21.22 (Entire Document) • 04. GA PP- State Fair Hearing Process Policy -- NEVADA MEDICAID (pages 1 and 5) • a.05. LDP_NV_Medicaid_Member_Handbook: Reporting and Solving Problems: State Fair Hearings (page 38) • a. 25. NV Medicaid NOA Uphold Template (Entire Document)	☐ Met ☒ Not Met ☐ NA
	DBA Description of Process: LIBERTY complies with the extended State Fair Hearing submission request timeframes granted Nevada Medicaid from CMS in 2020, as well as the member notification of their State Fair Hearing rights requirements in 42 CFR §438.408(f)(2), 42 CFR §438.228, and Contract 3.12.6.2, under the current CMS waiver 1135 in effect. We detail in our Nevada Medicaid State Fair Hearing Process Policy (Evidence #4) that a member's right to request a state fair hearing has been extended during the COVID-19 Public Health Emergency, in accordance with the current CMS 1135 waiver (Evidence #27, 30). We also notify the member of their State Fair Hearing rights in the required Nevada Medicaid Template (Evidence #25) and in the appropriate language and reading level in the Nevada Medicaid Member Handbook (Evidence #5).		
	HSAG Findings: The DBA's member handbook and appeal resolution notices inaccurately indicated that members have 120 days to file for a SFH. Although the DBA indicated that it interpreted DHCFP's coronavirus disease 2019 public health emergency (COVID PHE) waiver to mean that the DBA could extend the SFH time frame to 120 days (i.e., provide an extra 30 days), the waiver allowed DHCFP to modify the time frame to allow an additional 120 days to request a SFH from the time		

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	frame already allowable under federal rule (i.e., no less than 90 days but no more than 120 days). However, the contract effective January 1, 2022, was updated to indicate that members have 90 days to file for a SFH, and there was no evidence that DHCFP delayed scheduling of SFHs or that the SFH time frame was extended to allow the additional 120 days for members to request a SFH. Upon review of the DHCFP Fair Hearings website, HSAG determined that members were being informed that they must file for a SFH within 90 days. Please refer to https://dhcfp.nv.gov/Resources/PI/Hearings/. As such, the DBA must update its member materials to ensure that members request a SFH within 90 days of the appeal resolution notice to comply with current DHCFP contract requirements.		
	Required Actions: The DBA must inform members that they must submit a request for a SFH in writing within 90 calendar days from the date of the DBA's notice of resolution of the appeal, and the DBA is required to inform members of their right to a SFH, how to obtain such a hearing, and representation rules must be explained and provided in writing to the member by the DBA pursuant to 42 CFR 431.200(b), 42 CFR 431.220(a)(6), and 42 CFR 438.408(e)(2)(i).		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard XIII—Health Information Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
Application Programming Interface			
42 CFR §438.242(b)(5) 42 CFR §431.60 Contract 3.13.7	8. The DBA must implement an Application Programming Interface (API) as specified in 42 CFR §431.60 (member access to and exchange of data) as if such requirements applied directly to the DBA. Information must be made accessible to its current members or the members' personal representatives through the API as follows: a. Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and member cost-sharing pertaining to such claims, no later than one (1) business day after a claim is processed; b. Encounter data no later than one (1) business day after receiving the data from providers compensated on the basis of capitation payments; c. All other encounter data, including adjudicated claims and encounter data from any subcontractors; d. Clinical data, including laboratory results, no later than one (1) business day after the data is received by the DBA.	**Evidence as Submitted by the DBA:** 1. I-Connect Services 10.08.0: Cite entire document 2. Member Portal: Cite entire document 3. Online Portal Guide: Cite entire document	☐ Met ☒ Not Met ☐ NA

Standard XIII—Health Information Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
	DBA Description of Process: In compliance with 42 CFR §438.242(b)(5), 42 CFR §431.60 and Contract 3.13.7, LIBERTY makes claims, encounters and other clinical data available to its members and providers. LIBERTY's member and provider portals give real time access to claims, utilization, cost share and other relevant information (see Evidence #1, #2, #3)		
	HSAG Findings: The DBA did not implement the API as specified in 42 CFR §431.60 (member access to and exchange of data) during the time period under review. DBA staff members explained that the API is due to be implemented in October 2022.		
	Required Actions: The DBA must implement an API as specified in 42 CFR §431.60 and in accordance with CMS' implementation guidelines.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard XIII—Health Information Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the DBA**	**Score**
Application Programming Interface			
42 CFR §438.242(b)(6) 42 CFR §431.70 42 CFR §438.10(h)(1-2) Contract 3.13.7.2-3.13.7.4	9. The DBA must maintain a publicly accessible standards-based API described in 42 CFR §431.70 (access to published provider directory information), which must include all information specified in 42 CFR §438.10(h)(1) and (2).	**Evidence as Submitted by the DBA:** 4. LIBERTY Management Information System Diagram: Cite entire document 5. I-Connect Services 10.08.0: Cite entire document 6. Nevada Medicaid Provider Directory Link	☐ Met ☒ Not Met ☐ NA
	DBA Description of Process: In compliance with 42 CFR §438.242(b)(6), 42 CFR §431.70, 42 CFR §438.10(h)(1-2), Contract 3.13.7.2-3.13.7.4, LIBERTY makes provider data available publicly. LIBERTY's online provider directory provides real time access to provider demographics and network status (See Evidence #1, #2, #3).		
	HSAG Findings: The DBA did not implement a publicly accessible standards-based API described in 42 CFR §431.70 (access to published provider directory information) during the time period under review. DBA staff members explained that the API is due to be implemented in October 2022.		
	Required Actions: The DBA must implement a publicly accessible standards-based API described in 42 CFR §431.70 and in accordance with CMS' implementation guidelines.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted