Division of Health Care Financing and Policy
Nevada Medicaid Managed Care

Calendar Year 2022 External Quality Review Compliance Review Report

for

SilverSummit Healthplan, 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 **SilverSummit Healthplan, Inc.** (**SilverSummit**). 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 **SilverSummit** 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	12	10	2	0	**83%**
Standard IX—Confidentiality	11	11	11	0	0	**100%**
Standard X—Grievance and Appeal Systems	38	38	29	9	0	**76%**
Standard XI—Subcontractual Relationships and Delegation	7	7	5	2	0	**71%**
Standard XII—Practice Guidelines	10	10	10	0	0	**100%**
Standard XIII—Health Information Systems	14	14	14	0	0	**100%**
Standard XIV—Quality Assessment and Performance Improvement Program	42	39	38	1	3	**97%**
Total	**134**	**131**	**117**	**14**	**3**	**89%**

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.

SilverSummit achieved an overall compliance score of 89 percent, indicating adherence to many of the reviewed federal and State requirements. However, opportunities for improvement were identified in the areas of Provider Selection, Grievance and Appeal Systems, and Subcontractual Relationships and Delegation as these program areas received performance scores below 90 percent. Detailed findings, including recommendations for program enhancements, are documented in Appendix A.

Corrective Action Process

For any elements scored *Not Met*, **SilverSummit** 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

<table>
<tr><th>Standards</th><th>Associated Federal Citation[1]</th><th>Year One (CY 2021)</th><th>Year Two (CY 2022)</th><th>Year Three (CY 2023)</th></tr>
<tr><td>Standard I—Disenrollment: Requirements and Limitations</td><td>§438.56</td><td>✓</td><td></td><td rowspan="11">Review of the MCEs' implementation of Year One and Year Two CAPs</td></tr>
<tr><td>Standard II—Member Rights and Member Information</td><td>§438.100</td><td>✓</td><td></td></tr>
<tr><td>Standard III—Emergency and Poststabilization Services</td><td>§438.114</td><td>✓</td><td></td></tr>
<tr><td>Standard IV—Availability of Services</td><td>§438.206</td><td>✓</td><td></td></tr>
<tr><td>Standard V—Assurances of Adequate Capacity and Services</td><td>§438.207</td><td>✓</td><td></td></tr>
<tr><td>Standard VI—Coordination and Continuity of Care</td><td>§438.208</td><td>✓</td><td></td></tr>
<tr><td>Standard VII—Coverage and Authorization of Services</td><td>§438.210</td><td>✓</td><td></td></tr>
<tr><td>Standard VIII—Provider Selection</td><td>§438.214</td><td></td><td>✓</td></tr>
<tr><td>Standard IX—Confidentiality</td><td>§438.224</td><td></td><td>✓</td></tr>
<tr><td>Standard X—Grievance and Appeal Systems</td><td>§438.228</td><td></td><td>✓</td></tr>
<tr><td>Standard XI—Subcontractual Relationships and Delegation</td><td>§438.230</td><td></td><td>✓</td></tr>
</table>

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

To ensure the CAP is fully implemented, **SilverSummit** 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 **SilverSummit**'s CAP.

Appendix A. Review of the Standards

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

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
General Rules		
1. The MCO 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 enrolled provider must be referred to DHCFP's fiscal agent for completion of the Medicaid provider enrollment process.* b. *The MCO 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* c. *A provider must be credentialed in accordance with the requirements of the Contract in order to become a network provider.* 42 CFR §438.214(a) 42 CFR §438.214(b)(2) 42 CFR §438.214(e) Contract 7.6.2.1; 7.6.2.2.3; 7.6.2.2.4; 7.6.2.2.7; 7.6.2.3; 7.9.6	**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 MCO:** CC.CRED.01 – Practitioner Credentialing and Recredentialing a. page 105 b. page 105 c. page 1-2	☒ Met ☐ Not Met ☐ NA

MCO Description of Process: SilverSummit has established standards for conducting the functions of practitioner selection and retention. These standards include practices for practitioner credentialing, recredentialing, and ongoing monitoring that meet the qualifications of applicable state and federal government regulations, applicable standards of accrediting bodies, including the National Committee for Quality Assurance (NCQA), and SilverSummit

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
requirements to the extent that those standards do not conflict with other laws of the state. For consideration to participate in the network, all individual practitioners who have an independent relationship with the Plan must complete an application for participation, submit copies of applicable supporting documentation, meet minimum administrative requirements, and meet the credentialing qualifications of SilverSummit. Credentialing and re-credentialing process for all contracted providers shall meet the guidelines and standards of the accrediting entity through which SilverSummit attains accreditation and in compliance with Nevada Administrative Code as well as all State and Federal rules and regulations.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** HSAG recommends that the MCO clearly delineate the requirements of sub-element (b) in a policy, procedure, and/or workflow to further demonstrate evidence of compliance. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
2. The MCO must follow a documented process for credentialing and recredentialing of network providers that meets DHCFP's requirements for acute, primary, behavioral, substance use disorders, and long-term services and supports (LTSS) providers. a. *The MCO complies with Nevada Administrative Code (NAC) 679B0405, which requires the use of Form NDOI-901 for use in credentialing providers.* b. *In the event State regulations or provider licensure laws conflict with the National Committee for Quality Assurance (NCQA) standards, State regulations and provider licensure laws control for purposes of the credentialing process.* 42 CFR §438.214(b)(1-2) 42 CFR §438.214(e) Contract 7.6.2.3; 7.9.6	**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 MCO:** • Credentialing Program Description • CC.CRED.01 – Practitioner Credentialing and Recredentialing, page 106 – Attachment Q includes items unique to NV • CC.CRED.09 – Organizational Assessment – page 1 • Link to form: https://doi.nv.gov/uploadedFiles/doinvgov/_public-documents/Insurers/Uniform%20Credentialing.pdf	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: For consideration to participate in the SilverSummit network, all providers who have an independent relationship with the Plan must complete an application for participation, submit copies of applicable supporting documentation, and meet the participation requirements.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG requested evidence of credentialing files for child/adolescent psychiatrists and psychologists and corresponding screen shots of the provider directory to demonstrate that the MCO is collecting the age bands (0–6, 7–12, 13–17, and 18–21) served by these providers. After the site review, the MCO submitted a screen shot of provider profiles in the provider directory that included the following under the "Age Limitations" section: "0 yr(s) – 120 yr(s)", "5 yr(s) – 120 yr(s)", "0 yr(s) – 18 yr(s)." The provider database screen shot that was submitted included data fields for the lowest age and highest age served only. The MCO did not provide sufficient evidence that it is making efforts to collect the specific age bands served by child/adolescent psychiatrists and psychologists as required by its contract with DHCFP. HSAG strongly recommends that the MCO make this a mandatory element in order for these provider types to be initially credentialed or recredentialed. **Recommendations:** While the MCO provided a credentialing file of one of its delegates that included Form NDOI [Nevada Division of Insurance]-901, HSAG recommends that the MCO updates its annual file review tool to include a scoring element related to the use of this form. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: For psychiatrists and psychologists who treat child and adolescent populations, the MCO must collect the specific age bands served by the provider at the time of credentialing in accordance with its contract with DHCFP, Section 7.6.2.3.1.4.		
Nondiscrimination		
3. The MCO 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 7.6.2.2.5	**HSAG Recommended Evidence:** • Policies and procedures • Documentation to support the prevention of and monitoring for discriminatory practices **Evidence as Submitted by the MCO:** • CC.CRED.04 – Nondiscrim Cred and Recred – page 1 and 2	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SilverSummit works to prevent and monitor for discriminatory credentialing/recredentialing by taking proactive steps in the Credentialing Committee review process to minimize the likelihood of discrimination, and by monitoring complaints and performing analysis of any perceived patterns of potential discrimination.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
4. The MCO 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 MCO 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 MCO must comply with the requirements specified in 42 CFR §438.214. 42 CFR §438.12 (a)(1-2) Contract 7.6.2.2.5	**HSAG Recommended Evidence:** • Policies and procedures • Documentation to support the prevention of and monitoring for discriminatory practices • Provider notice template • Example of one individual and one organizational executed provider contracts **Evidence as Submitted by the MCO:** • CC.CRED.04 – Nondiscrim Cred and Recred – page 1 and 2 • CC.CRED.01 – Practitioner Cred and Recred – page 45 • NV SilverSummit Credentialing Minutes 02.08.2022 – page 2 • Denial Letter – Initial Cred – template • Denial Letter – Recred - template	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SilverSummit does not discriminate against providers acting within the scope of his or her license or certification, if a provider is denied during the credentialing process, a letter is provided which includes the reason for the decision		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** While discussion during the site review indicated that ongoing monitoring for discriminatory practices occurred, HSAG recommends that the MCO conduct an annual analysis of credentialing denials as part of its monitoring process as stated in the MCO's credentialing policy. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Excluded Providers		
5. The MCO 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. a. *The MCO's written policies and procedures for its credentialing process complies with 42 CFR §1002.3* 42 CFR §438.214(d)(1) Contract 7.6.2.2.2 Contract 7.6.2.3	**HSAG Recommended Evidence:** • Policies and procedures • Three consecutive months of ongoing monitoring reports/documentation **Evidence as Submitted by the MCO:** • CC.CRED.01 – Practitioner Cred and Recred – page 2 and 106 • CC.CRED.06 – Ongoing Monitoring of Sanctions, page 1 • 2022 Sanctions Log - NV	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Credentialing reviews and verifies sanction and exclusions at initial credentialing, at recredentialing and on an ongoing basis during the intervals between formal re-verification of credentials. Exclusion from federal procurement activities is non-compliant with minimum administrative requirements and results in exclusion from payment and for participating practitioners and providers, immediate termination of network participation.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
State Requirements		
6. *If the MCO denies credentialing or does not extend a provider contract to a provider where the denial is due to the MCO's concerns about provider fraud, integrity, or quality, the MCO reports this to the State's Provider Enrollment Unit within fifteen (15) calendar days.* 42 CFR §438.214(e) Contract 7.6.2.3.3	**HSAG Recommended Evidence:** • Policies and procedures • One example of timely report to Provider Enrollment Unit (date of the denial and the date the provider was reported to the Provider Enrollment Unit must be included) **Evidence as Submitted by the MCO:** • CC.CRED.01 Practitioner Cred and Recred – page 105	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• CC.CRED.07 Pract_Disciplinary_Actions_and_Reporting – pages 6 and 7	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
7. *The MCO must have written policies and procedures for credentialing and recredentialing that are in accordance with Section 7.9.6 of the Contract.* a. *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.* i. *The MCO designates a credentialing committee, or other peer review body, which makes recommendations regarding credentialing decisions.* ii. *The MCO identifies those practitioners who fall under its scope of authority and action. This must include, at a minimum, all physicians and other licensed independent practitioners included in the MCO's network.* b. *Changes to the credentialing process will need to be provided in writing to the State's Provider Enrollment Unit thirty (30) calendar days prior to the change. If the change is unanticipated, the MCO will notify the State's Provider Enrollment unit within five (5) calendar days of the change.* 42 CFR §438.214(e) Contract 7.6.2.3.6; 7.9.6.2-7.9.6.4	**HSAG Recommended Evidence:** • Policies and procedures • One example of report of credentialing process change to DHCFP (the effective date of the change and the date the process change was reported to DHCFP must be provided) • Governing body approval of credentialing policies and procedures • DHCFP approval of credentialing policies and procedures • Credentialing committee charter • Three consecutive examples of credentialing committee meeting minutes **Evidence as Submitted by the MCO:** • CC.CRED.03 Credentialing_Committee – page 1 - 3 • NV SilverSummit Credentialing Minutes 01.11.22 • NV SilverSummit Credentialing Minutes 02.08.2022 • NV SilverSummit Credentialing Minutes 03.08.2022	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the credentialing policies were last updated in May 2022; however, the updates were specific to another line of business (LOB) other than Nevada Medicaid. Therefore, there was no policy submission to DHCFP. **Recommendations:** The credentialing committee meeting minutes from February 2022 confirmed that the committee reviewed and "acknowledged" updates to the credentialing policies. However, HSAG recommends that the MCO ensure that the minutes clearly reflect that the committee "approved" the policy updates. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
8. *If the MCO 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 MCO must monitor the effectiveness of the delegate's credentialing and reappointment or recertification process.* 42 CFR §438.214(e) Contract 7.6.2.3.7	**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 MCO:** • CC.CRED.12 Oversight of Delegated Cred (all pages) • DELEGATED CREDENTIALING AGREEMENT -template • Del Cred Sample – P3 HP • Del Cred Sample – Renown	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SilverSummit oversight of groups with Delegated credentialing is documented in policy CC.CRED.12 Oversight of Delegated Credentialing. Prior to implementing a delegation arrangement, a pre-delegated credentialing audit is completed and a delegation agreement is executed. Annual delegated credentialing audits are performed and delegates participate and cooperate with continued monitoring activities.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, while the MCO was appropriately monitoring delegated credentialing functions, refer to Standard XI—Subcontractual Relationships and Delegation, Element 7, for related findings.		
Required Actions: None.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
File Reviews		
9. The MCO complies with individual practitioner credentialing requirements as specified in the Practitioner Credentialing and Recredentialing File Review Tool. 42 CFR §438.214(e) Contract 7.6.2.3.1; 7.6.2.3.2	**HSAG Recommended Evidence:** • Policies and procedures • Credentialing application template • Primary source verification workflow • Site review process flow • Decision notice template • Three examples of written notice of adverse credentialing decision (if samples selected for file review do not include any denials) • HSAG will also use the results of the Practitioner Credentialing File Reviews **Evidence as Submitted by the MCO:** • CC.CRED.01 Practitioner Cred and Recred • Denial_[provider name]_NV_01.11.22 • Denial_[provider name]_01.2022 (note, only 2 available)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SilverSummit has established standards for conducting the functions of practitioner selection and retention. These standards include practices for practitioner credentialing, recredentialing, and ongoing monitoring that meet the qualifications of applicable state and federal government regulations, applicable standards of accrediting bodies, including the National Committee for Quality Assurance (NCQA), and Plan requirements to the extent that those standards do not conflict with other laws of the state.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** While the case files demonstrated that Medicare/Medicaid sanctions and exclusions searches were conducted, 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. Additionally, while the MCO complied with verification time limits, HSAG will be 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. Further, one credentialing file included verification of licensure; however,		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
the license had expired by the time the provider went to the credentialing committee. As this provider was ultimately denied inclusion in the MCO's network, this observation was not considered a deficiency; however, HSAG recommends that the MCO enhance processes to ensure all licensures are reverified if the expiration date occurs prior to a credentialing decision. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
10. The MCO complies with individual practitioner recredentialing requirements as specified in the Practitioner Credentialing and Recredentialing File Review Tool. 42 CFR §438.214 Contract 7.6.2.3.4	**HSAG Recommended Evidence:** • Policies and procedures • Credentialing application template • Primary source verification workflow • Quality data review process documentation, including source data • Decision notice template • Three examples of written notice of adverse recredentialing decision (if samples selected for file review do not include any denials) • HSAG will also use the results of the Practitioner Recredentialing File Reviews **Evidence as Submitted by the MCO:** • CC.CRED.01 Practitioner Cred and Recred • Recreds due 1.31.22 – Quality Performance Report • (*there are zero examples of adverse recredentialing decisions*)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SilverSummit has established standards for conducting the functions of practitioner selection and retention. These standards include practices for practitioner credentialing, recredentialing, and ongoing monitoring that meet the qualifications of applicable state and federal government regulations, applicable standards of accrediting bodies, including the National Committee for Quality Assurance (NCQA), and Plan requirements to the extent that those standards do not conflict with other laws of the state.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Recommendations: While the recredentialing files confirmed that performance monitoring, including a review of utilization, quality of care, and member complaint data, occurred at the time of recredentialing, the performance monitoring tracking sheet did not address member satisfaction surveys. During the site review, MCO staff members explained that the member satisfaction survey is anonymous; therefore, results are not tied back to a specific provider. As such, the MCO received a *Met* score for this element; however, HSAG recommends that the MCO clearly document in its policy, procedure, workflow, and/or recredentialing files that the results of member satisfaction surveys were considered as required by its contract with DHCFP, but that the results are not tied to any one provider. Additionally, the MCO should be prepared to provide a demonstration of the databases and sources used to identify any performance concerns at the time of recredentialing during future compliance reviews. Implementation of these recommendations will be evaluated during future compliance reviews.		
Required Actions: None.		
11. The MCO 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 • Decision notice template • Three examples of written notice of adverse credentialing decision (if samples selected for file review do not include any denials) • HSAG will also use the results of the Organizational Credentialing File Reviews **Evidence as Submitted by the MCO:** • CC.CRED.09 – Organizational Assessment • (*there are zero examples of adverse credentialing decisions*)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SilverSummit has established standards for conducting the functions of provider selection and retention. These standards include practices for provider assessment and reassessment that meet the qualifications of applicable state and federal government regulations and applicable standards of accrediting bodies, including the National Committee for Quality Assurance (NCQA), to the extent that those standards do not conflict with other laws of the state.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** The case file review did not consistently demonstrate that a site review was completed (or that a site review occurred within the previous three years for recredentialed providers) for those providers not accredited. Due to the challenges of the pandemic, HSAG did not consider this		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
observation as a deficiency. However, moving forward, HSAG recommends that the MCO ensure that each organizational provider being credentialed is accredited or has the results of an on-site survey documented in the case file. Additionally, letters to the providers of the credentialing decision were not located in any of the case files. During the site review, MCO staff members explained that providers would be sent a contracting letter instead. The MCO should be prepared to demonstrate implementation of the contracting letters during future compliance reviews. Further, according to the MCO's policy, disclosure of ownership and control interest forms would be collected and disclosed individuals screened for exclusions. However, this was not demonstrated through the file reviews. As this was not a scoring element, this observation was not considered a deficiency; however, the MCO should be prepared to demonstrate implementation of its process during future compliance reviews.		
Required Actions: None.		
12. The MCO 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 • Decision notice template • Three examples of written notice of adverse recredentialing decision (if samples selected for file review do not include any denials) • HSAG will also use the results of the Organizational Recredentialing File Reviews **Evidence as Submitted by the MCO:** • CC.CRED.09 – Organizational Assessment • (*there are zero example of adverse recredentialing decisions*)	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: SilverSummit has established standards for conducting the functions of provider selection and retention. These standards include practices for provider assessment and reassessment that meet the qualifications of applicable state and federal government regulations and applicable standards of accrediting bodies, including the National Committee for Quality Assurance (NCQA), to the extent that those standards do not conflict with other laws of the state.		
HSAG Findings: The case file review identified two providers who were not recredentialed within 36 months. One provider was recredentialed within 37 months. After the site review, the MCO submitted documentation indicating that NCQA extended the recredentialing cycle to 38 months due to the pandemic. However, a second provider was recredentialed within 42 months. The MCO explained that the provider was removed from the provider directory when the 38-month time frame expired (December 2021); a new "initial" assessment was completed, and the provider was added back to the		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
directory after the provider was credentialed in April 2022. However, while the provider may have been removed from the MCO's directory, this does not alleviate the MCO's responsibility to recredential its providers within 36 months (or 38 months due to NCQA's waiver). Additionally, while the provider may have been removed from the directory, the provider may be rendering services to established members without being properly recredentialed. **Recommendations:** During the site review, MCO staff members explained that an updated provider application at the time of recredentialing is not required for organizational providers. However, the MCO should be verifying that all provider information is current. As such, HSAG recommends that the MCO reevaluate this process. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: The MCO must comply with the credentialing requirements in accordance with its contract with DHCFP.		

Standard VIII—Provider Selection						
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 IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. The MCO 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 MCO must: a. *Establish in writing, and enforce, policies and procedures on confidentiality, including confidentiality of medical 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 MCO.* 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, except as required or permitted by law.* 42 CFR §438.224 Contract 7.4.8; 7.9.9.1-7.9.9.3	**HSAG Recommended Evidence:** • Policies and procedures • Disclosure form(s) • Staff and provider training materials • Provider contract template • Staff and provider monitoring documentation **Evidence as Submitted by the MCO:** Element 1a • IX.1_CC.COMP.04 (entire policy; pgs. 1 and 7) • IX.1_Business Ethics and Code of Conduct (pg. 24-28) • IX.1a_CC.COMP.15 (pgs. 1-2; entire policy) • IX.1_CC.COMP.PRVC.09 (entire policy) • IX.1_CC.PS.03 (entire policy) Element 1b • IX.1b_Provider Contract Template (pgs.5-7,26,62) • IX.1b_2022 Provider Manual (pgs. 98-102) • IX.1b_Medical Record Audit (entire document) • IX.1b_2022 Provider Orientation Deck (slides 29-30) Element 1c • IX.1_CC.COMP.04 (entire policy; pgs. 1 and 7) • IX.1_Business Ethics and Code of Conduct (pg. 24) • IX.1_2022 New Hire Training (slides 15-16) • IX.1_Compliance Privacy and Confidentiality Training (pgs. 6-25; entire training deck)	☒ Met ☐ Not Met ☐ NA

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	• IX.1_CC.PS.03 (entire policy) • IX.1_Visitor Log	
MCO Description of Process: The *2022 New Hire Training, Compliance Privacy and Confidentiality Training* and the *2022 Provider Orientation Deck* demonstrate that employees and providers are informed of/ trained on the requirements to maintain the confidentiality of member information. Employees receive privacy and confidentiality training upon hire, annually and just in time training is provided for department specific needs. The health plan adheres to the following policies to maintain the confidentiality of member information: *CC.COMP.04, CC.COMP.15, and CC.COMP.PRVC.09.*The health plan follows the policies and procedures described in *CC.PS.03* to ensure the office and the information contained within it are secure and to maintain the confidentiality of member's medical records. The *Provider Contract Template* establishes facility and provider responsibility to maintain the confidentiality of member information and records. The *2022 Provider Manual* reiterates provider contractual and regulatory responsibility to maintain the confidentiality of member records and not release them without appropriate authorization. Provider offices are audited regularly by the Quality department to ensure that patient care sites have implemented mechanisms to guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the MCO. The *Medical Record Audit* provides sample evidence of periodic provider audits to validate the presence of HIPAA authorization forms and any follow-up steps that were taken.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Uses and Disclosures of PHI		
2. The MCO 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 MCO is permitted to use or disclose PHI as follows: a. To the individual.	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Business associate agreement template • Delegate agreement/contract	☒ Met ☐ Not Met ☐ NA

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
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 MCO 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) Contract 7.9.9.3.1-7.9.9.3.3; 7.9.9.4; 7.9.9.5	• HIPAA incident tracking mechanism **Evidence as Submitted by the MCO:** Element 2a-c, e-f • IX.2_CC.COMP.04 (entire policy; pgs. 8-9) • IX.2_Business Ethics and Code of Conduct (pgs. 24-28) • IX.2_2022 New Hire Training (slides 15-16) • IX.2_Compliance Privacy and Confidentiality Training (entire deck; pgs. 12-25) • IX.2_2022 Member Handbook (pgs. 65-67) • IX.2_SSHP BAA Template (pgs. 2-4) • IX.2_SBH Vendor Compliance Attestation (pg. 1) • IX.2_SBH Contract (pgs. 6,14,15,16 and 22) • IX.2_RSA Archer – Disclosures Work Process (entire document) • IX.2_CC.COMP.PRVC.14 (entire document) Element 2d • IX.2_CC.COMP.PRVC.03 (entire policy; pgs. 2-5)	
MCO Description of Process: A searchable version of the *SBH Vendor Compliance Attestation* and the *SBH Contract* are not available. The pages in the two documents that relate to this audit element are listed above. The plan has policies, procedures and business associate agreements in place to ensure the health plan and our business associates do not use or disclose protected health information (PHI) except as permitted or required. The plan requires vendors to attest annually that all employees have reviewed the *Business Ethics and Code of Conduct* and are trained upon hire and annually on General Compliance and HIPAA Privacy and Security as seen in the *SBH Vendor Compliance Attestation.* Any HIPAA incidents that occur are tracked in Archer in the Data Breach module according to the *RSA Archer- Disclosures Work Process* and *CC.COMP.PRVC.14.*		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
3. The MCO, 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 MCO's compliance with 45 CFR §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 MCO:** • IX.3_CC.COMP.PRVC.10 (entire policy; pgs. 3, 6-7) • IX.3_CC.COMP.04 (pgs. 7,10-11; 13) • IX.3_Compliance Privacy and Confidentiality Training (pgs. 11-16) • IX.3_2022 Member Handbook (pg. 66,68) • IX.3_SSHP BAA Template (entire document)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: When requested or required the plan will disclose PHI following the policies and procedures detailed in *CC.COMP.PRVC.10* and *CC.COMP.04.* All staff are educated on these requirements and the associated policies upon hire and annually as evidenced in the *Compliance Privacy and Confidentiality Training* deck.		
HSAG Findings: HSAG has determined that the MCO 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 MCO 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 MCO:** • IX.4_CC.COMP.PRVC.09 (entire policy) • IX.4_CC.COMP.04 (pg. 10 section 5) • IX.4_Compliance Privacy and Confidentiality Training (pg. 15) • IX.4_Business Ethics and Code of Conduct (pg. 27)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The plan has policies and procedures in place such as: *CC.COMP.PRVC.09* and *CC.COMP.04* to ensure reasonable efforts are made to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. All staff are educated on these requirements and the associated policies upon hire and annually as evidenced in the *Compliance Privacy and Confidentiality Training* deck and the *Business Ethics and Code of Conduct.*		
HSAG Findings: HSAG has determined that the MCO 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.	**HSAG Recommended Evidence:** • Policies and procedures • Training materials **Evidence as Submitted by the MCO:** • IX.5_CC.COMP.PRVC.09 (pg. 1) • IX.5_CC.COMP.04 (pg. 10) • IX.5_Compliance Privacy and Confidentiality Training (pg. 48)	☒ Met ☐ Not Met ☐ NA

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
e. Uses or disclosures that are required by law. f. Uses or disclosures that are required for compliance with applicable requirements of 45 CFR. 45 CFR §164.502(b)(2)		
MCO Description of Process: The plan has policies and procedures in place such as: *CC.COMP.04* and *CC.COMP.PRVC.09* that reflect these requirements. All staff are educated on these requirements and the associated policies upon hire and annually as evidenced in the *Compliance Privacy and Confidentiality Training deck.*		
HSAG Findings: HSAG has determined that the MCO 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 MCO:** • IX.6_CC.COMP.PRVC.03 (entire policy, pgs. 1, 3) • IX.6_CC.COMP.04 (pgs. 7-8) • IX.6_Authorization for Use and Disclosure Form • IX.6_Compliance Privacy and Confidentiality Training (pgs.14, 48)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The plan has policies and procedures in place such as: *CC.COMP.04* and *CC.COMP.PRVC.03* that reflect these requirements.		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
The Authorization for Use and Disclosure Form is available to members on the plan's website and provided upon request. If the plan seeks an authorization from an individual for a use or disclosure of PHI, the plan provides the requestor with a copy of the signed authorization as stated on the *Authorization for Use and Disclosure Form* and as directed in *CC.COMP.PRVC.03* on page 3. All staff are educated on these requirements and the associated policies upon hire and annually as evidenced in the *Compliance Privacy and Confidentiality Training* deck.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Privacy Rights		
7. The MCO 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 MCO:** • IX.7_2022 Member Handbook (pg. 67-68) • IX.7_CC.COMP.04 (pg. 8) • IX.7_CC.COMP.PRVC.10 (pgs. 5, 14-15) • IX.7_Privacy Report (entire document) • IX.7_Compliance Privacy and Confidentiality Training (pg. 48)	☒ Met ☐ Not Met ☐ NA

<table>
<tr><th colspan="3">Standard IX—Confidentiality</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td colspan="3">MCO Description of Process: The plan has not received a request to place any restrictions on the use and disclosure of their PHI to date, but if a request was received employees would follow the policies and procedures described in CC.COMP.PRVC.10 and CC.COMP.04 and document the request in the Privacy Report.

All staff are educated on these requirements and the associated policies upon hire and annually as evidenced in the Compliance Privacy and Confidentiality Training deck.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCO met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: None.</td></tr>
<tr><td>8. The MCO complies with the member’s right to access PHI and the requirements under 45 CFR §164.524.
a. The MCO must act on a request for access no later than 30 days after receipt of the request.
b. The MCO 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 MCO and member.

45 CFR §164.524</td><td>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 MCO:
• IX.8_CC.COMP.PRVC.10 (pgs. 6-7)
• IX.8_CC.COMP.04 (pgs. 7,8,14)
• IX.8_Authorization for Use and Disclosure Form
• IX.8_Access Request 1-3
• IX.8_Compliance Privacy and Confidentiality Training (pg. 48)</td><td>☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td colspan="3">MCO Description of Process: The plan has policies and procedures in place such as: CC.COMP.04 and CC.COMP.PRVC.10 that reflect these requirements. Three examples of the plan complying with a member’s right to access PHI, titled Access Request 1-3, were provided.</td></tr>
</table>

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
All staff are educated on these requirements and the associated policies upon hire and annually as evidenced in the *Compliance Privacy and Confidentiality Training* deck.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
9. The MCO complies with the member's right to have the MCO 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 MCO complies with the requirements under 45 CFR §164.526. a. The MCO 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	**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 MCO:** • IX.9_CC.COMP.04 (pg. 7-8) • IX.9_CC.COMP.PRVC.10 (entire policy) • IX.9_2022 Member Handbook (pg. 68) • IX.9_Request for Amendment Form (entire document) • IX.9_Privacy Report (entire document) • IX.9_Compliance Privacy and Confidentiality Training (pg. 48)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The plan has not received a request to amend a record to date, but if a request was received employees would follow the policies *CC.COMP.04* and *CC.COMP.PRVC.10,* provide the member with *the Request for Amendment Form*, document the request in the *Privacy Report,* and process the request within 60 days of the request. All staff are educated on these requirements and the associated policies upon hire and annually as evidenced in the *Compliance Privacy and Confidentiality Training* deck.		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
10. The MCO complies with the member's right to receive an accounting of disclosures of PHI made by the MCO 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 MCO must act on the member's request for an accounting, no later than 60 days after receipt of such a request. b. The MCO 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 MCO:** • IX.10_CC.COMP.PRVC.10 (pgs. 4-5) • IX.10_CC.COMP.04 (pg. 7) • IX.10_Accounting of Disclosure by Name and ID Number (entire document) • IX.10_2022 Member Handbook (pg. 68) • IX.10_Compliance Privacy and Confidentiality Training (pg. 48)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The plan has not received a request for the accounting of disclosures of PHI to date, but if a request was received employees would follow the policy *CC. COMP.PRVC.10* and the workflow titled, *Accounting of Disclosures by Name and ID Number*. All staff are educated on these requirements and the associated policies upon hire and annually as evidenced in the *Compliance Privacy and Confidentiality Training* deck.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Notice of Privacy Practices		
11. The MCO's members have a right to adequate notice of the uses and disclosures of PHI that may be made by the MCO, and of the member's rights and the MCO's legal duties with respect to PHI. a. The MCO 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 MCO 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 MCO:** • IX.11_CC.COMP.PRVC.05 (entire policy) • IX.11_CC.COMP.04 (pg. 7, 14) • IX.11_2022 Member Handbook (pgs. 64-69) • IX.11_Authorization for Use and Disclosure Form (entire document) • IX.11_Website Image of Notice of Privacy Practices	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The plan has policies and procedures in place such as *CC.COMP.PRVC.05 and CC.COMP.04* that reflect these requirements. The plan publishes the Notice of Privacy Practices on the plan's website and in the *Member Handbook.* The Notice of Privacy Practices are also provided upon request. All staff are educated on these requirements and the associated policies upon hire and annually as evidenced in the *Compliance Privacy and Confidentiality Training* deck.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
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 MCO has a staff person dedicated to the Contract who acts as the Grievances and Appeals Coordinator to manage member and provider disputes arising from the MCO's Grievance and Appeals System.* a. *The MCO shall have sufficient support staff (clerical and professional) available to process grievance and appeals in accordance with the requirements of the Contract.* Contract 7.2.1.2.12; 7.8.10.5.6	**HSAG Recommended Evidence:** • Job description • Organizational chart • Training materials **Evidence as Submitted by the MCO:** • Job description • Appeals & Grievances Org Chart Document • Policy (NV.QI.11-pg. 1)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
2. The MCO defines a grievance as an expression of dissatisfaction *or making a complaint* about any matter other than an adverse benefit determination (ABD)*, regardless of whether the communication requests any remedial actions*. 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 MCO to make an authorization decision. 42 CFR §438.400(b)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCO:** • Policy (NV.QI.11-pg17) • Member handbook (pg. 57)	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.228 Contract 7.8.10.2		
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** The Grievance Process Description document included definitions for both "complaints" and "grievances," and both were defined as expressions of dissatisfaction. During the site review, MCO staff members provided examples for those calls that were handled by member services and those that were forwarded to the grievances team for resolution. Although it appears that the MCO is tracking and trending all expressions of dissatisfaction as grievances, HSAG strongly recommends that the MCO evaluate its policy and processes to ensure that documentation supports that all expressions of dissatisfaction are being treated as grievances in alignment with the requirements under federal rule. Further, HSAG strongly recommends that the MCO revise its grievance resolution letters to remove language related to appeals. Implementation of these recommendations will be evaluated during future compliance reviews.		
Required Actions: None.		
3. A member may file a grievance with the MCO 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 Contract 7.8.10.6.1; 7.8.10.6.4	**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 MCO:** • Policy (NV.QI.11-pg. 3) • Member handbook (pg. 57) • AOR	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, all grievances reviewed as part of the case file review were submitted by the member or the parent of a child. Additionally, the MCO's policy described the requirement to obtain written consent when someone other than the member files a grievance. However, HSAG requested three examples of grievances submitted by a provider or an authorized		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
representative, along with the member's written consent, to confirm implementation. After the site review, the MCO provided an example of a grievance filed by the parent of a minor child and indicated that authorized consent was not required; however, no additional examples were provided to show that the MCO obtained written consent from someone other than a legally authorized representative when filing a grievance on a member's behalf. In future compliance reviews, to receive a *Met* score, the MCO should be prepared to provide evidence that the member's consent is obtained when someone other than the legally authorized representative files a grievance on a member's behalf (e.g., spouse, family member, provider) to demonstrate implementation of the requirements for this element.		
Required Actions: None.		
4. The member may file a grievance either orally or in writing. a. *If a grievance is filed orally, the MCO 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 7.8.10.6.1	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • HSAG will also use the results of the Grievance File Review **Evidence as Submitted by the MCO:** • Policy (NV.QI.11-Pg. 3, 5, and 18) • Member handbook (pg. 57)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Handling of Grievances		
5. The MCO must acknowledge receipt of each grievance. 42 CFR §438.406(b)(1) 42 CFR §438.228 Contract 7.8.10.10.2	**HSAG Recommended Evidence:** • Policies and procedures • Acknowledgement template notice and/or script • HSAG will also use the results of the Grievance File Review **Evidence as Submitted by the MCO:**	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
	• Policy (NV.QI.11- Pg. 3 and 5) • NV_Mcad_G_Ack Letter	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** Although HSAG confirmed that the MCO acknowledges grievances within three business days of receipt, the member handbook indicated that the MCO will send an acknowledgement letter within 10 business days. HSAG recommends that the MCO update the member handbook to include the three-day time frame. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
6. The MCO 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. 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 7.8.10.10.3; 7.8.10.10.4; 7.8.10.10.4.2; 7.8.10.10.4.3	**HSAG Recommended Evidence:** • Policies and procedures • Organizational chart • HSAG will also use the results of the Grievance File Review **Evidence as Submitted by the MCO:** • Policy NV.QI.11 (Pg. 3) • Appeals and Grievances Org Chart Document • MD_List Document	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO 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 MCO must resolve each grievance and provide notice as expeditiously as the member's health condition requires. a. The MCO must resolve the grievance and send *written* notice to the affected parties *no later than ninety (90) calendar days* from the day the MCO receives the grievance. b. *The MCO must also make reasonable efforts to provide oral notice of the resolution of the grievance.* c. 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 7.8.10.9.1.1; 7.8.10.11.1	**HSAG Recommended Evidence:** • Policies and procedures • Grievance resolution notice template • HSAG will also use the results of the Grievance File Review **Evidence as Submitted by the MCO:** • Policy (NV.QI.11- Pg. 5) • NV_Mcad_G_Res Letter • Member Handbook Pg. 58	☐ Met ☒ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: According to the case file review, all grievances were resolved in a timely manner. However, no evidence was provided to support reasonable efforts were made to provide oral notice of the grievance resolution. Additionally, the resolution letters indicated that the member could appeal the grievance decision and included the date on which the member would need to ask for the appeal, which is inappropriate, as only ABDs can be appealed through the member appeal process. **Recommendations:** Due to the extensive time frame for resolving member grievances, HSAG recommends that the MCO consider how it can shorten the amount of time that staff members are taking to resolve grievances. HSAG is also making a recommendation to DHCFP to reduce the current 90-day time frame allowance. Additionally, due to the minor typographical and grammatical errors and words within the notices that can be considerably shortened or written at a more appropriate reading grade level (e.g., use *"said"* instead of "indicated," use "asked for" instead of "requested"), HSAG recommends that the MCO implement a quality assurance process for reviewing resolution notices before sending them to members. Implementation of these recommendations will be evaluated during future compliance reviews.		
Required Actions: The MCO must also make reasonable efforts to provide oral notice of the resolution of the grievance.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
8. The MCO 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 MCO 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 7.8.10.9.3	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of grievances with extended time frame • HSAG will also use the results of the Grievance File Review **Evidence as Submitted by the MCO:** • Policy (NV.QI.11- pg. 5)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Plan has no extended grievances currently.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the case file review and MCO staff members confirmed that no grievance resolution time frame extensions were applied during the time period under review. Please refer to Element 9 of this standard for additional findings related to the extension process. **Recommendations:** Although the MCO's Member Grievance System Description policy indicated that the MCO may extend the time frame for disposition of a grievance for up to 14 calendar days as appropriate, the language was documented under the same paragraph as the clinically urgent grievances requirements. The policy also contained duplicative requirements throughout various sections within the policy. As such, HSAG recommends that the MCO review its policy and update the policy language to be more streamlined and ensure that the requirements are more clearly documented in the appropriate sections. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
9. If the MCO 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 7.8.10.9.3	**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 Grievance File Review **Evidence as Submitted by the MCO:** • Policy (NV.QI.11- Pg. 5 and 10) • NV_Mcad_G_ExtRes Letter • "Medicaid Extension Process"	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: Upon determination that an extension is necessary, plan sends email to DHCFP (contact information listed on department SharePoint site) for approval. Email should include case information as well as a reason why extension would be necessary. Upon approval, health plan staff will make an oral outreach to member to advise of the delay, within 2 calendar days plan will send written notice of extension with reason and new due date. Case timeline will be extended in the G&A database but not to exceed 44 days (Appeals)/104 days (Grievances) from the date of receipt.		
HSAG Findings: The Member Grievance System Description policy and Medicaid Extension Process did not indicate that the MCO will inform members of their grievance rights if they disagree with the decision to extend the grievance resolution time frame. The grievance extension template letter, noted as Grievance Resolution Letter within the template, also did not include language to inform the member of the right to file a grievance.		
Required Actions: The MCO's written documentation must support that if the MCO extends the grievance resolution time frame not at the request of the member (after DHCFP's approval for the extension), it must make reasonable efforts to give the member prompt oral notice of the delay; and within two 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.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Appeals General Requirements		
10. The MCO defines an appeal as a review by the MCO of an ABD. 42 CFR §438.400(b) 42 CFR §438.228 Contract 7.8.10.3	**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 MCO:** • Policy (NV.QI.11- pg. 17) • Member handbook (pg. 58) • Provider Resources Page on Site (print screen) • Provider Manual pg. 38	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
11. The MCO may have only one level of appeal for members. 42 CFR §438.402(b) 42 CFR §438.228 Contract 7.8.10.5.2	**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 MCO:** • Policy (NV.QI.11 pg. 9 and 12)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Plan has one level of appeal internally, then member/provider have external or SFH options as their next level of review.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
12. The MCO must establish and maintain an expedited review process for appeals, when the MCO 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 MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an member's appeal. 42 CFR §438.410(a-b) 42 CFR §438.228 Contract 7.8.10.5.3	**HSAG Recommended Evidence:** • Policies and procedures • Provider materials, such as the provider manual **Evidence as Submitted by the MCO:** • Policy (NV.QI.11 pg. 5 and 7) • Provider manual (pg.39)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
13. Following receipt of a notification of an ABD by an MCO, 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 MCO. 42 CFR §438.402(c)(2)(ii) 42 CFR §438.228 Contract 7.8.10.6.3	**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 MCO:** • Policy (NV.QI.11 pg. 6) • Timely Submission Tracking Print Screen	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
	• Member handbook (pg. 58 & 75G&A Concern Form) • Mcad_ABD_Notice • Provider manual (pg. 38)	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO 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 an appeal is filed orally, the MCO is required to document the contact for tracking purposes and to establish the earliest date of receipt. The MCO must not require the member to submit a written appeal after making an oral appeal.* 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(3)(ii) 42 CFR §438.228 Contract 7.8.10.6.1	**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 MCO:** • Policy (NV.QI.11-pg 3,6, 18, and 19) • Member handbook (pg. 58 and 59)	☐ Met ☒ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: Of the 10 appeals reviewed as part of the case file review, all 10 appeals were filed by the provider. Of those 10 appeals, the MCO did not obtain member consent as required for three of the cases. Additionally, the ABD notices included language indicating that if members appealed by phone, they must also send in a written, signed appeal. After the site review, the MCO explained that the appeals which required consent were expedited, and that no member consent was requested based on contract language. However, in review of these case files, the MCO did not process the appeals as expedited, as documentation indicated that the appeals did not meet expedited criteria. Therefore, the MCO should have followed its process to obtain the member's written consent.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Recommendations: Although contract language stipulates there is an exception to obtaining a member's written consent for expedited appeals, federal rule does not differentiate between standard and expedited appeals. Therefore, HSAG strongly recommends that the MCO remove the language stipulating there are exceptions to obtaining written permission and ensure it obtains members' written consent for any appeals filed on their behalf. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: The MCO must obtain the written consent of the member when a provider or an authorized representative requests an appeal on behalf of the member. The MCO must not require the member to submit a written appeal after making an oral appeal.		
Handling of Appeals		
15. If the MCO 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 MCO 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 7.8.10.5.3	**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 MCO:** • Policy (NV.QI.11-pg. 10 and 11) • NV_Mcad_Exp_Criteria_Not_Met template • Appeal Sample File (2)	☐ Met ☒ Not Met ☐ NA
MCO Description of Process:		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: According to the case file review, four appeals were submitted as expedited and were transferred to the standard appeal resolution time frame as the criteria for expediting were not met. Although the MCO provided members with appropriate written notices, and oral notice was made to providers in most cases, there was no evidence that the MCO also made a reasonable effort to give the members prompt oral notice of the delay.		
Required Actions: If the MCO denies a request for expedited resolution of an appeal, it must make reasonable efforts to give the member prompt oral notice of the delay.		
16. The MCO must acknowledge receipt of each appeal. 42 CFR §438.406(b)(1) 42 CFR §438.228 Contract 7.8.10.10.2	**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 MCO:** • Policy (NV.QI.11 pg. 7, 18, and 19) • NV_Mcad_A_Ack Letter	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** Through the case file review, HSAG determined that all appeals were acknowledged within three business days, and that this time frame was confirmed by MCO staff members during the site review. However, the Member Grievance System Description policy included conflicting time frames of three business days and 10 business days, the provider manual indicated that a written notice of acknowledgement is to be sent to the member within 10 calendar days, and the appeal workflow indicated acknowledgement is to be sent within two calendar days. As such, HSAG strongly recommends that these documents be updated for consistency. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
17. The MCO 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.	**HSAG Recommended Evidence:** • Policies and procedures • Organizational chart • HSAG will also use the results of the Appeal File Review	☒ 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. 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 7.8.10.10.3; 7.8.10.10.4; 7.8.10.10.4.1; 7.8.10.10.4.3	**Evidence as Submitted by the MCO:** • Policy (NV.QI.11 Pg. 3 and 4) • Appeals &Grievances Org Chart Document • MD_List Document	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
18. The MCO 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 7.8.10.10.5	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO:** • Policy (NV.QI.11-pg. 6,18, and19)	☐ Met ☒ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: Although the Member Grievance Process Description policy indicated that "standard oral appeal requests are treated as appeals (to establish the earliest possible filing date for the appeal). SilverSummit Healthplan may not require a written signed appeal following oral request" and the member handbook provided members with the phone number for Member Services to file an appeal, the ABD notice informed members that the MCO must		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
have a signed, written appeal. HSAG requested that the MCO provide evidence that when members would file appeals orally that written notice would not be required. However, after the site review, the MCO indicated that no examples were available wherein a member filed an appeal orally, suggesting members were not aware that they may file an appeal orally due to inaccurate information being provided in the ABD notice (e.g., requiring a written appeal). Additionally, all appeals within the sample included as part of the case file review were filed by the provider and not the member.		
Required Actions: The MCO must ensure that oral inquiries seeking to appeal an ABD are treated as appeals. The MCO must not require members to provide written, signed appeals in lieu of submitting appeals orally.		
19. The MCO 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 MCO 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 7.8.10.9.2; 7.8.10.10.6	**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 MCO:** • Policy (NV.QI.11 - pg. 4) • NV_Mcad_A_Ack Letter • Mcad_ABD_Notice pg. 2 • Member Handbook pg. 58-59	☐ Met ☒ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: Although the Member Grievance Process Description policy included language to support the requirements of this element, findings from the case file review, and a review of the ABD notice, appeal acknowledgement letters, and member handbook, did not demonstrate that members were being informed of their opportunity to present evidence and testimony in writing and in person, or to make legal and factual arguments in support of the appeal. There was also no evidence that this opportunity was provided to members sufficiently in advance of the resolution time frame for expedited resolution of appeals.		
Required Actions: The MCO must provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MCO 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.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
20. The MCO 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 MCO (or at the direction of the MCO) 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 7.8.10.10.7	**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 MCO:** • Policy (NV.QI.11- pg. 4) • Mcad_ABD_Notice pg. 1 and 2	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Resolution and Notification of Appeals		
21. The MCO must resolve standard appeals and send *written* notice to the affected parties as expeditiously as the member's health condition requires, but *no later than thirty (30) calendar days* from the day the MCO receives the appeal. 42 CFR §438.408(a) 42 CFR §438.408(b)(2) 42 CFR §438.228 Contract 7.8.10.9.1.2; 7.8.10.11.1	**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 MCO:** • Policy (NV.QI.11 - pg. 8) • TimelineTrackingScreen Documentation • NV_Mcad_A_Final_Adv_Det Letter	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
22. The MCO must resolve expedited appeals and send *written* notice to the affected parties no later than seventy-two (72) hours after the MCO receives the appeal. a. *The MCO is required to make a good faith effort to provide an oral notice of the disposition in addition to the required written notice.* 42 CFR §438.408(b)(3) 42 CFR §438.228 Contract 7.8.10.9.1.3; 7.8.10.11.1	**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 MCO:** • Policy (NV.QI.11 - pg. 11) • TimelineTrackingScreen Documentation • NV_Mcad_A_Final_Adv_Det Letter	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. However, refer to Element 27 of this standard for findings related to providing members with oral notice of the appeal disposition.		
Required Actions: None.		
23. The MCO 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 MCO 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	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of appeals with extended time frames • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO:** • Policy (NV.QI.11 - pg. 10)	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Contract 7.8.10.9.3		
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the case file review and MCO staff members confirmed that no appeal resolution time frame extensions were applied during the time period under review.		
Required Actions: None.		
24. If the MCO 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. 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 7.8.10.9.3	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of appeals with extended timeframes (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) • Appeal extension letter template • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO:** • Policy (NV.QI.11 - pg. 10) • NV_Mcad_A_Ext_Letter	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Plan has never extended a case.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the case file review and MCO staff members confirmed that no appeal resolution time frame extensions were applied during the time period under review.		
Required Actions: None.		

<table>
<tr><th colspan="3">Standard X—Grievance and Appeal Systems</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td>25. In the case that the MCO fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the MCO'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
Contract 7.8.10.9.4</td><td>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 MCO:
• Timeline Tracking Screen</td><td>☐ Met
☒ Not Met
☐ NA</td></tr>
<tr><td colspan="3">MCO Description of Process:</td></tr>
<tr><td colspan="3">HSAG Findings: Although the MCO provided documentation to support that it had resolved all appeals in a timely manner during the time period under review, no evidence was provided to support the process the MCO will follow should they have an appeal that is not resolved within the required time frame, and specifically, the process for notifying members that they may initiate a SFH.
Recommendations: HSAG recommends that the MCO develop an appeal resolution notice template to use when appeals are not determined and members are not provided notice within the required time frame, explaining the reason that members can initiate a SFH. Implementation of this recommendation will be evaluated during future compliance reviews.</td></tr>
<tr><td colspan="3">Required Actions: The MCO must have a process to ensure that if the MCO fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the MCO's appeals process and may initiate a SFH.</td></tr>
<tr><td>26. For all appeals, the MCO 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.</td><td>HSAG Recommended Evidence:
• Policies and procedures
• Appeal resolution notice templates (upheld and overturned)
• HSAG will also use the results of the Appeal File Review

Evidence as Submitted by the MCO:
• Policy (NV.QI.11 – pg. 9)
• NV_Mcad_A_Final_Adv_Det Letter</td><td>☒ Met
☐ Not Met
☐ NA</td></tr>
</table>

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
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 MCO'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	• NV_Mcad_A_Apprvl_Res	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. However, refer to Element 29 of this standard for findings related to the time frame for requesting a SFH.		
Required Actions: None.		
27. For notice of a *standard* and expedited appeal resolution, the MCO is *required to make a good faith effort* to provide oral notice *of the disposition in addition to the required written notice.* 42 CFR §438.408(d)(2)(ii) 42 CFR §438.228 Contract 7.8.10.11.1	**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 MCO:** • Policy (NV.QI.11 - pg. 11) • Three examples of oral notice for an expedited appeal resolution • "Appeal_Work_ Flow_Updated_120221" Process Document	☐ Met ☒ Not Met ☐ NA
MCO Description of Process:		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: The MCO's appeal workflow indicated that a resolution notice will be mailed to each member and verbal outreach attempted to advise of the appeal outcome. Additionally, for several of the appeals reviewed as part of the case file review, the MCO contacted the provider to provide oral notice of the disposition of the appeal. However, none of the 10 appeals reviewed as part of the case file review supported that the MCO was also making a good faith effort to provide members with oral notice of the disposition of each appeal.		
Required Actions: For notice of a standard and expedited appeal resolution, the MCO must make a good faith effort to provide oral notice of the disposition in addition to the required written notice.		
State Fair Hearings		
28. The member may request a SFH only after receiving notice that the MCO is upholding the ABD related to the appeal. 42 CFR §438.408(f)(1)(i) 42 CFR §438.228 Contract 7.8.10.6.2; 7.8.10.12.1	**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 MCO:** • Policy (NV.QI.11 - pg. 14 and 15) • NV_Mcad_A_Final_Adv_Det Letter • Member handbook (pg. 60)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
29. *The member must submit a request for a SFH in writing within ninety (90) calendar days from the date of the MCO's notice of resolution of the appeal.* a. *The MCO is required to inform the member of their right to a SFH, how to obtain such a hearing, requirements for*	**HSAG Recommended Evidence:** • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice	☐ Met ☒ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
continuation of benefits, and representation rules must be explained and provided in writing to the member by the MCO 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 7.8.10.12.1; 7.8.10.12.2	• HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO:** • Policy (NV.QI.11 - pg. 14 and 15) • NV_Mcad_A_Final_Adv_Det Letter • Member Handbook pg. 60	
MCO Description of Process:		
HSAG Findings: According to the case file review, one appeal resolution notice indicated that the member had 120 days to request a SFH. Additionally, the MCO's member handbook indicated members had 120 days from the date on the resolution letter to ask for a SFH.		
Required Actions: The MCO must inform members that they must submit a request for a SFH in writing within 90 calendar days from the date of the MCO's notice of resolution of the appeal.		
Continuation of Benefits		
30. The MCO 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.	**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 MCO:** • Policy (NV.QI.11 - pg. 15) • NV_Mcad_A_Final_Adv_Det Letter • Member Handbook pg. 58-59 • Mcad_ABD_Notice	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Timely files means on or before the later of the following: within ten (10) calendar days of the MCO sending the notice of ABD, or the intended effective date of the MCO's proposed ABD. 42 CFR §438.420 (a-b) 42 CFR §438.228 Contract 7.8.10.8.1; 7.8.10.8.1.1-7.8.10.8.1.6		
MCO Description of Process: No request for continuation of benefits was received within the reporting period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
31. If, at the member's request, the MCO 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 MCO 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 7.8.10.8.2; 7.8.10.8.2.1-7.8.10.8.2.3	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of documentation related to continuation of member benefits **Evidence as Submitted by the MCO:** • Policy (NV.QI.11 -pg. 15)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: No request for continuation of benefits was received within the reporting period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
32. If the final resolution of the appeal or SFH is adverse to the member, that is, upholds the MCO's ABD, the MCO 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 and in accordance with the policy set forth in 42 CFR §431.230(b). 42 CFR §438.420 (d) 42 CFR §438.228 Contract 7.8.10.8.3	**HSAG Recommended Evidence:** • Policies and procedures • One example of cost recovery **Evidence as Submitted by the MCO:** • Policy (NV.QI.11 -pg. 15)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: No examples of cost recovery		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
33. If the MCO or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO 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 7.8.10.8.4	**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 MCO:** • Policy (NV.QI.11 – pg. 16)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: No examples of reverses decision.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
34. If the MCO 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 MCO must pay for those services.* 42 CFR §438.424(b) 42 CFR §438.228 Contract 7.8.10.8.4	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of a SFH reversal with corresponding authorization of services **Evidence as Submitted by the MCO:** • Policy (NV.QI.11- pg. 16)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: No example of reversed decision via SFH		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. According to the Member Grievance Process Description policy, if services were furnished while the SFH was pending, and the SFH resolution reverses SilverSummit's decision to deny, limit, or delay services, SilverSummit will pay for disputed services in accordance with State policy and regulations.		
Required Actions: None.		
Grievances, Appeals, and State Fair Hearings		
35. In handling grievances and appeals, the MCO 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 (TTY)/telecommunications device for the deaf (TTD) and interpreter capability. a. *The MCO 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)	**HSAG Recommended Evidence:** • Policies and procedures • Member handbook(s) • One example of assistance to members in filing a grievance and appeal **Evidence as Submitted by the MCO:** • Policy (NV.QI.11-pg. 1 and 3) • Member handbook (pg. 57 and 59)	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.228 Contract 7.8.10.10.1		
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
36. The MCO 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 7.8.10.4; 7.8.10.4.1-7.8.10.4.5	**HSAG Recommended Evidence:** • Policies and procedures • Provider manual • Provider contract template • Subcontractor agreement template **Evidence as Submitted by the MCO:** • Policy (NV.QI.11- pg. 2) • Provider manual pg. 37-39 • Contract template "CNC-NV-ICM PPA Template 2022" pg. 2, 37, and 48 • New_Provider_Orientation 2022 (pg. 65)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** Although the MCO provided information to its providers about the grievance and appeal system, the MCO should review all provider-facing materials (e.g., provider manual, trainings) that include grievances, appeals, and SFH information to ensure the information is accurate and aligns with current processes and requirements. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
37. The MCO 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. *The MCO will participate in the SFH process, at the MCO's expense, in each circumstance in which a member for whom the MCO has made an ABD requests a SFH. The MCO is bound by the decision of the Fair Hearing Officer.* 42 CFR §438.406(b)(6) 42 CFR §438.408(f)(3) 42 CFR §438.228 Contract 7.8.10.10.8; 7.8.10.12.3	**HSAG Recommended Evidence:** • Policies and procedures • Evidence of SFH participation **Evidence as Submitted by the MCO:** • Policy (NV.QI.11 pg. 14) • Evidence of SFH participation	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Recordkeeping Requirements		
38. Grievance and appeal records must be accurately maintained *for a period of no less than ten (10) years* 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.	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Appeals and Grievances File Reviews **Evidence as Submitted by the MCO:** • Policy (NV.QI.11- pg. 5) • Member handbook (pg. 57)	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
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) 42 CFR §438.228 Contract 7.8.10.5.7		
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems						
Met	=	29	X	1	=	29
Not Met	=	9	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	38	Total Score		=	29
Total Score ÷ Total Applicable					=	76%

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. Notwithstanding any relationship(s) that the MCO may have with any delegate, MCO maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. a. *The MCO must evaluate the prospective subcontractor's ability to perform the activities to be delegated.* b. *The MCO 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 MCO must provide full and complete information about the ownership of any subcontractor with whom the MCO 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 7.2.2.1; 7.2.2.2; 7.2.2.3; 7.2.2.4	**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 MCO:** • XI.1_Policy_CC.COMP.60_TPRM_Program (*pg. 2, Policy, pg. 3-4, Pre-Service Audit*) • XI.1_Policy_NV.COMP.101 Subcontractor_Management (*pg.1, #3-4*) • XI.1_Policy_NV.COMP.101-Q157 Checklist (*attachment to policy)* • XI.1-7_Delegated Services Agreement Template (*throughout)* • XI.1_Somatus_State Approval Email_020422 • XI.1_Somatus_Due_Diligence_Questionnaire_01-11-21 • XI.1_Somatus-2021 Pre-Delegation Audit Results Letter • XI.1_Envolve Vision Amnd_Email Approval_DHCFP_121021 • XI.1-5_NIA_Radiology Services Management Agreement_eff 01.01.18	☒ Met ☐ Not Met ☐ NA

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	(pg. 5, Article III Network Obligations; pg. 10, 4.3-Program Integrity Required Disclosures) • XI.1-5_Envolve Vision Services Agreement_Eff 07.01.17 *(pg.5 Article III Network Obligations; pg. 26, 5. Ownership Disclosures)* • XI.1-4_SBH_Health Services Agreement_Final *(pg. 6, 2.15 Program Integrity Required Disclosures; pg.38, 5. Ownership Disclosures)*	

MCO Description of Process:

- All vendors, other than Somatus, were included for prior review/approval as part of the original RFP (2017 contract) as well as the new RFP (2022 contract). Significant changes/amendments are communicated, as demonstrated in the "*Envolve Vision Amnd_Email Approval_DHCFP_121021*" file.
- Regarding 1.c – We have had no requests for ownership information to date; however, upon request, we would reach out to the contract manager to see if there was a current one on file. If no current one is available, we would reach out to subcontractor with the request, in order to submit to the State within the 35 calendar days. The requirement to provide this information is also built into our provider agreements.

HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, MCO staff members confirmed that the MCO has not received any requests from DHCFP for information about the ownership of any subcontractor with whom the MCO has had a business transaction totaling more than $25,000.

Recommendations: While MCO staff members confirmed that the MCO has not received any requests from DHCFP for information about the ownership of any subcontractor with whom the MCO has had a business transaction totaling more than $25,000, HSAG recommends that the MCO document in a policy or procedure the 35-calendar-day time frame requirement for reporting to DHCFP to ensure staff awareness of this standard. HSAG further recommends the MCO also consider including a time frame standard in its subcontracts to ensure its delegates report to the MCO in a timely manner. Implementation of these recommendations will be evaluated during future compliance reviews.

Required Actions: None.

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
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. b. The delegate agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO'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 MCO determine that the delegate has not performed satisfactorily. 42 CFR §438.230(b)(2) 42 CFR §438.230(c)(1) Contract 7.2.2.5	**HSAG Recommended Evidence:** • Delegation agreement/contract template • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • XI.1-7_Delegated Services Agreement Template (*pg. 2, #2 – Delegated Services; Exhibit B-1 & other associated exhibits; Pg. 3, 3.1 Reports; Pg. 4, a. Sub-delegates; Pg. 5; Pg. 11, V. Correction Actions*) • XI.1-5_NIA_Radiology Services Management Agreement_eff 01.01.18 (*pg. 5, Article III Vendor Obligations; pg. 145, Exhibit 1-V; pg. 7, 3.10 Compliance with Policies; pg. 355, NV Medicaid Product Attachment; pg. 13, Article IX Term and Termination-throughout; pg. 14, 9.4 (e); pg. 24, Exhibit 1-Scope of Services; pg. 121, 6. Termination, 7. Performance Standards)* • XI.1-5_Envolve Vision Services Agreement_Eff 07.01.17 (*pg. 5, Article III Network Obligations; pg.14 Article IX Term and Termination; pg. 35, Exhibit 5 Reports; pg. 44, Attachment B Delegated Services Agreement (throughout)* • XI.1-4_SBH_Health Services Agreement_Final *(pg. 6, 2.14 Compliance w/Regulatory Requirements; pg. 20, Schedule D, Scope of Services C. Crisis Call Center; pg. 23, D. Reporting Requirements; pg. 35, 2.1 Medicaid and/or CHIP Product)* • XI.2,3-4_Somatus_MSA_Centene	☒ Met ☐ Not Met ☐ NA

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	(pg. 5-6, Section 8 Term and Termination) • XI.2,5_Somatus_SOW1 *(pg. 1, Statement of Work – all throughout)*	
MCO Description of Process: Please Note: Summit Behavioral Health (SBH) is only considered delegated for the Crisis Calls – all other parts of contract/agreement pertain to provider services.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** While an executed agreement implied that the delegate agreed to perform the delegated activities and comply with the reporting responsibilities, HSAG recommends that the MCO add a contract provision in its written arrangements which specifically states that the delegate agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's contract obligations. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
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 7.2.2.7	**HSAG Recommended Evidence:** • Delegation agreement/contract template • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • XI.1-7_Delegated Services Agreement Template *(Pg.2, 2 - Delegated Services; Pg. 6, 13. Confidentiality)* • XI.1-5_NIA_Radiology Services Management Agreement_eff 01.01.18 *(pg. 7, 3.10 Compliance with Policies; pg. 8, 3.16 Compliance with Laws; pg. 9, 4.2 HIPAA Compliance; pg. 12-13, Article VIII Insurance, 8.1 Vendor Insurance; pg. 11, Article VI Records/Inspections; pg. 77, 2.4.4*	☒ Met ☐ Not Met ☐ NA

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	Medical Records Retention; pg.81, 5.1 Statutory & Regulatory Compliance) • XI.1-4_SBH_Health Services Agreement_Final *(pg. 6, 2.14 Compliance with Regulatory Requirements; pg. 7, 4.1 Records; pg. 8, 5.1 Insurance; pg.37, Governmental Program Requirements - throughout)* • XI.3-4_SBH_BAA *(HIPAA/Confidentiality – throughout)* • XI.1-5_Envolve Vision Services Agreement_Eff 07.01.17 (*pg.7, 3.13 Medical Records/Advance Directives; pg. 9, 3.22 Compliance with Laws, 4.1 Product and State-Mandated Provisions; pg. 9, 4.2 HIPAA Compliance; pg.13, Article VIII Insurance)* • XI.2,3-4_Somatus_MSA_Centene *(Pg. 3, Section 6 Compliance with Law; pg. 4, 6.5 Compliance with Law; pg. 6, Section 10 Insurance; pg. 12, Insurance Addendum; pg.18, Business Associate Agreement; pg. 2, 2.3 Records and Audit)*	
MCO Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** The MCO cited a provision under a Medicare addendum as evidence of compliance for the record retention requirement. As the MCO is serving the Nevada Medicaid program, HSAG recommends that the MCO conduct a thorough review of all delegated written arrangements for the Nevada Medicaid program and ensure all provisions (e.g., all requirements included as part of this review tool) clearly apply to Nevada Medicaid. Refer to Element 4 of this standard for additional findings. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
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, 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 MCO'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)	**HSAG Recommended Evidence:** • Delegation agreement/contract template • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • XI.1-7_Delegated Services Agreement Template *(pg. 10, III. Annual Evaluation)* • XI.1-5_NIA_Radiology Services Management Agreement_eff 01.01.18 *(pg. 11, Article VI Records/Inspections; pg.12, 6.3 On-Site Inspections; pg. 76, 2.4.2 Inspection of Records; pg. 44, 7. Audits; pg.101, 3.8 Availability of Internal Practices, Books and Records; pg. 362, NV-12.B)* • XI.2,3-4_Somatus_MSA_Centene *(pg. 2 Records and Audit; pg.21, 3.8 Availability of Internal Practices, Books and Records)* • XI.1-4_SBH_Health Services Agreement_Final *(pg. 7, Article IV-Records & Inspections; pg.42, NV-12.B)* • XI.3-4_SBH_BAA *(pg.4, 3.6 Access to Records, 3.8 Availability of Internal Practices, Books and Records)* • XI.1-5_Envolve Vision Services Agreement_Eff 07.01.17 *(pg. 11, Article VI Records/Inspections, 6.2 Access; pg.30-31, NV-11.B)*	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: N/A		

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: While the MCO's written arrangements with its delegates included right to audit provisions, they did not fully align with the requirements of this element. National Imaging Associates' (NIA's) contract included a provision (2.4.2 Inspection of Records) that aligned with the requirements of this element, except sub-element (d); however, this provision was located under a Medicare addendum. Additionally, Article VI Records/Inspections and 6.3 On-Site Inspections of NIA's contract included a provision allowing access to records and on-site inspections; however, such access was available during normal business hours at a mutually agreed-to date and time and on reasonable notice. This language conflicts with the requirements of sub-element (d) in which the right to audit exists at any time when there is a reasonable possibility of fraud or similar risk. Summit Behavioral Health Systems' (SBHS's) contract included the following language: "Company or Payor and the Nevada Commissioner of Insurance are authorized, upon reasonable prior notice, to audit, inspect and copy the Provider's books, records and any other evidence of its operations to determine whether it has complied with the applicable provisions of Nevada law, including any regulations adopted pursuant thereto." SBHS's Business Associate Agreement (BAA) also included right to audit requirements under Section 3.6 Access to Records and 3.8 Availability of Internal Practices, Books and Records. However, neither the contract nor BAA included all required provisions, and specifically, sub-elements (c) and (d). **Recommendations:** HSAG recommends that the MCO conduct a thorough review of all contracts with its delegates for the Nevada Medicaid program and ensure that the requirements of this element are clearly outlined. HSAG recommends that the MCO include these provisions in its subcontracts verbatim to the federal rule. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: The MCO must ensure its contracts or written arrangements indicate, and the delegate agrees that: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, 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 MCO's contract with the State. • 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. • 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. • 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.		

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
Monitoring and Auditing		
5. *The MCO is responsible for oversight of all subcontracts and is accountable for any responsibilities it delegates to any subcontractor.* a. *The MCO must monitor the subcontractor's performance on an on-going basis.* 42 CFR §438.230 Contract 7.2.2.2; 7.2.2.8	**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 MCO:** • XI.5-6_Policy_NV.COMP.101_Subcontractor_Management *(pg. 1, #'s 2, 6, 10)* • XI.1-7_Delegated Services Agreement Template *(Pg. 10, III. Annual Evaluation, Pg. 10, IV. Ongoing Monitoring Plan)* • XI.5_VMOC Meeting Minutes 03.07.2022 • XI.5_VMOC Meeting Minutes 12.07.2021 • XI.5_VMOC Meeting Minutes 08.31.2021 Summit Behavioral Health (SBH): • XI.5_SBH_Meeting Minutes 02.09.22 – Final (*throughout*) • XI.5_SBH_2022 Vendor Metrics Dashboard (*throughout*) NIA: • XI.1-5_NIA Radiology Services Management Agreement_Eff 01.01.18 (*pg. 150, Ex B-2, Oversight of Delegated Svcs Policy & Monitoring plan (throughout)* • XI.5_NIA_Q1_2022 JOC Meeting Minutes 02.28.22 • XI.5_NIA_Q1_2022 JOC Presentation	☒ Met ☐ Not Met ☐ NA

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	• XI.5_NIA_Q1_2022 Vendor Dashboard • XI.5_NIA_Local Monitoring Description <u>Envolve Vision:</u> • XI.1-5_Envolve Vision Services Agreement_Eff 07.01.17 *(pg.51 Exhibit 2, Oversight of Delegated Services Policy and Monitoring Plan)* • XI.5_JOC Vision and Dental – 2022Q2 • XI.5_Envolve Vision Meeting Minutes 02.14.22 • XI.5_Envolve Vision_Local Monitoring Description <u>Somatus:</u> • XI.2,5_Somatus_SOW 1 *(pg.3, K. Joint Operations Committee)* • XI.5_Somatus_Local Monitoring Description • XI.5_Somatus_Centene Apr 2022 JOC	
MCO Description of Process: We review performance, operations, issues, etc. for all vendors at our quarterly Vendor Management Oversight Committee (VMOC). All JOC's that have been held that quarter are also reviewed, in addition to information for other vendors.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
6. *The MCO 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 7.2.2.2; 7.2.2.8	**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 MCO:** • XI.5-6_Policy_NV.COMP.101_Subcontractor_Management *(#10)* • XI.1-7_Delegated Services Agreement Template (*pg. 10, III. Annual Evaluation)* • XI.6_TPRMO Annual Audit Description • XI.6_2022 TPRMO Audit Plan_copy • XI.6_NIA Annual Audit Results Summary 2021 • XI.6_Envolve Vision 2021 Annual Audit Results Summary • XI.6_SBH Audit Opening Meeting_05.06.22 • XI.6_SBH Q2 Audit Engagement Letter • XI.6_EPC 2021 Annual Audit Results Summary	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: • Summit Behavioral Health (SBH) is a local vendor, and not overseen by our TPRMO team. We included them in our Healthplan Q2 Audit & Monitoring plan. The audit scope is outlined in the engagement letter and the audit opening meeting was held on 5/6/22. • NIA, Envolve Vision, and Somatus are all national vendors, so they are included in TPRMO's annual audit plan (provided). Somatus had a pre-delegation audit in 2021, and their annual 2022 audit has not been finalized yet. The annual audit summary for Envolve People Care (EPC) was provided in addition to the vendor sample information.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

<table>
<tr><th colspan="3">Standard XI—Subcontractual Relationships and Delegation</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td rowspan="2">7. If the MCO identifies deficiencies or areas for improvement, the MCO and the subcontractor take corrective action.

42 CFR §438.230
Contract 7.2.2.2; 7.2.2.8</td><td>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</td><td rowspan="2">☐ Met
☒ Not Met
☐ NA</td></tr>
<tr><td>Evidence as Submitted by the MCO:
• XI.1-7_Delegated Services Agreement Template (pg. 4, 3.4 Corrective Action Plans; pg. 11, V. Corrective Actions)
• XI.7_EPC_CAP_NAL FND-6907
• XI.7_EPC_CAP_NAL Remediation
• XI.7_SBH_CAP Summary_FND-7329
• XI.7_Envolve Vision_CAP_Deficiencies</td></tr>
<tr><td colspan="3">MCO Description of Process:
• “XI.7_Envolve Vision_CAP_Deficiences” is not a formal corrective action plan, although deficiencies were identified and corrective action was taken via communication to the vendor.
• There were no corrective actions for Somatus and NIA, so a third example of a formal CAP for Envolve People Care (EPC) was provided.</td></tr>
<tr><td colspan="3">HSAG Findings: During the review of Standard VIII—Provider Selection, it was identified that the MCO was appropriately monitoring delegated credentialing functions through an annual review that included a policy and procedure review and a case file review. However, the Delegated Credentialing Audit Tool Summary Report for one delegate indicated that the delegate received a score between 90 percent and 100 percent and was recommended for continued delegation of credentialing with recommendations that would be reviewed during the next annual audit. However, the file review identified multiple deficiencies (e.g., noncompliance with licensure verification, board certification verification, Medicare/Medicaid sanctions and exclusions queries, notice of decision to provider). Evidence that a CAP was requested and subsequently completed by the delegate was not provided. Discussion during the site review indicated that the overall score did not meet the threshold for a CAP due to the weighted scores from the program areas reviewed (e.g., policies, case file review, report submissions). However, given the significant volume of the deficiencies from the results of the case file review, and in accordance with the MCO’s contract with DHCFP, the MCO should have required a CAP as the case file review is the true indicator of the delegate’s performance.</td></tr>
</table>

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
Recommendations: HSAG strongly recommends that the MCO update its scoring methodology for determining when a CAP is or is not required based on these findings. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: The MCO and its subcontractor must take corrective action when deficiencies or areas for improvement are identified.		

Standard XI—Subcontractual Relationships and Delegation						
Met	=	5	X	1	=	5
Not Met	=	2	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	7	**Total Score**		=	5
Total Score ÷ Total Applicable					=	**71%**

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
Adoption of Practice Guidelines		
1. *The MCO's Chief Medical Director oversees the development and revision of the MCO's clinical care standards and practice guidelines and protocols.* Contract 7.2.1.6.2.3	**HSAG Recommended Evidence:** • Job description • Committee charter • Committee meeting minutes **Evidence as Submitted by the MCO:** • SXII E1 Chief Medical Officer Job Description • SXII E1 2022 QAPI Description (pgs.13-16) • SXII E1 2021 Q4 QIC Meeting Minutes • SXII E1 2022 Q1 QIC Meeting Minutes • SXII E1 2022 Q2 QIC Meeting Minutes	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
2. The MCO must adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field. 42 CFR §438.236 (b)(1) Contract 7.6.12.1; 7.6.12.1.1	**HSAG Recommended Evidence:** • Policies and procedures • List of adopted practice guidelines • Meeting minutes documenting committee review/approval **Evidence as Submitted by the MCO:** • SXII E2 CP.CPC.03 Preventive Health and CPG Policy • SXII E2 CPG Grid • SXII E2 2022 QAPI Description (pgs. 13-16) • SXII E2 2022 Q1 QIC Meeting Minutes	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
3. The MCO must adopt practice guidelines that consider the needs of the MCO's members. 42 CFR §438.236 (b)(2) Contract 7.6.12.1.2	**HSAG Recommended Evidence:** • Policies and procedures • List of adopted practice guidelines • Meeting minutes documenting committee review/approval **Evidence as Submitted by the MCO:** • SXII E3 CP.CPC.03 Preventive Health and CPG Policy • SXII E3 CPG Grid • SXII E3 2022 QAPI Description (pgs. 13-16) • SXII E3 2022 Q1 QIC Meeting Minutes	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
4. The MCO must adopt practice guidelines that are adopted in consultation with network providers. 42 CFR §438.236 (b)(3) Contract 7.6.12.1.3	**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 MCO:** • SXII E4 CP.CPC.03 Preventive Health and CPG Policy • SXII E4 CPG Grid • SXII E4 2022 QAPI Description (pgs. 13-16) • SXII E4 2022 Q1QIC Meeting Minutes	☒ Met ☐ Not Met ☐ NA

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
5. The MCO must adopt practice guidelines that are reviewed and updated periodically as appropriate. 42 CFR §438.236 (b)(4) Contract 7.6.12.1.4	**HSAG Recommended Evidence:** • Policies and procedures • List of adopted practice guidelines • Meeting minutes documenting committee review/approval **Evidence as Submitted by the MCO:** • SXII E5 CP.CPC.03 Preventive Health and CPG Policy • SXII E5 CPG Grid • SXII E5 2022 QAPI Description (pgs. 13-16) • SXII E5 2022 Q1 QIC Meeting Minutes	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
6. *The MCO must adopt practice guidelines that comply with requirements for parity in mental health and substance use disorder benefits in accordance with 42 CFR §438.910(d).* a. *The MCO's prior authorization requirements are documented and applied in a manner that comply with the guidelines for parity in mental health and substance use disorder.* Contract 7.6.12.1.5	**HSAG Recommended Evidence:** • Policies and procedures • List of adopted practice guidelines • Utilization review program description • Meeting minutes documenting committee review/approval • Prior authorization criteria for mental health/substance use disorder treatment **Evidence as Submitted by the MCO:**	☒ Met ☐ Not Met ☐ NA

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
	• SXII E6 CP.CPC.03 Preventive Health and CPG Policy • SXII E6 CPG Grid • SXII E6 2022 Q1 QIC Meeting Minutes • SXII E6 NV.UM.01 Utilization Management Program Description (pg. 19)	
MCO Description of Process: PA criteria for SUB is done utilizing the American Society of Addition Medicine (ASAM) Third Edition Adult and Adolescent. PA is level of care specific		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Dissemination of Guidelines		
7. The MCO 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 7.6.12.2	**HSAG Recommended Evidence:** • Policies and procedures • Utilization review program description • 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 MCO:** • SXII E7 CP.CPC.03 Preventive Health and CPG Policy • SXII E7 2021 Utilization Management Program Description (pg. 19) • SXII E7 Website Provider Practice Guidelines • SXII E7 2022 Q1 QIC Meeting Minutes • SXII E7 CPG Grid	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Clinical Practice Guidelines provider and member notification will occur in Q3 so not done during the review period.		

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** HSAG recommends that the MCO's policies clearly identify the process for also disseminating prior authorization policies and procedures to all affected providers, members, and potential members, on request. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
Application of Guidelines		
8. 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 7.6.12.3	**HSAG Recommended Evidence:** • Policies and procedures • Coverage guidelines/criteria • Utilization review program description • Member educational guidance (i.e., disease management) • Member materials (i.e., member handbook, member newsletters) • Three examples of coverage denial notices **Evidence as Submitted by the MCO:** • SXII E8 CP.CPC.03 Preventive Health and CPG Policy • SXII E8 NV.UM.01 Utilization Management Program Description (pg. 19) • SXII E8 Member Educational Material Understanding Asthma • SXII E8 Member Newsletter Q1 2022 • SXII E8 CPG Grid	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: We have no examples of coverage denials. Any service requiring PA is done using Interqual or ASAM and they are both consistent with our clinical guidelines.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
9. *Network providers are required to use designated practice guidelines and protocols.* Contract 7.6.12.4	**HSAG Recommended Evidence:** • Policies and procedures • Provider materials, such as provider manual • Provider contract template • Utilization review program description **Evidence as Submitted by the MCO:** • SXII E9 CP.CPC.03 Clinical Practice Guidelines • SXII E9 CPG Grid • SXII E9 Website Provider Practice Guidelines • SXII E9 Provider Contract (pg. 36) • SXII E9 NV.UM.01 Utilization Management Program Description (pg. 19)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
10. *The MCO offers feedback to individual network providers on adherence to evidence-based practice guidelines and positive and negative care variances from standard clinical pathways that may impact outcomes or costs.* a. *The MCO uses this information to guide activities, such as performance improvement projects for network providers.* Contract 7.6.9	**HSAG Recommended Evidence:** • Policies and procedures • Utilization review program description • Three examples of provider education re: adherence to practice guidelines • Analyses of information, and documentation of follow-up activities **Evidence as Submitted by the MCO:** • SXII E10 CP.CPC.03 Clinical Practice Guideline Policy	☒ Met ☐ Not Met ☐ NA

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
	• SXII E10 CPG Grid • SXII E10 NV.UM.01 Utilization Management Program Description (pg. 19)	
MCO Description of Process: Providers are educated during office visits but no formal power point or documentation maintained for education completed.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XII—Practice Guidelines						
Met	**=**	**10**	**X**	**1**	**=**	**10**
Not Met	**=**	**0**	**X**	**0**	**=**	**0**
Not Applicable	**=**	**0**				
Total Applicable	**=**	**10**	**Total Score**		**=**	**10**
Total Score ÷ Total Applicable					**=**	**100%**

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. The MCO 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 payment c. Grievances and appeals d. Disenrollments for other than loss of Medicaid eligibility – submitted screenshot e. *Enrollment* f. *Eligibility* g. *Provider network data* h. *Encounter data* i. *Electronic Visit Verification (EVV)* 42 CFR §438.242(a) Contract 7.12.2.1; 7.12.2.2; 7.12.4.1	**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 MCO:** • XIII.1_2022 Technology Refresh Plan • XIII.1_Appeals_Grievances_Case_Tracker • XIII.1_Auth Detail.xlsx • XIII.1_CC.CLMS.10 • XIII.1_CC.LTSS.CM.09_Electronic_Visit_Verification • XIII.1_Centene System Diagram • XIII.1_Daily Claims Receipts • XIII.1_Disenrollment Tracking_v2.1 • XIII.1_Encounter Acceptance Summary Jan-May 2022 • XIII.1_Encounter Lag Report • XIII.1_Grievance_System_Description • XIII.1_Monthly Claims Receipts + EDI + Paper • XIII.1_NV Readable 834 - 05072022_228836 processed • XIII.1_NV.CLMS.10 • XIII.1_NV.ENC.01 • XIII.1_Silver Summit Authenticare Data Flow Diagram	☒ Met ☐ Not Met ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
	• XIII.1_SSHP - Systems Landscape • XIII.1_2021 Centene All States SOC1_Confidential • XIII.1_2021 Centene Corporation Security_SOC2_Confidential	

MCO Description of Process: File: "**1. SSHP - Systems Landscape.pdf**" provides the systems diagram of all the systems/applications used to handle managed care requirements.

a. Utilization: File "**1. Auth Detail.xlsx**" is a report extract from TruCare that is the source of truth for all Utilization information. The report shows data captured and extracted for authorization from TruCare. It has two tabs, Inpatient and Outpatient auths.

b. Claims payment:

Amisys is the system that is used for the claims processing. All the information for claims is stored in Amisys and then subsequently in data warehouse (EDW) where all the reporting I done. Following files are provided for this deliverable.
1. Daily Claims Receipts.jpg – Shows the dashboard image of daily claims receipts.
1. Monthly Claims Receipts + EDI + Paper.jpg – Shows the dashboard image of claims receipts for the month based on the source, EDI, Web or Paper.
1. NV.CLMS.10.docx – is the policy used for claims operations

c. Grievances and appeals

Grievances and Appeals are managed in "Prime" system. Attached are the reports of G&A tracker and Grievance system description.

File "**1. Appeals_Grievances_Case_Tracker.pdf"**
File "**1. Grievance_System_Description.docx**"

d. Disenrollments for other than loss of Medicaid eligibility
All disenrollments and enrollments are managed in UMV that come through 834. However, any god cause disenrollment requests are managed as grievance. See attached report of all GCDs for the said period.

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
e. Enrollment **f. Eligibility** Unified Member View (UMV) is the source of truth for member data. Daily and monthly 834s are processed in UMV. Attached file "**1. NV Readable 834 - 05072022_228836 processed.xlsx**" shows the daily processing information. **g. Provider network data** Portico is the system used to manage the provider data. This system also feeds data warehouse along with other systems that need provider data. Please see attached File "**1. Provider Directory.pdf**" that shows the entire provider network. **h. Encounter data** EncounterPro is the system used for submission of encounters (adjudicated claims). Attached file "**1. NV.ENC.01.doc**" is the encounter policy and the files "**1. Encounter Acceptance Summary Jan-May 2022.xlsx**" and "1. Encounter Lag acceptance rate is in high 99.xx%. **i. Electronic Visit Verification (EVV)** EVV system has been implemented in coordination with the state. The system is operational. File "**1. Silver Summit Authenticare Data Flow Diagram.pptx**" shows the data flow and file "**1.CC.LTSS.CM.09_Electronic_Visit_Verification.doc**" has the EVV policy. **Information Systems Capability Audit** As one of the recommended documents for this submission, systems capability audit is attached and was conducted by KPMG. The two files for SOC1 and SOC2 audit are provided. File "**1. 2021 Centene Corporation Security_SOC2_Confidential**" File "**1. 2021 Centene All States SOC1_Confidential**" In addition, file "**1. 2022 Technology Refresh Plan.xlsx**" has the annual refresh plan for major systems.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the reason for a member's disenrollment was available in the UMV database but not readily available to general staff using the MCO's information systems. **Recommendations:** The MCO verified that it had received 56,781 records with a termination reason code, and all were for "07 = Termination of Benefits." However, HSAG recommends that the MCO conduct a periodic analysis of the reason for member terminations and collaborate with DHCFP regarding the		

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Requirement	**Supporting Documentation**	**Score**
possibility of obtaining more detailed termination reasons in the future. This may provide the MCO with meaningful information to conduct an analysis of potential opportunities for improvement; for example, terminations when a member chose to disenroll from the MCO and enroll in another MCO. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
Basic Elements of a Health Information System		
2. The MCO 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 DHCFP to meet the requirements of section 1903(r)(1)(F) of the Act (electronic claims submission). 42 CFR §438.242(b)(1) Contract 7.7.1.3	**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 MCO:** • XIII.2_2022 Provider Billing Manual SSHP • XIII.2_Claims Auto Adjudication • XIII.2_HCFA Electronic Claim Image • XIII.2_NV Encounters Acceptance Report • XIII.2_NV.CLMS.10 • XIII.2_UB Electronic Claim Image • XIII.2_CC.CLMS.10	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SSHP (Centene) uses Amisys as the claims system for processing of all medical and behavioral claims. It captures all the elements on a HCFA 1500 or UB and receives all the information from EDI which accepts all the claims from clearing houses, web portals as well as paper claims that get converted into an electronic format for processing. Attached are the documents that have instructions to providers, claim images generated from the information documented in the system demonstrating that all the elements are captured. Also is the document that shows the acceptance of encounters by the state as a proof of the system capabilities and processes implemented to capture all the needed and required data. • File "**2. 2022 Provider Billing Manual SSHP.pdf**" is the billing guide instructions for the provider		

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Requirement	**Supporting Documentation**	**Score**
• File "**2. Claims Auto Adjudication.jpg**" shows the auto adjudication rate that shows the claim percentage that is processed by the system without manual intervention. • File "**2. HCFA Electronic Claim Image.JPG**" – Claim image generated from the data captured in Amisys for a HCFA claim. • File "**2. UB Electronic Claim Image.JPG**" – Claim image generated from the data captured in Amisys for an UB claim. • File "**2. NV Encounters Acceptance Report.xlsx**" shows the encounters that are accepted by the state. • File "**2. NV.CLMS.10.docx**" is the policy for claims processing.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
3. The MCO shall comply with the following: a. The MCO 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 7.12.4.1.1	**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 MCO:** • XIII.3_2022 Provider Billing Manual SSHP **See above** • XIII.3_HCFA Electronic Claim Image **See above** • XIII.3_Nevada 834 Companion Guide • XIII.3_NV Readable 834 - 05072022_228836 processed • XIII.3_NV.CLMS.10 **See above** • XIII.3_CC.CLMS.10 **See above** • XIII.3_Provider Data Form.PDF1 • XIII.3_UB Electronic Claim Image **See above**	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SilverSummit HealthPlan (Centene) uses Amisys for claims processing, UMV for member data processing and Portico for Provider data processing.		

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Requirement	**Supporting Documentation**	**Score**

Claims:
Attached files show the instructions to the providers for claim submissions, claim images generated using the data in Amisys to demonstrate the capture of all required information and the claims policy.

- File "**3. 2022 Provider Billing Manual SSHP.pdf**" is the billing guide instructions for the provider
- File "**3. HCFA Electronic Claim Image.JPG**" – Claim image generated from the data captured in Amisys for a HCFA claim.
- File "**3. UB Electronic Claim Image.JPG**" – Claim image generated from the data captured in Amisys for an UB claim.
- File "**3. NV.CLMS.10.docx**" is the policy for claims processing.

Member: Member information is received from the state via 834. Daily and monthly 834s are processed into UMV system.

- File "**3. Nevada 834 Companion Guide.pdf**" is the companion guide from the state for 834 describing the data provided for the member by the state. This information is captured in UMV and then provided to all the connected systems including the vendor systems.
- File "**3. NV Readable 834 - 05072022_228836 processed.xlsx**" is the evidence of the 834 processed with the data captured in the process.

Provider: Provider data is entered into the system via CenProv ticketing system. This information, once entered in Portico, is subsequently made available to all the subsystems. Attached is the data entry form for CenProv.

- File "**3. Provider Data Form.PDF1.pdf**"

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

Required Actions: None.

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Requirement	**Supporting Documentation**	**Score**
4. The MCO 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 MCO 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 7.12.4.1.2-7.12.4.1.3	**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 MCO:** • XIII.4_Timely Filing Summary • XIII.4_NV.CLMS.10 **See above** • XIII.4_NV.ENC.01 **See above** • XIII.4_CC.PP.021 Clean Claims Policy • XIII.4_Claims Rejection Reason Reject • XIII.4_EDI SNIP Levels	☒ Met ☐ Not Met ☐ NA

MCO Description of Process: Silversummit Healthplan (Centene) uses EDI 837 I and P for Medical and Behavioral claims.

Our EDI is set at SNIP Level 5 Lite. Attached is the document that describes the SNIP levels (File "**4. EDI SNIP Levels.docx**). Claims are rejected for missing key data that is required for SNIP Level 5 Lite back to the provider (See attached File "**4. Claims Rejection Reason Reject.xlsx**). The provider does receive the information so that the claim can be submitted with corrected information. Any claims submitted out of time limit receive a timely filing denial. See attached report of File "**4. Timely Filing Summary.xlsx**"

- File "**4. EDI SNIP Levels.docx**" – explains EDI SNIP level definitions
- File "**4. Claims Rejection Reason Reject.xlsx**" – Provider claims rejected at source for not meeting the SNIP level edits
- File "**4. Timely Filing Summary.xlsx**" – Any claims that pass the SNIP edits but do not meet timely filing requirements are denied
- File "**4. CC.PP.021 Clean Claims Policy.pdf**" – Clean claim submission requirement in policy document
- File "**4. NV.CLMS.10.docx**" – Claims policy

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
5. The MCO must make all collected data *outlined in the Contract, DHCFP's electronic MoveIt reporting repository, or any successor repository, attachments, and guidance* available to the DHCFP and upon request to CMS. 42 CFR § 438.242(b)(4) Contract 7.12.4.1.4	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Encounter data submission requirements/reports • Encounter data acceptance/rejection reports **Evidence as Submitted by the MCO:** • XIII.5_ NV Encounters Acceptance Report **See above** • XIII.5_ NV-SSHP-Individual Submission Detail Report • XIII.5_ NV.ENC.01 • XIII.5_ NVSS Reporting Attestation 2022.05.27 • XIII.5_ Report Frequency List_2022 MCO Contract_8.2.22 • XIII.5_MCO Reports to DHCFP SFTP Folders • XIII.5_MOVEit Folders • XIII.5_SFTP Folders	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: MoveIt was the file transfer application that was used before by the state to send and receive the information. This has been switched to the new sFTP process. We exchange variety of documents. Please see attached Encounter individual submission report from the site. File "**5. NV-SSHP-Individual Submission Detail Report.xlsx**" and Encounter Acceptance Report in File "**5. NV Encounters Acceptance Report.xlsx**" Also, attached are the reports that are submitted by compliance to SSHP. • File "**5. Report Frequency List_2022 MCO Contract_8.2.22.pdf**" List of standard reports provided to the state. In addition, please see the attached encounter policy, file "**5. NV.ENC.01.doc**"		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
Member Eligibility Database		
6. *The MCO's enrollment system is capable of linking records for the same member that are associated with different Medicaid and/or Nevada Check Up identification numbers (e.g., members who are re-enrolled and assigned new identification numbers).* Contract 7.12.3.1	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • HSAG will use the results from the information systems demonstration **Evidence as Submitted by the MCO:** • XIII.6_NV.ELIG.11_Eligibility_Guidelines_03.22.22 • XIII.6_Trucare Member Merge • XIII.6_UMV member merge	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Our member records system, UMV, captures all the key fields for the member including Medicaid ID, SSN, DOB, Name etc. These fields are used to identify a person and if the same person has multiple Medicaid IDs assigned then these members will be assigned the same MPI (Member Person ID). File "**6. UMV member merge.pdf**" shows the two members with the same MPI. One of the records is inactive with the end date of the span and the new record is active. In TruCare, the system for population health, has a process to merge the two records so that all the clinical information may be combined into one for the holistic view of the member. File "**6. TruCare Member Merge.jpg**" shows the system capability to merge the two members. Also, attached are the reports that are submitted by compliance to SSHP. File "**6. NV.ELIG.11_Eligibility_Guidelines_03.22.22.docx**" Eligibility policy.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
Application Programming Interface		
7. The MCO 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 MCO. 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 MCO; e. Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) business day after the effective date of any such information or updates to such information. 42 CFR §438.242(b)(5) 42 CFR §431.60 Contract 7.12.6; 7.12.6.1.1-7.12.6.1.4	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • API project plan(s) • API documentation • HSAG will use the results from the API demonstration **Evidence as Submitted by the MCO:** • XIII.7_CC_MBRS_36_Member_Secure_Web_Portal_May_2022 • XIII.7_Member Pharmacy Portal • XIII.7_Member Portal - PDL Link • XIII.7_Member Portal 1-Home • XIII.7_Member Portal 2-Home • XIII.7_Member Portal 3-Overview • XIII.7_Member Portal 4-Health Alert • XIII.7_Member Portal 5-Let Us Know • XIII.7_Member Portal 6-Authorization • XIII.7_Member Portal 7-Care Plus • XIII.7_Member Portal 8-Claims • XIII.7_Member Portal 9-Claims Search • XIII.7_Preferred_DL_FORMULARY-SilverSummitHealthPlan_Nevada	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Each member who is assigned to SilverSummit HealthPlan has their own secure member portal access where they are able to see their: • Adjudicated claims with payment decision with provider name, file "**7. Member Portal 8-Claims.jpg**" • Authorizations can be viewed, "**7. Member Portal 6-Authorizations.jpg**" • They can also see all claims for vision via this portal, "**7. Member Portal 9-Claims Search.jpg**" • Also, members can access the list of preferred drugs, "**7. Preferred_DL_FORMULARY-SilverSummitHealthPlan_Nevada.pdf**", "**7. Member Portal - PDL Link.jpg**" or link: https://www.silversummithealthplan.com/content/dam/centene/Nevada/Medicaid/PDFs/Preferred_DL_FORMULARY-SilverSummitHealthPlan_Nevada.pdf • "**Member Portal 1-Home.jpg**" and "**Member Portal 2-Home.jpg**" member home screen with PCP, ID card image, account status, etc • "**Member Portal 3-Overview.jpg**" displays members PCP, address and phone number • "**Member Portal 4-Health Alert.jpg**", "**Member Portal 5-Let Us Know.jpg**" provide our members with information on their health and tools that help us manage their care • "**Member Portal 5-Authorizations.jpg**" members see their authorizations and "**Member Portal 6-Care Plus.jpg**" displays their current care plan		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** The documents initially submitted as evidence of compliance did not relate to the requirements of this element. Discussion during the site review and follow-up documents submitted by the MCO confirmed compliance with the Patient Access API. As such, HSAG recommends that the MCO conduct ongoing education with internal staff members, including member-facing staff members, of the Patient Access API and its functionality. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
8. The MCO 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 7.8.8.3-7.8.8.4	**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 MCO:** • XIII.8_FAP Link • XIII.8_NV.PRVR.19_-_Provider_Directory_Portico • XIII.8_Primary Care Physician Change Form • XIII.8_Provider Directory 1-Practitioner • XIII.8_Provider Directory 2-Practitioner • XIII.8_Provider Directory 3-Facility • XIII.8_Provider Directory 4-Facility • XIII.8_NV_PRVR_26_Additions_and_Demographic_Changes_6.2022	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SilverSummit Health Plan has a published provider directory https://findaprovider.silversummithealthplan.com/ File "**8. FAP Link.rtf**" Here, members can see providers "**8. Provider Directory 3-Facility.JPG**", "**8. Provider Directory 4-Facility.JPG**" and practitioners "**8. Provider Directory 1-Practitioner.JPG**", "**8. Provider Directory 2-Practitioner.JPG**". Here all information can be seen including specialist or PCP indicator, specialty, ages serviced, provider's web/URL (where available), new patient indicator, board certifications, street address, phone number, available hours as well cultural and linguistic capabilities, languages spoken by physician and staff, cultural training and accommodations for members with physical disabilities. File "**8.NV_PRVR_26_Additions_and_Demographic_Changes_6.2022**" is our policy for providers additions and demographic changes		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** The documents initially submitted as evidence of compliance did not relate to the requirements of this element. Discussion during the site review and follow-up documents submitted by the MCO confirmed compliance with the Provider Directory API. As such, HSAG recommends that the		

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Requirement	**Supporting Documentation**	**Score**
MCO conduct ongoing education with internal staff members, including member-facing staff members, of the Patient Access API and its functionality. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
Member Encounter Data		
9. The MCO must collect and maintain sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members. 42 CFR §438.242(c)(1) Contract 7.12.4	**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 MCO:** • XIII.9_NV.CLMS.10 **See above** • XIII.9_CC.CLMS.10 **See above** • XIII.9_CC.PP.021 Clean Claims Policy **See above**	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Attached are the three claims policies that are used in processing a claim. Corporate claims policy has 6 steps of adjudication, one of which is the provider eligibility. That section defines all the requirements that are verified when the claim is received. NV Addendum defines the contract requirements for processing timelines for completion. In addition, clean claim policy discusses the requirements for clean claim. Reimbursement section has specific focus on provider but overall policy has other requirements for clean claim.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
10. The MCO must submit member encounter data to DHCFP *within ninety (90) calendar days of receipt of the encounter and in the appropriate CMS-1500 and UB-04 format or an alternative format if prior approved by DHCFP,* based on program administration, oversight, and program integrity needs.	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Encounter data submission requirements • Three concurrent encounter submissions compliance reports (acceptance/rejection reports)	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
a. The member encounter data must include all DHCFP-specific requirements for encounter data submissions, including allowed amount and paid amount, that DHCFP is required to report to CMS under 42 CFR §438.818. b. The member encounter data must be submitted to DHCFP in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate. 42 CFR §438.242(c)(2-4) Contract 7.12.4.2-7.12.4.8	• Excerpts of encounter data files for professional, institutional, and pharmacy **Evidence as Submitted by the MCO:** • XIII.10_NV.ENC.01 **See above** • XIII.10_Encounter Institutional 837I MCO Companion Guide - Mod_April2021 • XIII.10_ Encounter Professional 837P MCO Companion Guide - Mod_April2021 • XIII.10_NCPDP_Encounter_Companion_Guide 2020 • XIII.10_Encounter Acceptance Summary Jan-May 2022 **See above** • XIII.10_EncounterWorkFlow • XIII.10_NV-SSHP-Individual Submission Detail Report	
MCO Description of Process: Encounters are submitted weekly to DHCFP and our encounter acceptance rates are at high 99%. In addition, to submission we also review the status of challenges monthly with DHCFP Encounters team. Attached is the Encounter Policy (**10.NV.ENC.01.doc**), DHCFP companion guides used for encounter submission for Institutional, Professional and Pharmacy claims. We have also attached the Encounter Acceptance Summary Report that demonstrates our acceptance. We also have submitted three individual submissions reports to demonstrate the daily success and rejections.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** The MCO 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 MCO paid/denied a clean claim on day 90, the 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 are submitted to DHCFP, the MCO 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 MCO 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 MCO 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.		

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Requirement	**Supporting Documentation**	**Score**
Claims Payment		
11. *The MCO has written policies and procedures for processing claims submitted for payment from any source and shall monitor its compliance with these procedures.* Contract 7.7.1.5-7.7.1.7	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Claims processing guidelines • HSAG will use the results from the information systems demonstration **Evidence as Submitted by the MCO:** • XIII.11_CC.CLMS.10 **See above** • XIII.11_NV.CLMS.10 **See above** • XIII.11_2022 Provider Billing Manual SSHP **See above** • XIII.11_Monthly Claims Receipts + EDI + Paper	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The claims processing guidelines and timelines are described in policies, file "**11. CC.CLMS.10.docx**" and "**11. NV.CLMS.10.docx**". SSHP (Centene) accepts claims via clearinghouses, web portal, and paper. Instruction for submission of claims can be found in the provider billing manual, file "**11. 2022 Provider Billing Manual SSHP.pdf**". File "**11. Monthly Claims Receipts + EDI + Paper.jpg**" provides evidence of monthly claims receipts by source.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Information Technology System for Care Management Programs		
12. *The MCO's information technology system for its Care Management program maximizes the opportunity for communication between the MCO, PCP, the member, other service providers, and case managers.* Contract 7.5.6.8.1	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • HSAG will use the results from the information systems demonstration **Evidence as Submitted by the MCO:**	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• XIII.12_CC.CM.01_Care_Management_Program_Description_022022 • XIII.12_CM and PCP Notes Feb., March and April 2022 • XIII.12_TruCare Screenshot	

MCO Description of Process: The Health Information System that SilverSummit Healthplan utilizes is called TruCare. This system is integrated to include all aspects of care management, utilization management, and service authorizations. Care managers are able to document communication between the Healthplan and its members, as well as communication between the Healthplan and the members' providers. Every member enrolled in care management has a unique file within the system specific for their care management. In addition to care management components, the care manager is also able to access any aspects of the members' service authorizations and utilization management records, which include inpatient records and outpatient authorizations. The following excerpt is taken from the Healthplan's Care Management Program Description, on page 9 (which is also included as evidence):

Care Management Information System

Assessments, care plans, and all care management activities are documented in a clinical documentation system. The centralized clinical documentation system facilitates automatic documentation of the individual user's name, along with date and time notations for all entries. The clinical documentation system also allows the care team to generate reminder/task prompts for follow-up according to the timelines established in the care plan. Reminders/tasks can be sent to any team member, e.g., allowing care managers to request that non-clinical staff arrange for referrals to community resources.

The clinical documentation system contains additional clinical information, e.g., inpatient admissions, outpatient referral authorizations, reviews by Medical Directors, etc. related to the member. In addition, the clinical documentation system enables the care manager to add all providers and facilities associated with the member's case to a list which allows the information to be readily available without having to review authorization and referral data. These features permit the care team to easily access all clinical information associated with a member's case in one central location.

The clinical documentation system has a biometric data reporting feature that can be utilized to manage members on a daily and ongoing basis. It contains modules that allow graphing of measures such as blood pressure, lab values, daily weights, etc. which can be used to track progress and measure effectiveness of care management interventions.

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

Required Actions: None.

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Requirement	**Supporting Documentation**	**Score**
13. *The MCO has an integrated database that allows MCO staff that may be contacted by a member in Case Management to have immediate access to and review of the most recent information within the MCO's information systems relevant to the case, including the MCO's 24-hour Nurse Line. The integrated database must include all of the following:* a. *Administrative data* b. *Call center communications (contact tracking)* c. *Service authorizations* d. *HL7 inpatient and ER notifications* e. *Person centered care treatment plans* f. *Patient assessments* g. *Case management notes* Contract 7.5.6.8.2; 7.5.6.8.4	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • HSAG will use the results from the information systems demonstration **Evidence as Submitted by the MCO:** • XIII.13_Administrative Data - Member Demographics • XIII.13_Call Center Communication Evidence 03-22 • XIII.13_Care plan example 2022 • XIII.13_CC.CM.01-Care Management Program Description 022022 • XIII.13_CM and PCP Notes Feb., March and April 2022 • XIII.13_ER Notification 01-22 - 04-22 V2 • XIII.13_HL7 Inpatient Data and Outpatient Service Auth example • XIII.13_TruCare Screenshot • XIII.13_NV.CM.02 Care Coordination Care Management Services 11-21 • XIII.13_Patient Assessment May 2022	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Health Information System that SilverSummit Healthplan utilizes is called TruCare. This system is integrated to include all aspects of care management, utilization management, and service authorizations. By utilizing TruCare, the Healthplan's staff has immediate access to the member's information including any information relevant to the member's case. Care managers are able to access administrative data, service authorizations for both inpatient admissions and outpatient services, the person-centered care treatment plans, patient assessments and case management notes. Utilization management staff also has the ability to submit referrals to Case Management using Trucare (see also Care Management / Care Coordination Services Policy NV.CM.02, page 6). Call center communications are also found in TruCare, in the Note section of the system. The call center is managed by the Healthplan's parent company's (Centene, Corp.) Disease Management department (and is located out of AZ); log reports are sent daily to the Care Management Department. This service is provided to the members 24 hours per day 7 days per week. ER notifications are not found in TruCare because there are no authorization requests required of this service, however, monthly reports are provided to the Care Management department. Reports are		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
reviewed and high utilizers are identified for care management. Every member enrolled in care management has a unique file within the system specific for their care management needs, and is accessible to all care management staff, ranging from the nurse case manager to the program specialist / social worker and to the non-clinical support staff. The following excerpt is taken from the Healthplan's Care Management Program Description, on page 9 (which is also included as evidence): **Care Management Information System** Assessments, care plans, and all care management activities are documented in a clinical documentation system. The centralized clinical documentation system facilitates automatic documentation of the individual user's name, along with date and time notations for all entries. The clinical documentation system also allows the care team to generate reminder/task prompts for follow-up according to the timelines established in the care plan. Reminders/tasks can be sent to any team member, e.g., allowing care managers to request that non-clinical staff arrange for referrals to community resources. The clinical documentation system contains additional clinical information, e.g., inpatient admissions, outpatient referral authorizations, reviews by Medical Directors, etc. related to the member. In addition, the clinical documentation system enables the care manager to add all providers and facilities associated with the member's case to a list which allows the information to be readily available without having to review authorization and referral data. These features permit the care team to easily access all clinical information associated with a member's case in one central location. The clinical documentation system has a biometric data reporting feature that can be utilized to manage members on a daily and ongoing basis. It contains modules that allow graphing of measures such as blood pressure, lab values, daily weights, etc. which can be used to track progress and measure effectiveness of care management interventions. **Please Note:** The ER Notification Report is over 500 pages long, so a screenshot has been provided of each tab (tab 1- visit totals and tab 2 - diagnoses). The report includes the names of members and how many times they were in the ER per month along with a grand total. The names which would typically appear in the first column, have been hidden, so each line seen on the report represents one member. The second tab of the report lists all of the ER diagnoses.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

<table>
<tr><th colspan="3">Standard XIII—Health Information Systems</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td>Electronic Visit Verification</td><td></td><td></td></tr>
<tr><td rowspan="2">14. The MCO implements the State's contracted Electronic Visit Verification (EVV) system for the following services:
a. Personal Care Services, upon the Contract go-live date.
b. Home Health Services, no later than January 1, 2023.
c. Any additional services identified by DHCFP.

Contract 7.12.7</td><td>HSAG Recommended Evidence:
• Policies, procedures, and workflows
• HSAG will use the results from the information systems demonstration</td><td rowspan="2">☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td>Evidence as Submitted by the MCO:
• XIII.14_CC.LTSS.CM.09_Electronic_Visit_Verification
• XIII.14_EVV Summary Report
• XIII.14_EVV</td></tr>
<tr><td colspan="3">MCO Description of Process: EVV system has been implemented in coordination with the state. The system is operational. File "14. Silver Summit Authenticare Data Flow Diagram.pptx" shows the data flow and file "14.CC.LTSS.CM.09_Electronic_Visit_Verification.doc" has the EVV policy. Also see the report of providers paid/denied during the audit period "14.EVV Summary Report.xlsx"</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, sub-element (b) was not applicable to the time period of review.</td></tr>
<tr><td colspan="3">Required Actions: None.</td></tr>
</table>

<table>
<tr><th colspan="7">Standard XIII—Health Information Systems</th></tr>
<tr><td>Met</td><td>=</td><td>14</td><td>X</td><td>1</td><td>=</td><td>14</td></tr>
<tr><td>Not Met</td><td>=</td><td>0</td><td>X</td><td>0</td><td>=</td><td>0</td></tr>
<tr><td>Not Applicable</td><td>=</td><td>0</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Total Applicable</td><td>=</td><td>14</td><td colspan="2">Total Score</td><td>=</td><td>14</td></tr>
<tr><td colspan="5">Total Score ÷ Total Applicable</td><td>=</td><td>100%</td></tr>
</table>

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
General Rules		
1. The MCO 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 MCO, 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 7.9.2.1	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan **Evidence as Submitted by the MCO:** • XIV.1_2021 Quality Work Plan • XIV.1_2022 Quality Work Plan • XIV.1_2022 Quality Program Description • XIV.1_MCO_PIP-Val_Module 4_PPC_submission Form • XIV.1_MCO_PIP-Val_Module 4_Validation DM • XIV.1_Module 1 HbA1c Poor Control Greater Than 9.0 • XIV.1_Module 2 HbA1c Poor Control Greater Than 9.0 • XIV.1_Module 2 Timeliness of Prenatal Care • XIV.1_Module 3 HgbA1c Poor Control Greater than 9.0% Intervention 2 • XIV.1_Module 3 HgbA1c Poor Control Greater than 9.0% Intervention • XIV.1_Module 3 Timeliness of Prenatal Care Intervention • XIV.1_PIP-Val_Module 4_Submission-HgbA1c Poor Control • XIV.1_PPC MCO_PIP-Val_Module 4_Validation • XIV.1_Process Map Identification and Outreach • XIV.1_Process Map Identifying Members with Poor Control HgbA1c	☒ Met ☐ Not Met ☐ NA

MCO Description of Process: QAPI is updated annually based on prior years activities, challenges, barriers, and areas of opportunity
- 2022 QAPI includes systematic activities to monitor and evaluate the care delivered to members according to predetermined, objective standards and effect improvements as needed (full document details out the requirements)

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
2. *The MCO must submit a QAPI program description and progress report using the template required by DHCFP by March 30 annually. The program description must:* a. *Encompass all levels of the MCO's organization.* b. *Have a clear linkage to DHCFP's Quality Strategy.* Contract 7.9.2.5	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan • Evidence of QAPI program submission to DHCFP **Evidence as Submitted by the MCO:** • XIV.2_2022 QAPI Program Description (throughout, pgs. 11-41) • XIV.2_Email Submission of QAPI • XIV.2_2021 Quality Work Plan • XIV.2_2022 Quality Work Plan	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: • The 2022 QAPI Program Description was submitted to DHCFP by 3/30/22 on the new template provided. The Program Description encompasses all levels of SilverSummit's organization (pages 11-41), and demonstrates a clear linkage to DHCFP's Quality Strategy.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Basic Elements of QAPI Programs		
3. *The written QAPI program description must contain a detailed set of quality assurance objectives that are developed annually and include a timetable for implementation and accomplishment.* Contract 7.9.3.1.1	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan **Evidence as Submitted by the MCO:** • The 2021 and 2022 QAPI work plans	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• XIV.3_2022 QAPI Program Description (pg. 11) • XIV.3_2021 Quality Work Plan • XIV.3_2022 Quality Work Plan	
MCO Description of Process: • The 2022 QAPI Program Description details our quality assurance objectives that are reviewed and updated annually, and the Work Plan details a timetable for implementation and accomplishment (see page 11).		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
4. *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 7.9.3.2.1	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan **Evidence as Submitted by the MCO:** • XIV.4_2022 QAPI Program Description (pgs. 4-7; 52-55) • XIV.4_Secret Shop March • XIV.4_Secret Shop Track and Trend 2022 • XIV.4_May 2022 • XIV.4_NV.QI.05_Evaluation_of_the_Accessibility_of_Services • XIV.4_PHM 2BC PHM Annual Population Assessment MCD • XIV.4_Program Integrity Monthly Report • XIV.4_Secret Shop February • XIV.4_Secret Shop January	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• XIV.4_2021 Continuity and Coordination of Between Medical Care and Behavioral Healthcare • XIV.4_2021 Continuity and Coordination of Medical Care • XIV.4_2021 Quality Work Plan • XIV.4_2022 Quality Work Plan	
MCO Description of Process: Annually, SilverSummit analyzes coordination and continuity of care between PCP and Specialist and PCP and BH providers to determine areas of opportunity, barriers, and challenges. Continuity and Coordination Process and Monitoring report is for 2021 as the period under review is too short a period to fully assess for 2022. • The 2022 QAPI Program Description outlines the scope and includes availability, accessibility, coordination, and continuity of care • The 2021 and 2022 QAPI Work Plan shows activities to address availability, accessibility, coordination, and continuity of care • The Secret Shopper files include calls, track and trend report, and provider action		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** HSAG recommends that the MCO enhance the QAPI workplan objectives by incorporating specific measurable goals and/or thresholds. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
5. *The written QAPI program description provides for continuous performance of the activities, including tracking of issues over time.* Contract 7.9.3.4	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan **Evidence as Submitted by the MCO:** • XIV.5_2022 QAPI Program Description (pgs. 3-4; 55-57) • XIV.5_2021 Quality Work Plan • XIV.5_2022 Quality Work Plan	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: • The 2022 QAPI Program Description details continuous performance of activities including tracking of issues (see pages 3-4; 55-57)		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
• The 2021 and 2022 QAPI Work Plans demonstrate activities that were implemented for continuous improvement		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
6. The QAPI program must include mechanisms to assess both underutilization and overutilization of services *and appropriate follow up.* a. *If fraud and abuse is suspected, a referral was made to the MCO's program integrity unit and DHCFP Surveillance and Utilization Review (SUR) Unit for appropriate action.* 42 CFR §438.330(b)(3) Contract 7.9.4.5.4	**HSAG Recommended Evidence:** • QAPI program description • Policies and procedures • 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 MCO:** • XIV.6_MME_BENCHMARK for overutilization • XIV.6_2022 QAPI Program Description (pgs. 6; 24-25; 55) • XIV.6_Disallow Reasons and Education • XIV.6_Final Report SIU • XIV.6_March Agenda • XIV.6_SIU Investigation case on over utilization • XIV.6_SIU March Meeting Minutes • XIV.6_CC.UM.01.03_Monitoring_Utilization	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: • The 2022 QAPI Program Description (pages 6, 24-25, and 55) describe under and over utilization performance improvement activities, committee focus on under and over utilization, and QAPI scope details focusing on over/under utilization		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

<table>
<tr><th colspan="3">Standard XIV—Quality Assessment and Performance Improvement Program</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td rowspan="2">7. The QAPI program must include mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs, as identified by DHCFP in the Quality Strategy.
a. The QAPI program methodology must provide for review of the entire range of care provided by the MCO, including services provided to Children with Special Health Care Needs (CSHCN), by assuring that all demographic groups, care settings (e.g., inpatient, ambulatory, including care provided in private practice offices and home care); and types of services (e.g., preventive, primary, specialty care, and ancillary) are included in the scope of the review.
b. The review of the entire range of care must be carried out over multiple review periods and not on a concurrent basis.
c. This review occurs no less than annually.

42 CFR §438.330(b)(4)
Contract 7.9.3.2.2</td><td>HSAG Recommended Evidence:
• QAPI program description
• Assessment tools
• Clinical guidance/criteria
• Metrics/performance measures to assess special health care needs</td><td rowspan="2">☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td>Evidence as Submitted by the MCO:
• XIV.7_2021 Continuity and Coordination of Between Medical Care and Behavioral Healthcare
• XIV.7_2021 Continuity and Coordination of Medical Care
• XIV.7_2021 Quality Program Evaluation Medicaid (pgs. 67; 69-76)
• XIV.7_2022 QAPI Program Description (pgs. 4-7)</td></tr>
<tr><td colspan="3">MCO Description of Process:</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCO met the requirements for this element.
Recommendations: While the QAPI program description contained a general statement that the plan will monitor and report on the coordination of healthcare services for members identified as CSHCN, HSAG recommends that the MCO enhance its QAPI program description to include additional details on how the MCO reviews the entire range of care provided by the MCO specific to members with special healthcare needs. Implementation of this recommendation will be evaluated during future compliance reviews.</td></tr>
<tr><td colspan="3">Required Actions: None.</td></tr>
</table>

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
8. 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) Contract 7.9.3.2.3	**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 MCO:** • XIV.8_2022 QAPI Program Description (pgs. 4 and 7) • XIV.8_Functional Assessment Instructions • XIV.8_Functional_Assessment_Form • XIV.8_PCS Transfer Form	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Adequate Resources		
9. *The QAPI program must have sufficient material resources and staff with the necessary education, experience, or training to effectively carry out its specified activities.* a. *The MCO dedicates sufficient staff to fulfill the MCO's set of clearly defined functions and responsibilities, so that staffing is proportionate to and adequate for the planned number of and types of quality improvement (QI) initiatives within the managed care program.* b. *A QI Manager is dedicated to the managed care program with reporting authority to the MCO's medical director.*	**HSAG Recommended Evidence:** • QAPI program description • Quality staffing structure/organizational chart • Job descriptions • Training materials **Evidence as Submitted by the MCO:** • XIV.9_2021_EPSDT_Program_Descripton • XIV.9_HEDIS_Coordinator • XIV.9_2022 QAPI Program Description (pgs. 41-42; 44-46	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Contract 7.9.4.13; 7.9.4.13.1	• XIV.9_Accreditation_Specialist • XIV.9_Chief_Medical_Officer • XIV.9_Clinical_Appeals_Coordinator • XIV.9_Data_Analyst_I_(Healthcare_Analytics) • XIV.9_Grievance_and_Appeals_Coordinator • XIV.9_Manager, AG • XIV.9_Manager_HEDIS_Operations_(Non-Clinical) • XIV.9_Manager_Quality_Improvement • XIV.9_Provider_Quality_Liaison • XIV.9_Quality_Improvement_Coordinator • XIV.9_Senior_Quality_Improvement_Specialist • XIV.9_Training 2022 BH At-A-Glance Provider Toolkit • XIV.9_Vice_President_Quality_Improvement • XIV.9_Centene U HEDIS Training • XIV.9_Centene U PIP • XIV.9_Quality Organizational Chart • XIV.9_Centene U Quality of Care • XIV.9_Centene U RA • XIV.9_HEDIS 101 • XIV.9_HEDIS MY 2022 Measure Testing • XIV.9_NCQA Centene U Training	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
10. *The MCO must have QI teams composed of MCO staff fully dedicated to the managed care program that represent the following areas of expertise:* a. *Continuous quality improvement.* b. *Analytics.* c. *Subject matter expertise in clinical and/or nonclinical improvement topic(s) being addressed through improvement efforts.* d. *Health equity.* e. *The MCO's policies and processes related to the improvement topic.* f. *Member and provider perspectives (may be staff or liaisons with the MCO's member and provider services departments).* Contract 7.9.4.13.2; 7.9.4.13.2.1-7.9.4.13.2.6	**HSAG Recommended Evidence:** • QAPI program description • Quality staffing structure/organizational chart **Evidence as Submitted by the MCO:** • XIV.10_2022 QI Program Description (pgs. 41-42; 44-46) • XIV.10_Quality Organizational Chart	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Healthcare Effectiveness Data and Information Set (HEDIS®)[A-1] Coordinators and/or PQL staff are paired with a provider relations representative to be the liaison between the member and provider services department and quality. The HEDIS and/or PQL staff joined the provider relations representative on meetings, visits, or Joint Operating Committee meetings with providers as the quality representative.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

[A-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Quality Assurance Committee		
11. *At a minimum, the MCO's quality committee structure must include the following committees:* a. *Executive Committee* b. *Quality Management Committee that reports to the Executive Committee* c. *Utilization Management (UM) Subcommittee that reports to the Quality Management Committee* d. *Care Management Subcommittee that reports to the Quality Management Committee* e. *Member Services Subcommittee that reports to the Quality Management Committee* f. *Member Advisory Board that reports to the Quality Management Committee* g. *Provider Services Subcommittee that reports to the Quality Management Committee* h. *Provider Advisory Board that reports to the Quality Management Committee* Contract 7.9.4.11.1; 7.9.4.11.1.1-7.9.4.11.1.8	**HSAG Recommended Evidence:** • QAPI program description • Quality committee structure **Evidence as Submitted by the MCO:** • XIV.11_Q2 2022 BOD Minutes • XIV.11_2021 Q4_QIC Meeting Minutes • XIV.11_Q2 2022 MAC Meeting Minutes • XIV.11_SSHP Board of Directors Q1 2022 Minutes • XIV.11_SSHP Board of Directors Q4 2021 Minutes • XIV.11_Q1 2022 MAC meeting minutes • XIV.11_2022 Q1_QIC Meeting Minutes • XIV.11_2022 Q2_QIC Meeting Minutes • XIV.11_2022 QAPI Program Description (pgs. 9-11; 12-16; 18-20; 23-26; 28-33) • XIV.11_PAC Meeting Minutes Oct 2021 • XIV.11_PAC_March 23 2022_Meeting • XIV.11_Q1 2022 Member Advisory Board Minutes • XIV.11_Q1 2022 MAC meeting minutes (2) • XIV.11_Q1 2022 PHMCO Meeting Minutes • XIV.11_Q2 2022 Member Advisory Board Minutes • XIV.11_Q2 SSHP Board of Directors Slide Deck • XIV.11_Q4 2021 MAC meeting minutes	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• XIV.11_Q4 2021 PHMCO Meeting Minutes • XIV.11_Q2 2022 PHMCO Meeting Minutes	
MCO Description of Process: Member Advisory Board is new for contract, and we had meeting in Q1 but I included Q2 even though occurred outside audit period as it occurred in June; For all Committees generally only have had 1 during review period but I added previous 2021 quarters so you would have and Q2 2022 as some meetings occurred after 5/1/22. Note-We have not held Q2 PAB as providers were not available so moved to July 2022 but will conduct 4 in 2022		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
12. *The structure/committee meets on a regular basis with a specified frequency, no less than quarterly to oversee QAPI program activities.* a. *This frequency is sufficient to demonstrate that the structure/committee is following up on all findings and required actions.* Contract 7.9.4.11.2	**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 MCO:** • XIV.12_Q2 2022 BOD Minutes • XIV.12_2021 Q4_QIC Meeting Minutes • XIV.12_2022 Q1 BOD Slides • XIV.12_2022 QAPI Program Description (pgs. 12-41) • XIV.12_Q2 2022 MAC Meeting Minutes • XIV.12_SSHP BOD Q1 2022 Minutes • XIV.12_SSHP BOD Q4 2021 Minutes • XIV.12_2021 Q4 BOD Slides • XIV.12_2021 Q4_PAC PAB Meeting Minutes	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• XIV.12_2022 Q1_QIC Meeting Minutes • XIV.12_PHMCO Meeting Minutes Q4 2021 • XIV.12_Q1 2021 PHMCO Meeting Minutes • XIV.12_Q1 2022 MAB Minutes • XIV.12_Q1 2022 MAC meeting minutes • XIV.12_Q1 2022 PAB meeting minutes • XIV.12_Q2 2022 _QIC Meeting Minutes • XIV.12_Q2 2022 MAB Minutes • XIV.12_Q2 2022 PHMCO Meeting Minutes • XIV.12_Q2 SSHP Board of Directors Slide Deck • XIV.12_Q4 21 MAC meeting minutes	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
13. *There is active participation in the QAPI committee from network providers, who are representative of the composition of the MCO's network.* a. *The MCO includes providers on, at a minimum, the UM and Provider Services Subcommittees.* Contract 7.9.4.11.6; 7.9.4.14.4	**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 MCO:** • XIV.13_2021 Q4_QIC Meeting Minutes	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**

	• XIV.13_2022 QAPI Program Description
	  ○ PHM/CO (UM and CM committee) (pgs. 23-26)
	  ○ Provider Services (pgs. 28-30)
	  ○ Structure (pgs. 12-13)
	  ○ Committee Charters (pgs. 12-41)
	• XIV.13_Q1 2022 PHMCO Meeting Minutes
	• XIV.13_Q1 Member Advisory Board Minutes
	• XIV.13_Q2 2022 MAC Meeting Minutes
	• XIV.13_Q2 2022 PHMCO Meeting Minutes
	• XIV.13_Q4 2021 PHMCO Meeting Minutes
	• XIV.13_2022 Q1_QIC Meeting Minutes
	• XIV.13_PHMCO Meeting Minutes Q4 2021
	• XIV.13_Q1 2022 MAC meeting minutes
	• XIV.13_Q1 2022 PAB meeting minutes
	• XIV.13_Q2 2022 Member Advisory Board Minutes
	• XIV.13_Q2_QIC Meeting Minutes
	• XIV.13_Q4 21 MAC meeting minutes
	• XIV.13_Q4 2021 PAC Meeting Minutes	

MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

<table>
<tr><th colspan="3">Standard XIV—Quality Assessment and Performance Improvement Program</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td>14. The Provider Advisory Board has broad representation of Provider types in the Network, including at least:
a. One (1) PCP serving children and adolescents;
b. One (1) PCP serving adults;
c. One (1) OB/GYN;
d. One (1) psychiatrist;
e. One (1) licensed Behavioral Health clinical professional;
f. One (1) substance abuse professional;
g. One (1) community-based Care Coordinator or community Case Manager serving a Network Provider;
h. One (1) peer support specialist or a Behavioral Health Case Manager; and
i. Other practitioners, such that there is broad representation from across the geographic service area under the Contract.

Contract 7.9.4.14.6</td><td>HSAG Recommended Evidence:
• QAPI program description
• Quality committee structure
• Provider Advisory Board charter, including a listing of provider names and specialties who serve on the Provider Advisory Board
• Three consecutive committee meeting minutes for the Provider Advisory Board

Evidence as Submitted by the MCO:
• XIV.14_2022 QAPI Program Description (pgs. 28-29)
• XIV.14_PAB Committee Roster
• XIV.14_PAC Q1 2022 PAB meeting minutes</td><td>☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td colspan="3">MCO Description of Process: The Provider Advisory Board is a new contract requirement for 2022 and only 1 committee meetings prior to having to submit evidence to HSAG. The June meeting had to be rescheduled for July due to provider availability, but we will ensure four meetings occur in 2022.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the MCO received a Met score for this element as the MCO has been actively recruiting network providers to serve on its Provider Advisory Board. Additionally, due to the shortened review period, only one quarterly meeting occurred during the time period under review.
Recommendations: HSAG strongly recommends that the MCO have strategies in place to ensure the MCO has and continues to have broad representation of network providers who actively participate in the Provider Advisory Board to maintain compliance with the requirements for this element. The MCO's implementation of this recommendation will be evaluated during future compliance reviews.</td></tr>
<tr><td colspan="3">Required Actions: None.</td></tr>
</table>

<table>
<tr><th colspan="3">Standard XIV—Quality Assessment and Performance Improvement Program</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td rowspan="2">15. The Provider Advisory Board meets quarterly with minutes submitted to DHCFP within thirty (30) calendar days of the meeting.

Contract 7.9.4.14.7</td><td>HSAG Recommended Evidence:
• QAPI program description
• Quality committee structure
• Provider Advisory Board charter
• Three consecutive committee meeting minutes for the Provider Advisory Board
• Evidence of submission of each set of minutes to DHCFP</td><td rowspan="2">☐ Met
☒ Not Met
☐ NA</td></tr>
<tr><td>Evidence as Submitted by the MCO:
• XIV.15_2022 QI Program Description (pgs. 28-29)
• XIV.15_Q1 2022 PAB Meeting Minutes</td></tr>
<tr><td colspan="3">MCO Description of Process: The Provider Advisory Board is a new contract requirement for 2022 and only 1 committee meetings prior to having to submit evidence to HSAG. The June meeting had to be rescheduled for July due to provider availability, but we will ensure four meetings occur in 2022.</td></tr>
<tr><td colspan="3">HSAG Findings: The MCO staff members confirmed during the site review that the MCO did not submit the Provider Advisory Committee meeting minutes to DHCFP within 30 calendar days of the meeting as required by contract.</td></tr>
<tr><td colspan="3">Required Actions: The MCO must ensure that the Provider Advisory Board meets quarterly with minutes submitted to DHCFP within 30 calendar days of the meeting.</td></tr>
<tr><td rowspan="2">16. The MCO develops a Member Advisory Board comprised of a minimum of twelve (12) members or members' designated legal representatives from across the geographic service area under the Contract.

Contract 7.9.4.15.4</td><td>HSAG Recommended Evidence:
• QAPI program description
• Quality committee structure
• Member Advisory Board charter, including a listing of all members who serve on the Member Advisory Board
• Three consecutive committee meeting minutes for the Member Advisory Board</td><td rowspan="2">☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td>Evidence as Submitted by the MCO:
• XIV.16_2022 QAPI Program Description (pgs. 30-31)
• XIV.16_MAB Committee Roster</td></tr>
</table>

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• XIV.16_Q1 Member Advisory Board Minutes • XIV.16_Q2 Member Advisory Board Minutes	
MCO Description of Process: Member Advisory Board is a new contractual requirement and we have only had 2 quarterly meetings prior to the evidence needing to be submitted to HSAG.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
17. *The Member Advisory Board meets quarterly with minutes submitted to DHCFP within thirty (30) calendar days of the meeting.* Contract 7.9.4.15.5	**HSAG Recommended Evidence:** • QAPI program description • Quality committee structure • Member Advisory Board charter • Three consecutive committee meeting minutes for the Member Advisory Board • Evidence of submission of each set of minutes to DHCFP **Evidence as Submitted by the MCO:** • XIV.17_2022 QAPI Program Description (pgs. 30-31) • XIV.17_MAB Committee Roster • XIV.17_Q1 2022 Member Advisory Board Meeting Minutes DHCFP Submission • XIV.17_Q2 2022 Member Advisory Board Meeting Minutes DHCFP Submission • XIV.17_Q1 2022 Member Advisory Board Minutes • XIV.17_Q2 2022 Member Advisory Board Minutes	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
18. *The MCO develops methods to encourage and ensure adequate member participation in the quarterly Member Advisory Board meetings, including but not limited to:* a. *Accommodating virtual participation* b. *Providing meeting materials ahead of time* c. *Providing meeting materials in literacy level appropriate for participants* d. *Arranging transportation when appropriate* e. *Providing childcare when appropriate.* Contract 7.9.4.15.6	**HSAG Recommended Evidence:** • QAPI program description • Three consecutive committee meeting minutes for the Member Advisory Board • Processes to encourage and ensure member participation • Evidence as Submitted by the MCO: • XIV.18_2022 QAPI Program Description (pgs. 30-31) • XIV.18_Member Advisory Board Meeting calendar invite March • XIV.18_Member Advisory Board Meeting calendar invite • XIV.18_Q1 2022 Member Advisory Board Minutes • XIV.18_Q2 2022 Member Advisory Board Minutes	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: No evidence regarding process. Items that we can discuss		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** HSAG recommends that the MCO formally document the processes (e.g., teleconferencing, email invitations with meeting materials) currently in place that are used to encourage and ensure adequate member participation in quarterly Member Advisory Board meetings. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
Performance Measurement		
19. The QAPI program must include the collection and submission of performance measurement data. The MCO must annually: a. Measure and report to DHCFP on its performance, using the standard measures required by DHCFP;	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan • Performance measures reports • Evidence of submission of performance measurement reports to DHCFP (e.g., HEDIS Final Audit Report)	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
b. Submit to DHCFP data, specified by DHCFP, which enables DHCFP to calculate the MCO's performance using the standard measures identified by DHCFP; or c. Perform a combination of the activities described in subelements (a) and (b). 42 CFR §438.330(b)(2) 42 CFR §438.330(c) Contract 7.9.2.9-7.9.2.9.10	**Evidence as Submitted by the MCO:** • XIV.19_Denodo Process Flow for CDC_Poor Control_Males • XIV.19_2021 CABH UME_NV_Appendix • XIV.19_2021 MY HEDIS Rates CHIP • XIV.19_Frequent Flyers-Jan- April2022 • XIV.19_MCO_PIP-Val_Module 4_Validation DM • XIV.19_Medicaid HEIDS Rates • XIV.19_NV BH Datasheet • XIV.19_Module 1 Timeliness of Prenatal Care • XIV.19_2021 Quality Program Evaluation (pgs. 18-23) • XIV.19_2021_Quality_Work_Plan • XIV.19_2022 QAPI Program Description (pgs. 55-56) • XIV.19_MCO_PIP-Val_Module 4_PPC • XIV.19_MCO_PIP-Val_Module 4_PPC_submission Form • XIV.19_Module 1 HbA1c Poor Control Greater Than 9.0% • XIV.19_Module 2 HbA1c Poor Control Greater Than 9.0 • XIV.19_Module 2 Timeliness of Prenatal Care • XIV.19_Module 3 HgbA1c Poor Control Greater than 9.0% Intervention • XIV.19_Module 3 Timeliness of Prenatal Care Intervention • XIV.19_PIP-Val_Module 4_Submission-HgbA1c Poor Control • XIV.19_Process Map Identification and Outreach Timeliness of Prenatal care • XIV.19_Process Map Identifying Members with Poor Control HgbA1c • XIV.19_2022 Quality Work Plan	

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• XIV.19_MCO_PIP-Val_Module 4_Validation PPC	
MCO Description of Process: Behavioral Health Utilization Performance Metrics is for 2021 as these metrics are only done on an annual reporting. CABH monitors and reviews internally and can discuss during onsite if needed		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Performance Improvement Projects		
20. The QAPI program must include performance improvement projects (PIPs). a. *The MCO annually conducts and reports on a minimum of three (3) clinical PIPs and three (3) non-clinical PIPs.* i. *The MCO participates in one (1) statewide PIP focusing on reduction in African American maternal and infant morbidity and mortality as defined by DHCFP.* ii. *The MCO selects an additional two (2) projects from the list below, to serve as the MCO's required PIPs in accordance with 42 CFR §438.330(a)(2) and 42 CFR §438.358:* 1. *Increasing access to and use of primary care and preventive services across the covered population.* 2. *Improving quality of and access to Behavioral Health Services.* 3. *Reducing preventable thirty (30) day hospital readmissions.* 4. *Social determinants of health and health equity.* Note: Refer to Plan Year 2022 PIP Memorandum for MCOs from DHCFP 5-19-2022.	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan • Policies and procedures • PIP documentation for all active PIPs **Evidence as Submitted by the MCO:** • XIV.20_2022 QAPI Program Description (pgs. 55-56) • XIV.20_MCO_PIP-Val_Module 4_Validation DM • XIV.20_Module 1 HbA1c Poor Control Greater Than 9.0 • XIV.20_2021 Quality Program Evaluation (pgs. 18-23) • XIV.20_MCO_PIP-Val_Module 4_PPC_submission Form • XIV.20_Module 1 Timeliness of Prenatal Care • XIV.20_Module 2 HbA1c Poor Control Greater Than 9.0 • XIV.20_Module 2 Timeliness of Prenatal Care • XIV.20_Module 3 HgbA1c Poor Control Greater than 9.0% Intervention 1 • XIV.20_Module 3 HgbA1c Poor Control Greater than 9.0% Intervention 2 • XIV.20_Module 3 Timeliness of Prenatal Care Intervention	☐ Met ☐ Not Met ☒ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.330(b)(1) 42 CFR §438.330(d)(1) Contract 7.9.5.4-7.9.5.6	• XIV.20_NV.QI.12_Quality_PIPs • XIV.20_PIP-Val_Module 4_Submission-HgbA1c Poor Control • XIV.20_PPC PIP-Val_Module 4_Validation • XIV.20_PPC Process Map Identification and Outreach • XIV.20_Process Map Identifying Members with Poor Control HgbA1c • XIV.20_2022 Quality Work Plan	
MCO Description of Process: PIPs are for what ended in 2021 as of date we have not implemented new PIPs to HSAG training scheduled for August 2022. We will be implementing all 6 PIPs noted from Year 2022 PIP Memorandum for MCOS received on 5/19/22		
HSAG Findings: As DHCFP did not announce the required PIP topics to the MCOs until May 2022, HSAG has determined that the requirements of this element are not applicable. The MCO's compliance with these PIP requirements will be evaluated during future compliance reviews.		
Required Actions: None.		
21. 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. 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 DHCFP. d. Planning and initiation of activities for increasing or sustaining improvement. 42 CFR §438.330(d)(2) Contract 7.9.5.2; 7.9.5.2.1-7.9.5.2.4	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan • Policies and procedures • PIP documentation for all active PIPs **Evidence as Submitted by the MCO:** • XIV.21_MCO_PIP-Val_Module 4_Validation DM • XIV.21_Module 1 HbA1c Poor Control Greater Than 9.0 • XIV.21_2021 Quality Program Evaluation (pgs. 18-23) • XIV.21_2021_Quality_Work_Plan • XIV.21_2022 QI Program Description (pgs. 55-56) • XIV.21_MCO_PIP-Val_Module 4_PPC_submission Form • XIV.21_Module 1 Timeliness of Prenatal Care • XIV.21_Module 2 HbA1c Poor Control Greater Than 9.0	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• XIV.21_Module 2 Timeliness of Prenatal Care • XIV.21_Module 3 HgbA1c Poor Control Greater than 9.0% Intervention 2 • XIV.21_Module 3 HgbA1c Poor Control Greater than 9.0% Intervention • XIV.21_Module 3 Timeliness of Prenatal Care Intervention • XIV.21_NV.QI.12_Quality_PIPs • XIV.21_PIP-Val_Module 4_Submission-HgbA1c Poor Control • XIV.21_PPC PIP-Val_Module 4_Validation • XIV.21_PPC Process Map Identification and Outreach • XIV.21_Process Map Identifying Members with Poor Control HgbA1c • XIV.21_2022 Quality Work Plan	
MCO Description of Process: PIPs are for what ended in 2021 as of date we have not implemented new PIPs to HSAG training scheduled for August 2022. We will be implementing all 6 PIPs noted from Year 2022 PIP Memorandum for MCOS received on 5/19/22		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, while the QAPI Program Description and workplan included the requirements for this element, DHCFP did not announce the required PIP topics to the MCOs until May 2022. Therefore, HSAG did not evaluate implementation of the requirements under this element. The MCO's compliance with all PIP-related requirements will be evaluated during future compliance reviews.		
Required Actions: None.		
22. *The MCO's PIPs are described in the annual written QAPI program description and include:* a. *How the PIP relates to the MCO's other Population Health initiatives and DHCFP's Quality Strategy.* b. *The theory of change for each PIP (e.g., cause and effect diagrams, key driver diagrams).*	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan • PIP documentation for all active PIPs **Evidence as Submitted by the MCO:**	☐ Met ☐ Not Met ☒ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
c. *Criteria considered when choosing and prioritizing the MCO's PIPs by population stream.* d. *The MCO's evaluation strategy addressing the process, outcome, and balancing measures for each initiative, including:* i. *Baseline, milestones, and target goals.* ii. *Timeframes for baseline, milestones, and target goals.* iii. *Data sources.* iv. *Numerator and denominators for each measure.* v. *Frequency of measurement (e.g., daily, weekly, monthly)* Contract 7.9.5.8;7.9.5.8.1-7.9.5.8.4; 7.9.5.8.4.1-7.9.5.8.4.4	• XIV.22_MCO_PIP-Val_Module 4_Validation DM • XIV.22_Module 1 HbA1c Poor Control Greater Than 9.0 • XIV.22_2022 Quality Work Plan • XIV.22_2021 Quality Work Plan • XIV.22_2022 QAPI Program Description (pgs. 26-28; 47-50; 55-56) • XIV.22_MCO_PIP-Val_Module 4_PPC_submission Form • XIV.22_Module 1 Timeliness of Prenatal Care • XIV.22_Module 2 HbA1c Poor Control Greater Than 9.0 • XIV.22_Module 2 Timeliness of Prenatal Care • XIV.22_Module 3 HgbA1c Poor Control Greater than 9.0% Intervention 2 • XIV.22_Module 3 HgbA1c Poor Control Greater than 9.0% Intervention • XIV.22_Module 3 Timeliness of Prenatal Care Intervention • XIV.22_PIP-Val_Module 4_Submission-HgbA1c Poor Control • XIV.22_Process Map Identification and Outreach Timeliness of Prenatal care • XIV.22_Process Map Identifying Members with Poor Control HgbA1c • XIV.22_MCO_PIP-Val_Module 4_Validation Timeliness of Prenatal Care	
MCO Description of Process: We have not implemented 2022 Contract PIPs to date awaiting HSAG training on new PIP process. Evidence refers to how previous assigned PIPs were conducted.		
HSAG Findings: As DHCFP did not announce the required PIP topics to the MCOs until May 2022, HSAG has determined that the requirements of this element are not applicable. The MCO's compliance with these PIP requirements will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
23. The MCO must report the status and results of each PIP to DHCFP as requested, but not less than once per year. a. *Each PIP is 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 MCO's QAPI program.* 42 CFR §438.330(d)(3) Contract 7.9.2.8; 7.9.5.3	**HSAG Recommended Evidence:** • Evidence of annual submission, including the documentation that was submitted, of all PIPs to DHCFP **Evidence as Submitted by the MCO:** • XIV.23_2021 Quality Program Evaluation • XIV.23_MCO_PIP-Val_Module 4_Validation DM • XIV.23_Module 1 HbA1c Poor Control Greater Than 9.0 • XIV.23_MCO_PIP-Val_Module 4_PPC_submission Form • XIV.23_Module 1 Timeliness of Prenatal Care • XIV.23_Module 2 HbA1c Poor Control Greater Than 9.0 • XIV.23_Module 2 Timeliness of Prenatal Care • XIV.23_Module 3 HgbA1c Poor Control Greater than 9.0% Intervention 2 • XIV.23_Module 3 HgbA1c Poor Control Greater than 9.0% Intervention • XIV.23_Module 3 Timeliness of Prenatal Care Intervention • XIV.23_PIP-Val_Module 4_Submission-HgbA1c Poor Control • XIV.23_Process Map Identification and Outreach Timeliness of Prenatal care • XIV.23_Process Map Identifying Members with Poor Control HgbA1c • XIV.23_MCO_PIP-Val_Module 4_Validation Timeliness of Prenatal Care	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: PIPs were not assigned by the State during the lookback period therefore is not applicable		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, while the QAPI Program Description and 2021 annual evaluation included the requirements for this element, DHCFP did not announce the required PIP topics to the MCOs until May 2022. Therefore,		

<table>
<tr><th colspan="3">Standard XIV—Quality Assessment and Performance Improvement Program</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td colspan="3">HSAG did not evaluate implementation of the requirements under this element. The MCO’s compliance with all PIP-related requirements will be evaluated during future compliance reviews.</td></tr>
<tr><td colspan="3">Required Actions: None.</td></tr>
<tr><td colspan="3">Critical Incident Management System</td></tr>
<tr><td rowspan="2">24. 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).

42 CFR §438.330(b)(5)(ii)
Contract 7.9.14</td><td>HSAG Recommended Evidence:
• QAPI program description
• Critical incident policies and procedures
• Critical incident reports
• Committee meeting minutes
• Provider remediation plan template(s)</td><td rowspan="2">☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td>Evidence as Submitted by the MCO:
• XIV.24_NV.QI. 29 Critical Incident
• XIV.24_2022 QAPI Program Description (pgs. 6; 50-51)
• XIV.24_Critical Incident Report 1
• XIV.24_Critical Incident Report 2
• XIV.24_Critical Incident Report 4
• XIV.24_Email correspondence related to initial report Critical Incident 3</td></tr>
<tr><td colspan="3">MCO Description of Process:</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCO met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: None.</td></tr>
</table>

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
25. *The MCO must designate a Critical Incident Manager responsible for administering the incident management system and ensuring compliance with the requirements of Section 7.9.14 of the Contract.* a. *This position may be assigned as a responsibility to a lead within the quality department and may or may not be a full time equivalent (FTE).* Contract 7.9.14.1	**HSAG Recommended Evidence:** • QAPI program description • Quality staffing structure/organizational chart **Evidence as Submitted by the MCO:** • XIV.25_2022 QAPI Program Description (pgs. 6; 50-51) • XIV.25_Quality_Improvement_Coordinator_I • XIV.25_Quality Organizational Chart	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Centene does not have a job description specific for Critical Incident Manager, but duties are assigned to Quality Improvement Coordinator		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
26. The MCO develops and implements policies and procedures, subject to DHCFP review and approval, to: a. Address and respond to incidents. b. Report incidents to the appropriate entities per required timeframes. c. Track and analyze incidents. 42 CFR §438.330(b)(5)(ii) Contract 7.9.14	**HSAG Recommended Evidence:** • QAPI program description • Critical incident policies and procedures • Three examples of completed critical incident reports • Committee meeting minutes with aggregated critical incident analysis • Provider remediation plan template(s) **Evidence as Submitted by the MCO:** • XIV.26_NV.QI. 29 Critical Incident • XIV.26_2022 QAPI Program Description (pgs. 6; 50-51) • XIV.26_Critical Incident Report 1 • XIV.26_Critical Incident Report 2 • XIV.26_Critical Incident Report 4	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• XIV.26_Email correspondence related to initial report Critical Incident 3	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
27. The MCO submits an individual critical incident report for the following incidents: a. *Homicide or attempted homicide by a member.* b. *A major injury or major trauma that has the potential to cause prolonged disability or death of a member that occurs in a facility licensed by the State to provide publicly funded behavioral health services.* c. *An unexpected death of a member that occurs in a facility licensed by the State to provided publicly funded behavioral health services.* d. *Abuse, neglect, or exploitation of a member (not to include child abuse).* e. *Violent acts allegedly committed by a member, to include:* i. *Arson.* ii. *Assault resulting in serious bodily harm.* iii. *Homicide or attempted homicide by abuse.* iv. *Drive-by shooting.* v. *Extortion.* vi. *Kidnapping.* vii. *Rape, sexual assault, or indecent liberties.*	**HSAG Recommended Evidence:** • QAPI program description • Critical incident policies and procedures • Three examples of completed critical incident reports **Evidence as Submitted by the MCO:** • XIV.27_NV.QI. 29 Critical Incident • XIV.27_2022 QAPI Program Description (pgs. 6; 50-51) • XIV.27_Critical Incident Report 1 • XIV.27_Critical Incident Report 2 • XIV.27_Critical Incident Report 4 • XIV.27_Email correspondence related to initial report Critical Incident 3	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
viii. *Robbery.* ix. *Vehicular homicide.* f. *Unauthorized leave of a mentally ill offender or a sexual or violent offender from a mental health facility, secure Community Transition Facilities (i.e., Evaluation and Treatment Centers, Crisis Stabilization Units, Secure Detox Units, and Triage Facilities) that accept involuntary admissions.* g. *Any even involving a member that has attracted or is likely to attract media attention.* Contract 7.9.14.2; 7.9.14.2.1-7.9.14.2.5; 7.9.14.2.5.1-7.9.14.2.5.9		
MCO Description of Process: To date we have only had two critical incident identified		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
28. The MCO reports critical incidents within one (1) business day in which the MCO becomes aware of the event. The report must include: a. *The date the MCO became aware of the incident.* b. *The date of the incident.* c. *A description of the incident.* d. *The name of the facility where the incident occurred, or a description of the incident location.* e. *The name(s) and age(s) of member(s) involved in the incident.* f. *The name(s) and title(s) of facility personnel or other staff involved.* g. *The name(s) and relationship(s), if known, of other persons involved and the nature and degree of their involvement.*	**HSAG Recommended Evidence:** • QAPI program description • Critical incident policies and procedures • Critical incident timeliness reports • Three examples of completed critical incident reports **Evidence as Submitted by the MCO:** • XIV.28_NV.QI.29 Critical Incident • XIV.28_2022 QAPI Program Description (pgs. 6; 50-51) • XIV.28_Critical Incident Report 1 • XIV.28_Critical Incident Report 2 • XIV.28_Critical Incident Report 4	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
h. *The member's whereabouts at the time of the report, if known (i.e., home, jail, hospital, unknown, etc.) or actions taken by the MCO to locate the member.* i. *Actions planned or taken by the MCO to minimize harm resulting from the incident.* j. *Any legally required notifications made by the MCO.* Contract 7.9.14.3; 7.9.14.3.1-7.9.14.3.10	• XIV.28_Email correspondence related to initial report Critical Incident 3	
MCO Description of Process: To date we have only had two Critical Incident identified to date		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
29. The MCO submits follow-up reports using the Incident Reporting System and closes the case within forty-five (45) calendar days after the critical incident was initially reported. A case cannot be closed until the following information is provided: a. *A summary of any debriefings.* b. *Whether the member is in custody (jail), in the hospital, or in the community.* c. *Whether the member is receiving services and include the types of services provided.* d. *If the member cannot be located, the steps the MCO has taken to locate the member using available, local resources.* e. *In the case of the death of a member, verification from official sources that includes the date, name, and title of the sources. When official verification cannot be made, the MCO must document all attempts to retrieve it.*	**HSAG Recommended Evidence:** • QAPI program description • Critical incident policies and procedures • Three examples of completed critical incident reports with resolutions • Committee meeting minutes • Critical incident timeliness reports **Evidence as Submitted by the MCO:** • XIV.29_2022 QAPI Program Description (pgs. 6; 50-51) • XIV.29_Critical Incident Report 1 • XIV.29_Critical Incident Report 2 • XIV.29_Critical Incident Report 3 • XIV.29_Critical Incident Report 4 • XIV.29_NV.QI.29 Critical Incident	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Contract 7.9.14.4; 7.9.14.4.1-7.9.14.4.5		
MCO Description of Process: Since only 2 since new contract will be presented in Q3 QIC.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Member Participation in the QAPI		
30. *Members are kept informed about the quality initiatives and results through member newsletters and website postings and through the Member Advisory Board.* Contract 7.9.4.15.1	**HSAG Recommended Evidence:** • Member newsletters and website screenshots demonstrating members are informed of quality initiatives **Evidence as Submitted by the MCO:** • XIV.30_SSHP NV Q3 • XIV.30_Sweet Spot Social Media 3 • XIV.30_Sweet Spot Social Media 4 • XIV.30_Sweet Spot Social Media. 2 • XIV.30_Sweet Spot Social Media • XIV.30_Q1 2022 Member Advisory Board Minutes • XIV.30_Q2 2022 Member Advisory Board Minutes • XIV.30_SSHP-NV-Q4	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Provided Q3 and Q4 2021 Newsletters as we have not added to the 2 current newsletters but have plan to add to Q3 newsletter some upcoming events		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** HSAG recommends that the MCO enhance information provided to members regarding quality initiatives and results to include additional detail and any actions taken based on the analyses of data. 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**
Provider Participation in the QAPI		
31. *Network providers and other providers must be kept informed about the written QAPI program through provider newsletters and updates to the provider manual.* Contract 7.9.4.14.1	**HSAG Recommended Evidence:** • Provider newsletters and website screenshots demonstrating providers are informed of quality initiatives • Provider manual **Evidence as Submitted by the MCO:** • XIV.31_2022 Q1 Provider Newsletter (pgs. 8, 12-21) • XIV.31_Provider Notice webshot • XIV.31_Q2 2022 Provider Newsletter_Issue_2_2022 (pgs. 8-12) • XIV.31_Provider website snippet	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Plan of Correction Procedure		
32. *The MCO implements a Plan of Correction (POC) to identify improvements and/or enhancements of existing outreach, education, and case management activities, which will assist the MCO to improve the quality rates/scores. A POC must include, but may not be limited to, the following:* a. *Specific problem(s) which require corrective action;* b. *The type(s) of corrective action to be taken for improvement;* c. *The goals of the corrective action;* d. *The timetable for action;*	**HSAG Recommended Evidence:** • QAPI program description • Policies and procedures • All active internal POCs during the time period under review **Evidence as Submitted by the MCO:** • XIV.32_CC.QI.19 Peer_Review_Comm_and_Process • XIV.32_2022 QAPI Program Description (pgs. 18-20; 51; 57; 59)	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
e. *The identified changes in process, structure, internal/external education;* f. *The MCO's staff person(s) responsible for implementing and monitoring the POC;* g. *The POC should also identify improvements and enhancements of existing outreach and case management activities, if applicable.* Contract 7.9.2.7.1-7.9.2.7.9		
MCO Description of Process: We have had no POCs during this reporting period		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the MCO did not have any POCs implemented during the time period under review; however, the MCO's CC.QI.19 Peer Review Committee and Process policy included the requirements for this element.		
Required Actions: None.		
33. *The QAPI includes written procedures for taking corrective action, also referred to as POC and as described in Section 7.9.2.7 of the Contract, whenever inappropriate or substandard services are furnished, or services that should have been furnished were not. These written corrective action procedures includes:* 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;*	**HSAG Recommended Evidence:** • QAPI program description • Policies and procedures • All active provider POCs during the time period under review **Evidence as Submitted by the MCO:** • XIV.33_2022 QAPI Program Description (pgs. 18-20) • XIV.33_CC.QI.19 Peer_Review_Comm_and_Process	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
e. *The approach to modifying the corrective action if improvements do not occur; and* f. *Procedures for terminating the affiliation with the physician, or other health professional or provider.* Contract 7.9.4.8.1; 7.9.4.8.1.1-7.9.4.8.1.6		
MCO Description of Process: No POCs during this review period		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
34. *As actions are taken to improve care, the MCO must monitor and evaluate the POC to assure required changes have been made.* a. *In addition, changes in practice patterns must be monitored.* b. *The MCO must assure timely follow-up on identified issues to ensure actions for improvement have been effective.* Contract 7.9.4.8.2	**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 MCO:** • XIV.34_2022 QAPI Program Description (pgs. 18-20) • XIV.34_CC.QI.19 Peer_Review_Comm_and_Process	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: No POCs during this review period		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the MCO did not have any POCs implemented during the time period under review; however, the MCO's CC.QI.19 Peer Review Committee and Process policy included the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Accountability to the Governing Body		
35. *The governing body has approved the overall QAPI and the annual QAPI.* Contract 7.9.4.10.1	**HSAG Recommended Evidence:** • Governing body meeting minutes with annual QAPI program approval **Evidence as Submitted by the MCO:** • XIV.35_2022 Q1 BOD Slides • XIV.35_SSHP Board of Directors Q1 2022 Minutes	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
36. *The governing body has formally designated an entity or entities within the MCO 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 7.9.4.10.2	**HSAG Recommended Evidence:** • QAPI program description **Evidence as Submitted by the MCO:** • XIV.36_2022 QAPI Program Description (pgs. 9-11)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: 2022 Program Evaluation has not been approved to date will be presented in Q3 BOD meeting but Program Description has		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
37. *The governing body routinely receives written reports from the QAPI program describing actions taken, progress in meeting quality assurance objectives, and improvements made.* Contract 7.9.4.10.3	**HSAG Recommended Evidence:** • Three consecutive written reports reviewed by the governing body • Three consecutive governing body meeting minutes **Evidence as Submitted by the MCO:**	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• XIV.37_2022 Q1 BOD Slides • XIV.37_Q4 2021 BOD Minutes • XIV.37_2022 Q2 BOD Minutes • XIV.37_2021 Q4 BOD Slides • XIV.37_Q2 SSHP Board of Directors Slide Deck • XIV.37_SSHP Board of Directors Q1 2022 Minutes	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
38. *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 7.9.4.10.4	**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 MCO:** • XIV.38_Submission QAPI to DHCFP • XIV.38_SSHP Board of Directors Q1 2022 Minutes	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
39. *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 MCO.* 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 7.9.4.10.5	**HSAG Recommended Evidence:** • Three consecutive written reports reviewed by the governing body • Three consecutive governing body meeting minutes **Evidence as Submitted by the MCO:** • XIV.39_2022 Q2 BOD Minutes • XIV.39_2022 Q1 BOD Slides • XIV.39_Qtr 4 2021 BOD Minutes • XIV.39_2021 Q4 BOD Slides • XIV.39_Q2 SSHP Board of Directors Slide Deck • XIV.39_SSHP Board of Directors Q1 2022 Minutes	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
QAPI Program Reviews, Analysis, and Evaluation		
40. The MCO must develop a process to evaluate the impact and effectiveness of its QAPI Program. The QAPI program evaluation must include: a. The performance on the measures on which it is required to report. b. The outcomes and trended results of each PIP. c. The results of any efforts to support community integration for members using LTSS. d. *Quality assurance studies and other activities completed.* e. *Trending of clinical and service indicators and other performance data.*	**HSAG Recommended Evidence:** • QAPI program evaluation • Evidence of QAPI program evaluation annual submission to DHCFP **Evidence as Submitted by the MCO:** • XIV.40_2022 Quality Program Evaluation (pgs. 10-11; 18-26; 34-43; 47-75 80) • XIV.40_Submission 2021 QAPI Eval and 2022 QAPI Description to DHCFP	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
f. *Demonstrated improvements in quality.* g. *Areas of deficiency and recommendations for corrective action.* h. *An evaluation of the overall effectiveness of the QAPI program.* 42 CFR §438.330(e) Contract 7.9.2.4; 7.9.4.9.2		
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
41. *The QAPI program evaluation provides evidence that quality assurance activities have contributed to significant improvements in the care delivered to members and include:* a. *A description of DHCFP and MCO-initiated improvement projects, including the annual PIPs; and the outcomes and trended results for each improvement project, including documentation of successful and unsuccessful interventions.* b. *A summary of the MCO's assessment of the effectiveness of improvement projects based on performance measurement data.* c. *A description of how the MCO meets the requirements for the development and dissemination of clinical practice guidelines.* d. *A description of mechanisms the MCO uses to detect both underutilization and overutilization.* e. *A description of mechanisms the MCO uses to assess the quality and appropriateness of care furnished to members with special health care needs and members receiving long-term services and supports.*	**HSAG Recommended Evidence:** • QAPI program evaluation • **Evidence as Submitted by the MCO:** • XIV.41_Silver Summit to DHCFP Managed Care has ran successfully! • XIV.41_2022 Quality Program Evaluation (pgs. 2-4; 5-7; 8-9; 18-26; 26-27; 29-34; 43-45; 47-75; 77) • XIV.41_NVSS Reporting Attestation 2022.06.30	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
f. *A description of the MCO's efforts to prevent, detect, and remediate critical incidents.* g. *Summary of quality committee structure and activity providing structure, at a minimum for the internal quality improvement committee that monitors the annual quality strategy and work plan; and internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols and policies.* h. *An assessment of the quality and appropriateness of care furnished to all members, availability of services, second opinions, timely access and cultural considerations, with a report of aggregate data indicating methods used to monitor compliance.* i. *An assessment of the quality and appropriateness of care furnished to members with special health care needs, with a report of aggregate data indicating the number of members identified and methods used to evaluate the need for direct access to specialists.* j. *A demonstration of improvement in an area of poor performance in care coordination for members with special health care needs and behavioral conditions.* k. *A report on the member grievance and appeal system.* l. *Monitoring and enforcement of consumer rights and protections that ensures consistent response to complaints of violations of consumer rights and protections.* Contract 7.9.4.9.3; 7.9.4.9.3.1-7.9.4.9.3.11		
MCO Description of Process:		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the contract effective January 2022 included additional QAPI evaluation requirements which will be evaluated during future compliance reviews.		
Required Actions: None.		
42. *The MCO's evaluation also includes:* a. *How the MCO will incorporate the results in its quality improvement strategy.* b. *How the MCO plans to update its quality improvement strategy based on the findings of the self-evaluation.* Contract 7.9.4.9.5.1-7.9.4.9.5.2	**HSAG Recommended Evidence:** • QAPI program evaluation **Evidence as Submitted by the MCO:** • XIV.42_2021 Quality Program Evaluation (pgs. 10-11)	☐ Met ☐ Not Met ☒ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the requirements for this element were not applicable for the time period under review. Of note, the contract effective January 2022 included these additional QAPI evaluation requirements, which will be assessed during future compliance reviews.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program						
Met	=	38	X	1	=	38
Not Met	=	1	X	0	=	0
Not Applicable	=	3				
Total Applicable	=	39	Total Score		=	38
Total Score ÷ Total Applicable					=	97%

Appendix B. Compliance Review Corrective Action Plan

SFY 2021–22 Compliance With Standards Review Tool CAP Template

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**[B-1]	**Score**
General Rules			
42 CFR §438.214(b)(1-2) 42 CFR §438.214(e) Contract 7.6.2.3; 7.9.6	2. The MCO must follow a documented process for credentialing and recredentialing of network providers that meets DHCFP's requirements for acute, primary, behavioral, substance use disorders, and long-term services and supports (LTSS) providers. a. *The MCO complies with Nevada Administrative Code (NAC) 679B0405, which requires the use of Form NDOI-901 for use in credentialing providers.* b. *In the event State regulations or provider licensure laws conflict with the National Committee for Quality Assurance (NCQA) standards, State regulations and provider licensure laws control for purposes of the credentialing process.*	**Evidence as Submitted by the MCO:** • Credentialing Program Description • CC.CRED.01 – Practitioner Credentialing and Recredentialing, page 106 – Attachment Q includes items unique to NV • CC.CRED.09 – Organizational Assessment – page 1 • Link to form: https://doi.nv.gov/uploadedFiles/doinvgov/_public-documents/Insurers/Uniform%20Credentialing.pdf	☐ Met ☒ Not Met ☐ NA

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

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
	MCO Description of Process: For consideration to participate in the SilverSummit network, all providers who have an independent relationship with the Plan must complete an application for participation, submit copies of applicable supporting documentation, and meet the participation requirements.		
	HSAG Findings: HSAG requested evidence of credentialing files for child/adolescent psychiatrists and psychologists and corresponding screen shots of the provider directory to demonstrate that the MCO is collecting the age bands (0–6, 7–12, 13–17, and 18–21) served by these providers. After the site review, the MCO submitted a screen shot of provider profiles in the provider directory that included the following under the "Age Limitations" section: "0 yr(s) – 120 yr(s)", "5 yr(s) – 120 yr(s)", "0 yr(s) – 18 yr(s)." The provider database screen shot that was submitted included data fields for the lowest age and highest age served only. The MCO did not provide sufficient evidence that it is making efforts to collect the specific age bands served by child/adolescent psychiatrists and psychologists as required by its contract with DHCFP. HSAG strongly recommends that the MCO make this a mandatory element in order for these provider types to be initially credentialed or recredentialed. **Recommendations:** While the MCO provided a credentialing file of one of its delegates that included Form NDOI [Nevada Division of Insurance]-901, HSAG recommends that the MCO updates its annual file review tool to include a scoring element related to the use of this form. Implementation of this recommendation will be evaluated during future compliance reviews.		
	Required Actions: For psychiatrists and psychologists who treat child and adolescent populations, the MCO must collect the specific age bands served by the provider at the time of credentialing in accordance with its contract with DHCFP, Section 7.6.2.3.1.4.		
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

<table>
<tr><th colspan="4">Standard VIII—Provider Selection</th></tr>
<tr><th>Reference</th><th>Requirement</th><th>Information Submitted as Evidence by the MCO</th><th>Score</th></tr>
<tr><td colspan="4">File Reviews</td></tr>
<tr><td rowspan="4">42 CFR §438.214</td><td>12. The MCO complies with organizational recredentialing requirements as specified in the Organizational Credentialing and Recredentialing File Review Tool</td><td>Evidence as Submitted by the MCO:
• CC.CRED.09 – Organizational Assessment
• (there are zero example of adverse recredentialing decisions)</td><td>☐ Met
☒ Not Met
☐ NA</td></tr>
<tr><td colspan="3">MCO Description of Process: SilverSummit has established standards for conducting the functions of provider selection and retention. These standards include practices for provider assessment and reassessment that meet the qualifications of applicable state and federal government regulations and applicable standards of accrediting bodies, including the National Committee for Quality Assurance (NCQA), to the extent that those standards do not conflict with other laws of the state.</td></tr>
<tr><td colspan="3">HSAG Findings: The case file review identified two providers who were not recredentialed within 36 months. One provider was recredentialed within 37 months. After the site review, the MCO submitted documentation indicating that NCQA extended the recredentialing cycle to 38 months due to the pandemic. However, a second provider was recredentialed within 42 months. The MCO explained that the provider was removed from the provider directory when the 38-month time frame expired (December 2021); a new “initial” assessment was completed, and the provider was added back to the directory after the provider was credentialed in April 2022. However, while the provider may have been removed from the MCO’s directory, this does not alleviate the MCO’s responsibility to recredential its providers within 36 months (or 38 months due to NCQA’s waiver). Additionally, while the provider may have been removed from the directory, the provider may be rendering services to established members without being properly recredentialed.
Recommendations: During the site review, MCO staff members explained that an updated provider application at the time of recredentialing is not required for organizational providers. However, the MCO should be verifying that all provider information is current. As such, HSAG recommends that the MCO reevaluate this process. Implementation of this recommendation will be evaluated during future compliance reviews.</td></tr>
<tr><td colspan="3">Required Actions: The MCO must comply with the credentialing requirements in accordance with its contract with DHCFP.</td></tr>
</table>

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
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

<table>
<tr><th colspan="4">Standard X—Grievance and Appeal Systems</th></tr>
<tr><th>Reference</th><th>Requirement</th><th>Information Submitted as Evidence by the MCO</th><th>Score</th></tr>
<tr><td colspan="4">Timely Resolution and Notification of Grievances</td></tr>
<tr><td rowspan="3">42 CFR §438.408(a)
42 CFR §438.408(b)(1)
42 CFR §438.228
Contract 7.8.10.9.1.1; 7.8.10.11.1</td><td>7. The MCO must resolve each grievance and provide notice as expeditiously as the member’s health condition requires.
a. The MCO must resolve the grievance and send written notice to the affected parties no later than ninety (90) calendar days from the day the MCO receives the grievance.
b. The MCO must also make reasonable efforts to provide oral notice of the resolution of the grievance.
c. 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.</td><td>Evidence as Submitted by the MCO:
• Policy (NV.QI.11- Pg. 5)
• NV_Mcad_G_Res Letter
• Member Handbook Pg. 58</td><td>☐ Met
☒ Not Met
☐ NA</td></tr>
<tr><td colspan="3">MCO Description of Process:</td></tr>
<tr><td colspan="3">HSAG Findings: According to the case file review, all grievances were resolved in a timely manner. However, no evidence was provided to support reasonable efforts were made to provide oral notice of the grievance resolution. Additionally, the resolution letters indicated that the member could appeal the grievance decision and included the date on which the member would need to ask for the appeal, which is inappropriate, as only ABDs can be appealed through the member appeal process.
Recommendations: Due to the extensive time frame for resolving member grievances, HSAG recommends that the MCO consider how it can shorten the amount of time that staff members are taking to resolve grievances. HSAG is also making a recommendation to DHCFP to reduce the current 90-day time frame allowance. Additionally, due to the minor typographical and grammatical errors and words within the notices that can be considerably shortened or written at a more appropriate reading grade level (e.g., use “said” instead of “indicated,” use “asked for” instead of “requested”), HSAG recommends that the MCO implement a quality assurance process for reviewing resolution notices before sending them to members. Implementation of these recommendations will be evaluated during future compliance reviews.</td></tr>
</table>

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Required Actions: The MCO must also make reasonable efforts to provide oral notice of the resolution of the grievance.		
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 MCO**	**Score**
Timely Resolution and Notification of Grievances			
42 CFR §438.408(c)(2-3) 42 CFR §438.228 Contract 7.8.10.9.3	9. If the MCO 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.	**Evidence as Submitted by the MCO:** • Policy (NV.QI.11- Pg. 5 and 10) • NV_Mcad_G_ExtRes Letter • "Medicaid Extension Process"	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: Upon determination that an extension is necessary, plan sends email to DHCFP (contact information listed on department SharePoint site) for approval. Email should include case information as well as a reason why extension would be necessary. Upon approval, health plan staff will make an oral outreach to member to advise of the delay, within 2 calendar days plan will send written notice of extension with reason and new due date. Case timeline will be extended in the G&A database but not to exceed 44 days (Appeals)/104 days (Grievances) from the date of receipt.		
	HSAG Findings: The Member Grievance System Description policy and Medicaid Extension Process did not indicate that the MCO will inform members of their grievance rights if they disagree with the decision to extend the grievance resolution time frame. The grievance extension template letter, noted as Grievance Resolution Letter within the template, also did not include language to inform the member of the right to file a grievance.		
	Required Actions: The MCO's written documentation must support that if the MCO extends the grievance resolution time frame not at the request of the member (after DHCFP's approval for the extension), it must make reasonable efforts to give the member prompt oral notice of the delay; and within two 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.		

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
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

<table>
<tr><th colspan="4">Standard X—Grievance and Appeal Systems</th></tr>
<tr><th>Reference</th><th>Requirement</th><th>Information Submitted as Evidence by the MCO</th><th>Score</th></tr>
<tr><td colspan="4">Appeals General Requirements</td></tr>
<tr><td rowspan="3">42 CFR §438.402(c)(1)(ii)
42 CFR §438.402(c)(3)(ii)
42 CFR §438.228
Contract 7.8.10.6.1</td><td>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 an appeal is filed orally, the MCO is required to document the contact for tracking purposes and to establish the earliest date of receipt. The MCO must not require the member to submit a written appeal after making an oral appeal.</td><td>Evidence as Submitted by the MCO:
• Policy (NV.QI.11-pg 3,6, 18, and 19)
• Member handbook (pg. 58 and 59)</td><td>☐ Met
☒ Not Met
☐ NA</td></tr>
<tr><td colspan="3">MCO Description of Process:</td></tr>
<tr><td colspan="3">HSAG Findings: Of the 10 appeals reviewed as part of the case file review, all 10 appeals were filed by the provider. Of those 10 appeals, the MCO did not obtain member consent as required for three of the cases. Additionally, the ABD notices included language indicating that if members appealed by phone, they must also send in a written, signed appeal. After the site review, the MCO explained that the appeals which required consent were expedited, and that no member consent was requested based on contract language. However, in review of these case files, the MCO did not process the appeals as expedited, as documentation indicated that the appeals did not meet expedited criteria. Therefore, the MCO should have followed its process to obtain the member's written consent.
Recommendations: Although contract language stipulates there is an exception to obtaining a member's written consent for expedited appeals, federal rule does not differentiate between standard and expedited appeals. Therefore, HSAG strongly recommends that the MCO remove the language stipulating there are exceptions to obtaining written permission and ensure it obtains members' written consent for any appeals filed on their behalf. Implementation of this recommendation will be evaluated during future compliance reviews.</td></tr>
</table>

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Required Actions: The MCO must obtain the written consent of the member when a provider or an authorized representative requests an appeal on behalf of the member. The MCO must not require the member to submit a written appeal after making an oral appeal.		
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

<table>
<tr><th colspan="4">Standard X—Grievance and Appeal Systems</th></tr>
<tr><th>Reference</th><th>Requirement</th><th>Information Submitted as Evidence by the MCO</th><th>Score</th></tr>
<tr><td colspan="4">Handling of Appeals</td></tr>
<tr><td rowspan="4">42 CFR §438.406(b)(1)
42 CFR §438.410(c)
42 CFR §438.228
Contract 7.8.10.5.3</td><td>15. If the MCO 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 MCO 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.</td><td>Evidence as Submitted by the MCO:
• Policy (NV.QI.11-pg. 10 and 11)
• NV_Mcad_Exp_Criteria_Not_Met template
• Appeal Sample File (2)</td><td>☐ Met
☒ Not Met
☐ NA</td></tr>
<tr><td colspan="3">MCO Description of Process:</td></tr>
<tr><td colspan="3">HSAG Findings: According to the case file review, four appeals were submitted as expedited and were transferred to the standard appeal resolution time frame as the criteria for expediting were not met. Although the MCO provided members with appropriate written notices, and oral notice was made to providers in most cases, there was no evidence that the MCO also made a reasonable effort to give the members prompt oral notice of the delay.</td></tr>
<tr><td colspan="3">Required Actions: If the MCO denies a request for expedited resolution of an appeal, it must make reasonable efforts to give the member prompt oral notice of the delay.</td></tr>
</table>

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
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

<table>
<tr><th colspan="4">Standard X—Grievance and Appeal Systems</th></tr>
<tr><th>Reference</th><th>Requirement</th><th>Information Submitted as Evidence by the MCO</th><th>Score</th></tr>
<tr><td colspan="4">Handling of Appeals</td></tr>
<tr><td rowspan="4">42 CFR §438.406(b)(3)
42 CFR §438.228
Contract 7.8.10.10.5</td><td>18. The MCO must provide that oral inquiries seeking to appeal an ABD are treated as appeals.</td><td>Evidence as Submitted by the MCO:
• Policy (NV.QI.11-pg. 6,18, and19)</td><td>☐ Met
☒ Not Met
☐ NA</td></tr>
<tr><td colspan="3">MCO Description of Process:</td></tr>
<tr><td colspan="3">HSAG Findings: Although the Member Grievance Process Description policy indicated that “standard oral appeal requests are treated as appeals (to establish the earliest possible filing date for the appeal). SilverSummit Healthplan may not require a written signed appeal following oral request” and the member handbook provided members with the phone number for Member Services to file an appeal, the ABD notice informed members that the MCO must have a signed, written appeal. HSAG requested that the MCO provide evidence that when members would file appeals orally that written notice would not be required. However, after the site review, the MCO indicated that no examples were available wherein a member filed an appeal orally, suggesting members were not aware that they may file an appeal orally due to inaccurate information being provided in the ABD notice (e.g., requiring a written appeal). Additionally, all appeals within the sample included as part of the case file review were filed by the provider and not the member.</td></tr>
<tr><td colspan="3">Required Actions: The MCO must ensure that oral inquiries seeking to appeal an ABD are treated as appeals. The MCO must not require members to provide written, signed appeals in lieu of submitting appeals orally.</td></tr>
<tr><td>Corrective Action Plan
(Include required action, responsible individual, and completion date.)</td><td colspan="3"></td></tr>
<tr><td>DHCFP Feedback
(To be completed by DHCFP/HSAG.)</td><td colspan="2"></td><td>☐ Accepted
☐ Accepted With Recommendations
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</table>

<table>
<tr><th colspan="4">Standard X—Grievance and Appeal Systems</th></tr>
<tr><th>Reference</th><th>Requirement</th><th>Information Submitted as Evidence by the MCO</th><th>Score</th></tr>
<tr><td colspan="4">Handling of Appeals</td></tr>
<tr><td rowspan="4">42 CFR §438.406(b)(3)
42 CFR §438.228
Contract 7.8.10.10.5</td><td>19. The MCO 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 MCO 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.</td><td>Evidence as Submitted by the MCO:
• Policy (NV.QI.11 - pg. 4)
• NV_Mcad_A_Ack Letter
• Mcad_ABD_Notice pg. 2
• Member Handbook pg. 58-59</td><td>☐ Met
☒ Not Met
☐ NA</td></tr>
<tr><td colspan="3">MCO Description of Process:</td></tr>
<tr><td colspan="3">HSAG Findings: Although the Member Grievance Process Description policy included language to support the requirements of this element, findings from the case file review, and a review of the ABD notice, appeal acknowledgement letters, and member handbook, did not demonstrate that members were being informed of their opportunity to present evidence and testimony in writing and in person, or to make legal and factual arguments in support of the appeal. There was also no evidence that this opportunity was provided to members sufficiently in advance of the resolution time frame for expedited resolution of appeals.</td></tr>
<tr><td colspan="3">Required Actions: The MCO must provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MCO 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.</td></tr>
<tr><td>Corrective Action Plan
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Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

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<tr><td colspan="4">Resolution and Notification of Appeals</td></tr>
<tr><td rowspan="4">42 CFR §438.408(c)(3)
42 CFR §438.408(f)(1)(i)
42 CFR §438.228
Contract 7.8.10.9.4</td><td>25. In the case that the MCO fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the MCO’s appeals process. The member may initiate a State fair hearing (SFH).</td><td>Evidence as Submitted by the MCO:
• Policy (NV.QI.11 - pg. 4)
• NV_Mcad_A_Ack Letter
• Mcad_ABD_Notice pg. 2
• Member Handbook pg. 58-59</td><td>☐ Met
☒ Not Met
☐ NA</td></tr>
<tr><td colspan="3">MCO Description of Process:</td></tr>
<tr><td colspan="3">HSAG Findings: Although the MCO provided documentation to support that it had resolved all appeals in a timely manner during the time period under review, no evidence was provided to support the process the MCO will follow should they have an appeal that is not resolved within the required time frame, and specifically, the process for notifying members that they may initiate a SFH.
Recommendations: HSAG recommends that the MCO develop an appeal resolution notice template to use when appeals are not determined and members are not provided notice within the required time frame, explaining the reason that members can initiate a SFH. Implementation of this recommendation will be evaluated during future compliance reviews.</td></tr>
<tr><td colspan="3">Required Actions: The MCO must have a process to ensure that if the MCO fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the MCO’s appeals process and may initiate a SFH.</td></tr>
<tr><td>Corrective Action Plan
(Include required action, responsible individual, and completion date.)</td><td colspan="3"></td></tr>
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Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Resolution and Notification of Appeals			
42 CFR §438.408(d)(2)(ii) 42 CFR §438.228 Contract 7.8.10.11.1	27. For notice of a *standard* and expedited appeal resolution, the MCO is *required to make a good faith effort* to provide oral notice *of the disposition in addition to the required written notice*.	**Evidence as Submitted by the MCO:** • Policy (NV.QI.11 - pg. 11) • Three examples of oral notice for an expedited appeal resolution • "Appeal_Work_ Flow_Updated_120221" Process Document	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process:		
	HSAG Findings: The MCO's appeal workflow indicated that a resolution notice will be mailed to each member and verbal outreach attempted to advise of the appeal outcome. Additionally, for several of the appeals reviewed as part of the case file review, the MCO contacted the provider to provide oral notice of the disposition of the appeal. However, none of the 10 appeals reviewed as part of the case file review supported that the MCO was also making a good faith effort to provide members with oral notice of the disposition of each appeal.		
	Required Actions: For notice of a standard and expedited appeal resolution, the MCO must make a good faith effort to provide oral notice of the disposition in addition to the required written notice.		
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

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<tr><th>Reference</th><th>Requirement</th><th>Information Submitted as Evidence by the MCO</th><th>Score</th></tr>
<tr><td colspan="4">State Fair Hearings</td></tr>
<tr><td rowspan="4">42 CFR §438.408(f)(2)
42 CFR §438.228
Contract 7.8.10.12.1; 7.8.10.12.2</td><td>29. The member must submit a request for a SFH in writing within ninety (90) calendar days from the date of the MCO's notice of resolution of the appeal.
a. The MCO is required to inform the member of their right to a SFH, how to obtain such a hearing, requirements for continuation of benefits, and representation rules must be explained and provided in writing to the member by the MCO pursuant to 42 CFR §431.200(b); 42 CFR §431.220(a)(6) and 42 CFR §438.408(e)(2)(i).</td><td>Evidence as Submitted by the MCO:
• Policy (NV.QI.11 - pg. 14 and 15)
• NV_Mcad_A_Final_Adv_Det Letter
• Member Handbook pg. 60</td><td>☐ Met
☒ Not Met
☐ NA</td></tr>
<tr><td colspan="3">MCO Description of Process:</td></tr>
<tr><td colspan="3">HSAG Findings: According to the case file review, one appeal resolution notice indicated that the member had 120 days to request a SFH. Additionally, the MCO's member handbook indicated members had 120 days from the date on the resolution letter to ask for a SFH.</td></tr>
<tr><td colspan="3">Required Actions: The MCO must inform members that they must submit a request for a SFH in writing within 90 calendar days from the date of the MCO's notice of resolution of the appeal.</td></tr>
<tr><td>Corrective Action Plan
(Include required action, responsible individual, and completion date.)</td><td colspan="3"></td></tr>
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Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard XI—Subcontractual Relationships and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Contract or Written Arrangement			
42 CFR §438.230(c)(3)(i-iv)	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, 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 MCO'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,	**Evidence as Submitted by the MCO:** • XI.1-7_Delegated Services Agreement Template *(pg. 10, III. Annual Evaluation)* • XI.1-5_NIA_Radiology Services Management Agreement_eff 01.01.18 *(pg. 11, Article VI Records/Inspections; pg.12, 6.3 On-Site Inspections; pg. 76, 2.4.2 Inspection of Records; pg. 44, 7. Audits; pg.101, 3.8 Availability of Internal Practices, Books and Records; pg. 362, NV-12.B)* • XI.2,3-4_Somatus_MSA_Centene *(pg. 2 Records and Audit; pg.21, 3.8 Availability of Internal Practices, Books and Records)* • XI.1-4_SBH_Health Services Agreement_Final *(pg. 7, Article IV-Records & Inspections; pg.42, NV-12.B)* • XI.3-4_SBH_BAA	☐ Met ☒ Not Met ☐ NA

Standard XI—Subcontractual Relationships and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time.	*(pg.4, 3.6 Access to Records, 3.8 Availability of Internal Practices, Books and Records)* • XI.1-5_Envolve Vision Services Agreement_Eff 07.01.17 • *(pg. 11, Article VI Records/Inspections, 6.2 Access; pg.30-31, NV-11.B)*	
	MCO Description of Process: N/A		
	HSAG Findings: While the MCO's written arrangements with its delegates included right to audit provisions, they did not fully align with the requirements of this element. National Imaging Associates' (NIA's) contract included a provision (2.4.2 Inspection of Records) that aligned with the requirements of this element, except sub-element (d); however, this provision was located under a Medicare addendum. Additionally, Article VI Records/Inspections and 6.3 On-Site Inspections of NIA's contract included a provision allowing access to records and on-site inspections; however, such access was available during normal business hours at a mutually agreed-to date and time and on reasonable notice. This language conflicts with the requirements of sub-element (d) in which the right to audit exists at any time when there is a reasonable possibility of fraud or similar risk. Summit Behavioral Health Systems' (SBHS's) contract included the following language: "Company or Payor and the Nevada Commissioner of Insurance are authorized, upon reasonable prior notice, to audit, inspect and copy the Provider's books, records and any other evidence of its operations to determine whether it has complied with the applicable provisions of Nevada law, including any regulations adopted pursuant thereto." SBHS's Business Associate Agreement (BAA) also included right to audit requirements under Section 3.6 Access to Records and 3.8 Availability of Internal Practices, Books and Records. However, neither the contract nor BAA included all required provisions, and specifically, sub-elements (c) and (d). **Recommendations:** HSAG recommends that the MCO conduct a thorough review of all contracts with its delegates for the Nevada Medicaid program and ensure that the requirements of this element are clearly outlined. HSAG recommends that the MCO include these provisions in its subcontracts verbatim to the federal rule. Implementation of this recommendation will be evaluated during future compliance reviews.		
	Required Actions: The MCO must ensure its contracts or written arrangements indicate, and the delegate agrees that:		

Standard XI—Subcontractual Relationships and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	• The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, 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 MCO's contract with the State. • 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. • 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. • 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.		
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

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<tr><th>Reference</th><th>Requirement</th><th>Information Submitted as Evidence by the MCO</th><th>Score</th></tr>
<tr><td colspan="4">Contract or Written Arrangement</td></tr>
<tr><td rowspan="3">42 CFR §438.230
Contract 7.2.2.2; 7.2.2.8</td><td>7. If the MCO identifies deficiencies or areas for improvement, the MCO and the subcontractor take corrective action.</td><td>Evidence as Submitted by the MCO:
• XI.1-7_Delegated Services Agreement Template (pg. 4, 3.4 Corrective Action Plans; pg. 11, V. Corrective Actions)
• XI.7_EPC_CAP_NAL FND-6907
• XI.7_EPC_CAP_NAL Remediation
• XI.7_SBH_CAP Summary_FND-7329
• XI.7_Envolve Vision_CAP_Deficiencies</td><td>☐ Met
☒ Not Met
☐ NA</td></tr>
<tr><td colspan="3">MCO Description of Process:
• “XI.7_Envolve Vision_CAP_Deficiences” is not a formal corrective action plan, although deficiencies were identified and corrective action was taken via communication to the vendor.
• There were no corrective actions for Somatus and NIA, so a third example of a formal CAP for Envolve People Care (EPC) was provided.</td></tr>
<tr><td colspan="3">HSAG Findings: During the review of Standard VIII—Provider Selection, it was identified that the MCO was appropriately monitoring delegated credentialing functions through an annual review that included a policy and procedure review and a case file review. However, the Delegated Credentialing Audit Tool Summary Report for one delegate indicated that the delegate received a score between 90 percent and 100 percent and was recommended for continued delegation of credentialing with recommendations that would be reviewed during the next annual audit. However, the file review identified multiple deficiencies (e.g., noncompliance with licensure verification, board certification verification, Medicare/Medicaid sanctions and exclusions queries, notice of decision to provider). Evidence that a CAP was requested and subsequently completed by the delegate was not provided. Discussion during the site review indicated that the overall score did not meet the threshold for a CAP due to the weighted scores from the program areas reviewed (e.g., policies, case file review, report submissions). However, given the significant volume of the deficiencies from the results of the case file review, and in accordance with the MCO’s contract with DHCFP, the MCO should have required a CAP as the case file review is the true indicator of the delegate’s performance.</td></tr>
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<tr><th>Reference</th><th>Requirement</th><th>Information Submitted as Evidence by the MCO</th><th>Score</th></tr>
<tr><td rowspan="2"></td><td colspan="3">Recommendations: HSAG strongly recommends that the MCO update its scoring methodology for determining when a CAP is or is not required based on these findings. Implementation of this recommendation will be evaluated during future compliance reviews.</td></tr>
<tr><td colspan="3">Required Actions: The MCO and its subcontractor must take corrective action when deficiencies or areas for improvement are identified.</td></tr>
<tr><td>Corrective Action Plan
(Include required action, responsible individual, and completion date.)</td><td colspan="3"></td></tr>
<tr><td>DHCFP Feedback
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Standard XIV—Quality Assessment and Performance Improvement Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Quality Assurance Committee			
Contract 7.9.4.14.7	15. *The Provider Advisory Board meets quarterly with minutes submitted to DHCFP within thirty (30) calendar days of the meeting.*	**Evidence as Submitted by the MCO:** • XIV.15_2022 QI Program Description (pgs. 28-29) • XIV.15_Q1 2022 PAB Meeting Minutes	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: The Provider Advisory Board is a new contract requirement for 2022 and only 1 committee meetings prior to having to submit evidence to HSAG. The June meeting had to be rescheduled for July due to provider availability, but we will ensure four meetings occur in 2022.		
	HSAG Findings: The MCO staff members confirmed during the site review that the MCO did not submit the Provider Advisory Committee meeting minutes to DHCFP within 30 calendar days of the meeting as required by contract.		
	Required Actions: The MCO must ensure that the Provider Advisory Board meets quarterly with minutes submitted to DHCFP within 30 calendar days of the meeting.		
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