Division of Health Care Financing and Policy
Nevada Medicaid Managed Care

State Fiscal Year 2021 Compliance Review

for

Health Plan of Nevada

October 2021

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

According to federal requirements located within Title 42 of the Code of Federal Regulations (42 CFR) §438.358, the state, an agent that is not a Medicaid managed care entity (MCE), or its external quality review organization (EQRO) must conduct a review within a three-year period to determine a Medicaid MCE's compliance with the 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 comply with the federal requirements, the Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP) contracted with Health Services Advisory Group, Inc. (HSAG) as its EQRO to conduct compliance reviews of its contracted MCEs responsible for the delivery of comprehensive healthcare services, including physical health (PH), behavioral health (BH), and long-term services and supports (LTSS), as applicable, under the State's Medicaid managed care program.

Description of the External Quality Review of Compliance With Standards

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

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

Compliance Monitoring Standard	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard I—Disenrollment: Requirements and Limitations	✓		Review of MCE implementation of Year One and Year Two corrective action plans (CAPs)
Standard II—Member Rights and Member Information	✓		
Standard III—Emergency and Poststabilization Services	✓		
Standard IV—Availability of Services	✓		
Standard V—Assurances of Adequate Capacity and Services	✓		

Compliance Monitoring Standard	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard VI—Coordination and Continuity of Care	✓		
Standard VII—Coverage and Authorization of Services	✓		
Standard VIII—Provider Selection		✓	
Standard IX—Confidentiality		✓	
Standard X—Grievance and Appeal Systems		✓	
Standard XI—Subcontractual Relationships and Delegation		✓	
Standard XII—Practice Guidelines		✓	
Standard XIII—Health Information Systems		✓	
Standard XIV—Quality Assessment and Performance Improvement Program		✓	

Overview of Findings

Review of Standards

From a review of documents, observations, and interviews with key **Health Plan of Nevada** (**HPN**) staff members as well as file reviews conducted during the desk review and virtual interviews, the reviewers assigned **HPN** a score for each element and an aggregate score for each standard. 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—Methodology. If a requirement was not applicable to **HPN** 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. Table 1-2 presents a summary of **HPN**'s performance results.

Table 1-2—Summary of Standard Compliance Scores

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Disenrollment: Requirements and Limitations	7	7	7	0	0	**100%**
II	Member Rights and Member Information	22	22	20	2	0	**91%**
III	Emergency and Poststabilization Services	10	10	10	0	0	**100%**
IV	Availability of Services	10	10	10	0	0	**100%**
V	Assurances of Adequate Capacity and Services	2	2	2	0	0	**100%**

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
VI	Coordination and Continuity of Care	17	17	14	3	0	**82%**
VII	Coverage and Authorization of Services	15	15	14	1	0	**93%**
	Total	**83**	**83**	**77**	**6**	**0**	**93%**

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.

HPN demonstrated compliance in 77 of 83 elements, with an overall compliance score of 93 percent, indicating that most program areas had the necessary policies, procedures, and initiatives in place to carry out the majority of the functions included as part of the review, while other areas demonstrated opportunities for improvement to operationalize the elements required by federal and State regulations. Detailed findings, including recommendations for program enhancements, are documented in Appendix A.

Corrective Action Process

For any elements scored *Not Met*, **HPN** is required to submit a CAP to bring the element into compliance with the applicable standard(s). The process for submitting the CAP and the criteria used to evaluate the sufficiency of the CAP are described in Section 3 of this report.

2. Methodology

Introduction

The following description of the way HSAG conducted—in accordance with 42 CFR §438.358—the external quality review (EQR) of compliance with standards for the Nevada Medicaid managed care program addresses HSAG's:

- Objective of conducting the review of compliance with standards.
- Compliance review activities and technical methods of data collection.
- Description of data obtained.
- Data aggregation and analysis.

HSAG followed standardized processes in conducting the review of the MCE's performance.

Objective of Conducting the Review of Compliance With Standards

The primary objective of HSAG's review was to provide meaningful information to DHCFP and the MCE regarding compliance with the State and federal requirements. HSAG assembled a team to:

- Collaborate with DHCFP to determine the scope of the review as well as the scoring methodology, data collection methods, desk review schedules, virtual review[2-1] activity schedules, and virtual review agenda.
- Collect and review data and documents before and during the virtual review.
- Aggregate and analyze the data and information collected.
- Prepare the findings report.

To accomplish its objective, and based on the results of collaborative planning with DHCFP, HSAG developed and used a data collection tool to assess and document the MCE's compliance with certain federal Medicaid managed care regulations, State rules, and the associated DHCFP contractual requirements. Beginning in SFY 2021, DHCFP requested that HSAG conduct compliance reviews over a three-year cycle with one-half of the standards being reviewed in Year One and the remaining half of the standards in Year Two, and a comprehensive review of each element scored as *Not Met* during Year One (SFY 2021) and Year Two (SFY 2022) during Year Three (SFY 2023). The division of standards over the three years can be found in Table 1-1. The review tool developed for this year's review (SFY 2021) included requirements that addressed the following performance areas:

- Standard I—Disenrollment: Requirements and Limitations

[2-1] Due to the current pandemic, the on-site review component of the compliance activity was held virtually via Webex.

- Standard II—Member Rights and Member Information
- Standard III—Emergency and Poststabilization Services
- Standard IV—Availability of Services
- Standard V—Assurances of Adequate Capacity and Services
- Standard VI—Coordination and Continuity of Care
- Standard VII—Coverage and Authorization of Services

DHCFP and the MCE will use the information and findings that resulted from HSAG's review to:

- Evaluate the quality and timeliness of, and access to, care and services furnished to members.
- Identify, implement, and monitor interventions to improve these aspects of care and services.

Compliance Review Activities and Technical Methods of Data Collection

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and laws and on the requirements set forth in the contract between DHCFP and the MCE as they related to the scope of the review. HSAG also followed the guidelines set forth in the Centers for Medicare & Medicaid Services' (CMS') EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019[2-2] for the following activities:

Pre-Review Activities

Pre-review activities included:

- Scheduling the virtual reviews.
- Developing the compliance review tools.
- Preparing and forwarding to the MCE a pre-review information packet and instructions for completing and submitting the requested documentation to HSAG for its desk review.
- Hosting a pre-review preparation session with the MCE.
- Conducting a desk review of documents. HSAG conducted a desk review of key documents and other information obtained from DHCFP, and of documents the MCE submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the MCE's

[2-2] 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: Jul 12, 2021.

operations, identify areas needing clarification, and begin compiling information before the virtual review.

- Generating a list of 10 sample records for service authorization denials and care management from the universe files submitted to HSAG from the MCE.
- Developing the agenda for the one-day virtual review.
- Providing the detailed agenda to the MCE to facilitate preparation for HSAG's virtual review.

Virtual Review Activities

Virtual review activities included:

- An opening conference, with introductions and a review of the agenda and logistics for HSAG's one-day review activities.
- A review of the documents HSAG requested that the MCE have available during the interview sessions.
- A review of service authorization denial and care management records HSAG requested from the MCE.
- A review of the data systems that the MCE used in its operation such as utilization management, care coordination, and enrollment and disenrollment.
- Interviews conducted with the MCE's key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

HSAG documented its findings in the data collection tool (compliance review tool) shown in Appendix A—Review of the Standards, which serves as a comprehensive record of HSAG's findings, performance scores assigned to each requirement, and the actions required to bring the MCE's performance into compliance for those requirements that HSAG assessed as less than fully compliant.

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.
- MCE-maintained records for service authorization denials.
- MCE's online member handbook and provider directory.

HSAG obtained additional information for the compliance review through interactions, discussions, and interviews with the MCE's key staff members.

Table 2-1 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 2-1—Description of MCE Data Sources

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during the virtual review	November 1, 2020–May 31, 2021
Information obtained through interviews	September 15, 2021
Information obtained from a review of a sample of service authorization denial records for file reviews	Listing of all denials (excluding denials of payment and concurrent reviews) between November 1, 2020–May 31, 2021
Information obtained from a review of a sample of care management records for file reviews	Listing of members newly enrolled into care management on or after September 1, 2020

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. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. The protocol describes the scoring as follows:

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

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

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.
- 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 of the standards 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).

For the member handbook, provider directory, member rights, appointment standards, and time/distance standards checklists reviewed, HSAG assessed each applicable element within the checklist as either (1) *Yes*, the element was contained within the associated document(s), or (2) *No*, the element was not contained within the document(s). Elements *Not Applicable* to the MCE were assessed as *NA*. The findings from the checklists were used to determine overall compliance with the applicable standard and element in the compliance review tool (i.e., member handbook content requirements within Standard I–Member Rights and Member Information).

HSAG conducted file reviews of the MCE's records for service authorization denials and care management to verify that the MCE had put into practice what the MCE had documented in its policy, in addition to adhering to timely review of authorization and care management requirements. HSAG selected 10 records of service authorization denials and 10 records for care management 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 and timeliness of, and access to, care and services the MCE provided to members, HSAG aggregated and analyzed the data resulting from its desk and virtual 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.

- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.

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

3. Corrective Action Plan Process

Appendix C contains the CAP template that HSAG developed for **HPN** to use in preparing its CAP to be submitted to DHCFP. The template lists each element for which HSAG assigned a score of *Not Met*, as well as the associated findings and recommendations made to bring the organization's performance into full compliance with the requirement. **HPN** must use this template to submit its CAP to bring any elements scored *Not Met* into compliance with the applicable standard(s). **HPN**'s CAP must be submitted to DHCFP and HSAG no later than 30 calendar days of receipt of HSAG's final *State Fiscal Year 2021 Compliance Review* report.

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

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

Any CAPs that do not meet the preceding criteria will require resubmission by the organization until approved by DHCFP. DHCFP maintains ultimate authority for approving or disapproving any corrective action strategies proposed by **HPN** in its submitted CAP.

Appendix A. Review of the Standards

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

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Disenrollment Requested by the Managed Care Organization (MCO)		
1. The MCO may not request disenrollment: • Because of an adverse change in the member's health status, • *The member has a pre-existing medical condition,* • Because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this particular member or other members), • *A member's attempt to exercise his/her grievance or appeals rights,* or • *Based on the member's national origin, creed, color, sex, religion, and age.* 42 CFR §438.56(b)(2) Contract 3.5.2, 3.5.7.4 (C)(1-7)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCO:** HPN_WRHCO 351 Disenrollment at the request of HPN	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: HPN did not request any member disenrollments during the audit period.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Member Disenrollment Request by the MCO		
2. The MCO assures DHCFP that it does not request disenrollment for reasons other than those permitted under the contract. a. *The MCO may request disenrollment of a member if the continued enrollment of the member seriously impairs the MCO's ability to furnish services to either the particular member or other members.* b. *The MCO must confirm that the member has been referred to the MCO's Member Services Department and has either refused to comply with this referral or refused to act in good faith to attempt to resolve the problem.* 42 CFR §438.56(b)(3) Contract 3.5.7.4(A)	**HSAG Recommended Evidence:** • Policies and procedures • Example of an MCO disenrollment request (if the MCO has not requested any member disenrollment, state so in the MCO Description of Process) **Evidence as Submitted by the MCO:** HPN_WRHCO 351 Disenrollment at the request of HPN	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: HPN did not request any member disenrollments during the audit period.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
Disenrollment Requested by the Member		
3. A member may request disenrollment as follows: a. For cause, at any time. i. *If the MCO determines that there is sufficient cause to disenroll, the MCO must notify the DHCFP by using the state-required form. The MCO must make a determination as expeditiously as the member's health*	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCO:** HPN_Member Handbook: pg. 80	☒ Met ☐ Not Met ☐ NA

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
requires and within a timeline that may not exceed fourteen (14) calendar days following receipt of the request for disenrollment. b. Without cause, at the following times: i. During the 90 days following the date of the member's initial enrollment into the MCO, or during the 90 days following the date DHCFP sends the member notice of that enrollment, whichever is later. ii. At least once every 12 months thereafter. iii. Upon automatic reenrollment under 42 CFR §438.56(g), if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. iv. When DHCFP imposes the intermediate sanction specified in 42 CFR §438.702(a)(4). 42 CFR §438.56(c)(1-2) 42 CFR §438.56(g) 42 CFR §438.702(a)(4) Contract 3.5.7.3 (A-D), (F)(1)(d), (G)	HPN_WRHCO 284 Medicaid Disenrollment Policy HPN_Medicaid Disenrollment SOP page 3-7	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** While the member handbook included a statement that a member must show "good cause" for switching health plans, "good cause" was not defined nor were there examples provided of "good cause". HSAG strongly recommends that the MCO enhance the disenrollment section of the member handbook to define "good cause" and provide examples of "good cause" for disenrollment that will provide members with well-defined disenrollment information. Implementation of these recommendations will be further assessed during future compliance reviews.		
Required Actions: None.		

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Procedures for Disenrollment: Request for Disenrollment		
4. The member (or his or her representative) must submit an oral or written request, as required by DHCFP—*to the MCO*. 42 CFR §438.56(d)(1)(ii) Contract 3.5.7.3(F)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Example of a member disenrollment request **Evidence as Submitted by the MCO:** HPN_Member Handbook: pg. 80 HPN_Medicaid Disenrollment SOP HPN_WRHCO 284 Medicaid Disenrollment Policy HPN_Disenrollment_No Good Cause HPN_Disenrollment_Denial HPN_Disenrollment_Good Cause HPN_Disenrollment_Approval	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** The Medicaid Disenrollment Standard Operating Procedure (SOP) specified that a "Medicaid member enrolled for more than 90 days must send a written request for disenrollment before the Plan will review the request. The request can be via the disenrollment form, or other written request." During the interview session, MCO staff members confirmed that the MCO's process is to accept only a member's written disenrollment request and would require that a member complete the disenrollment form or provide other written documentation of their request to disenroll. HSAG recommends that the MCO consult with DHCFP to determine whether it is appropriate for the disenrollment form to be completed with the member over the phone without obtaining the member's actual signature.		
Required Actions: None.		

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Procedures for Disenrollment: Cause for Disenrollment		
5. The member may request to disenroll from the MCO for good cause at any time. Good cause for disenrollment includes: a. The member moves out of the MCO's service area. b. The plan does not, because of moral or religious objections, cover the service the member seeks. c. The member needs related services (for example, a Cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk. d. For members that use Managed Long Term Services and Supports (MLTSS), the member would have to change their residential, institutional, or employment supports provider based on that provider's change in status with the MCO and, as a result, would experience a disruption in their residence or employment. e. Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's care needs. 42 CFR §438.56(d)(2)(i-v) Contract 3.5.7.3(F)(1)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCO:** HPN_Member Handbook: pg. 80 HPN_Medicaid Disenrollment SOP HPN_Disenrollment_Good Cause HPN_Disenrollment_Approval	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. Although sub-element d was not demonstrated through documentation, HSAG has determined this sub-element to be not applicable as this specific requirement would most likely relate to LTSS waiver members under fee-for-service.		
Required Actions: None.		
Use of the MCO's Grievance Procedures		
6. *The DHCFP requires that the member seek redress through the MCO's grievance system before making a determination on the member's request.* a. The grievance process must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the time frame specified in 42 CFR §438.56(e)(1). b. *If the MCO cannot make a determination, the MCO may refer the request to DHCFP.* 42 CFR §438.56(d)(5)(i-ii) 42 CFR §438.56(e)(1) Contract 3.5.7.3 (I)	**HSAG Recommended Evidence:** • Policies and procedures • One case example of a member request for disenrollment grievance record, including the resolution letter • Most recent member disenrollment report **Evidence as Submitted by the MCO:** HPN_Medicaid Appeals Policy page 8 HPN_Disenrollment Appeal Case File HPN_WRHCO 284 Medicaid Disenrollment Policy	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: The requirements for this element were included in the HPN_WRHCO 284 Medicaid Disenrollment Policy.		
Required Actions: None.		

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
7. *If the MCO denies the request for disenrollment for lack of good cause, the MCO must send a Notice of Decision in writing to the member upon the date of the decision and include appeal rights. The MCO is required to inform the member of their right to first appeal through the MCO and if the appeal is denied, to request a State fair hearing and how to obtain such a hearing.* a. *If DHCFP receives a request directly from the member, the member will be directed to begin the process by requesting disenrollment through the vendor.* 42 CFR §438.56(d)(5)(i) Contract 3.5.7.3 (H),(K)	**HSAG Recommended Evidence:** • Policies and procedures • One case example of a member request for disenrollment denied due to lack of good cause, including the Notice of Decision letter sent to the member. • Disenrollment request monitoring report **Evidence as Submitted by the MCO:** HPN_WRHCO 284 Medicaid Disenrollment Policy HPN_Medicaid Disenrollment SOP HPN_Disenrollment Request_No Good Cause HPN_Disenrollment_Denial HPN_Disenrollment Request Log HPN_Disenrollment Appeal Case File page 26	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		

Standard I—Disenrollment: Requirements and Limitations						
Met	=	7	X	1	=	7
Not Met	=	0	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	7	Total Score		=	7
Total Score ÷ Total Applicable					=	100%

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Member Rights: General Rule		
1. The MCO has written policies regarding the member rights specified in 42 CFR §438.100. 42 CFR §438.100(a)(1) Contract 3.10.16.1	**HSAG Recommended Evidence:** • Policies and procedures **Evidence as Submitted by the MCO:** HPN_WRHCO 355 Member Rights and Responsibilities HPN_Website Rights.Responsibilities HPN_Provider Summary Guide Section 8.7	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
2. The MCO complies with any applicable federal and State laws that pertain to member rights and ensures that its employees and contracted providers observe and protect those rights. 42 CFR §438.100(a)(2)	**HSAG Recommended Evidence:** • Policies and procedures • Provider materials, such as the provider manual, provider contract, and provider training materials • Employee training materials • Auditing/oversight mechanisms **Evidence as Submitted by the MCO:** HPN_WRHCO 355 Member Rights and Responsibilities HPN_Provider Summary Guide Section 8.7 HPN_PCP FFS Template: pg. 6, Section K.1 HPN_Consulting Provider Template: pgs. 6-7, sec I.1 HPN_Medicaid Complaints Closed_110120 – 053121	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
Specific Rights: Basic Requirement		
3. The MCO ensures that each managed care member is guaranteed the rights as specified in 42 CFR §438.100(b)(2) and (3)—Refer to the Member Rights Checklist. 42 CFR §438.100(b)(1-3) Contract 3.6.1.1(B)(6), 3.6.1.2(A)(1), 3.10.16.1	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • HSAG will use the results of the Member Rights Checklist. **Evidence as Submitted by the MCO:** HPN_Member Handbook pg. 78-79 HPN_Website Rights.Responsibilities HPN_WRHCO 355 Member Rights and Responsibilities HPN_Provider Summary Guide Section 8.7	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
Language Requirements: Basic Rule		
4. The MCO uses: a. Definitions for managed care terminology, including appeal, copayment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance,	**HSAG Recommended Evidence:** • Policies and procedures • Model member handbook and notice templates, as applicable • Member materials, such as the member handbook	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, nonparticipating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. b. Model member handbook and member notices. 42 CFR §438.10(c)(4)(i-ii)	• Member notice templates, such as ABD, grievance, and appeal letter templates **Evidence as Submitted by the MCO:** HPN_Member Handbook pgs. 25, 31, 33, 68 for examples HPN_Medicaid Points of Care Flyer HPN_Health Plan ID Card Flyer HPN_Discover the Difference Flyer HPN_Example Member Notice 1 Eng HPN_Example Member Notice 2 Eng HPN_Health Care Terms Online	
MCO Description of Process: While the DHCFP does not provide model Member Handbooks or Notices, the health plan utilizes plain language, written at 8th grade reading level or below, to ensure our members understand the terminology in all communications we present. In the flyers and letters provided as examples, terms are used, followed by examples or other narrative to describe the word or situation.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** HSAG recommends that the MCO consult with DHCFP to determine whether a model member handbook and notices can be developed to comply with federal rule.		
Required Actions: None.		
5. Member information required in 42 CFR §438.10 may not be provided electronically by the MCO unless all of the following are met: a. The format is readily accessible; b. The information is placed in a location on the MCO's website that is prominent and readily accessible;	**HSAG Recommended Evidence:** • Policies and procedures • Example of member information that is only provided in an electronic format; and subsequent communication to inform the member of the availability of electronic information • Reporting or tracking mechanisms for providing member materials in paper form upon request	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
c. The information is provided in an electronic form which can be electronically retained and printed; d. The information is consistent with the content and language requirements of 42 CFR §438.10; and e. The member is informed that the information is available in paper form without charge upon request and the MCO provides it upon request within five (5) business days. 42 CFR §438.10(c)(6)(i-v)	**Evidence as Submitted by the MCO:** HPN_Member Handbook, pg 2, 60 HPN_Member Newsletter pages 2 and 4	
MCO Description of Process: As an example, the Provider Directory is provided electronically, in an accessible location, available on HPNMedicaid.com and the location is communicated to all member households in flyers, newsletters, and documents such as the Member Handbook, at a reading level and prevalent language to be easily understood. The Directory can be saved and printed.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
Language and Format		
6. The MCO makes its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its particular service area. a. Written materials that are critical to obtaining services must also be made available in alternative formats upon request of the potential member or member at no cost, include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the	**HSAG Recommended Evidence:** • Policies and procedures • Spanish member handbook (provide handbook and link to website) • Spanish provider directory (provide excerpts of directory and link to website) • Taglines included with member information **Evidence as Submitted by the MCO:** HPN_Member Handbook pages 3-4	☐ Met ☒ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
information provided, information on how to request auxiliary aids and services, and include the toll-free and Telecommunications Device for the Deaf/TeleTYpewriter (TTY/TDY) telephone number of the MCO's member/customer service unit. b. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost. 42 CFR §438.10(d)(3) Contract 3.6.1	HPN_Member Handbook Spanish (in drop down) HPN_Provider Directory Spanish_(Link) HPN_WRHCO 346 – Member and Provider Communication Policy HPN_Member Requests for Alternative Formats	
MCO Description of Process:		
HSAG Findings: The WRHCO 346 Member and Provider Communication Policy specified that taglines must be written in at least 12-point font. Although the MCO included taglines for most written critical materials in what appears to be 12-point font, the taglines, however, were not in a conspicuously visible font size in accordance with federal regulations. Additionally, taglines were not included in either the landing page for the online provider search tool or the printable version of the provider directory. **Recommendations:** HSAG recommends that the MCO define "conspicuously visible" font size to be greater than a 12-point font to ensure the taglines are clearly visible and stand out from the other text.		
Required Actions: The MCO must ensure that written materials that are critical to obtaining services, include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided.		
7. The MCO provides information to members who are limited English proficient through the provision of language services at no cost to the individual.	**HSAG Recommended Evidence:** • Policies and procedures • Linguistic analysis of the member population • Screen shot of the health information system (HIS) where the primary language of the member is stored	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
a. *Written information must also be available in the prevalent non-English languages, as determined by DHCFP, in its particular geographic service area.* b. The MCO shall also identify additional languages that are prevalent among the MCO's membership. i. *All materials shall be translated when the MCO is aware that a language is spoken by 3,000 or 10 percent (whichever is less) of the MCO's members who also have limited English proficiency (LEP) in that language.* ii. *All vital materials shall be translated when the MCO is aware that a language is spoken by 1,000 or 5% (whichever is less) of the MCO's members who also have LEP in that language. Vital materials must include, at a minimum, notices for denial, reduction, suspension, or termination of services*; appeal and grievance notices; provider directories; *and vital information from the member handbook.* iii. *All written notices informing members of their right to interpretation and translation services shall be translated into the appropriate language when the MCO's caseload consists of 1,000 members who speak that language and have LEP.* c. Written information shall be provided in any such prevalent languages identified by the MCO. 42 CFR §438.10(d)(4) 42 CFR. §438.340(b)(6) Contract 3.4.2.15(C)(3)(a-c), 3.6.1	• Workflow for generating member materials/information in a member's primary language (English and Spanish) that is stored in the HIS • Two examples of member notices, such as an ABD notice, grievance resolution letter, and appeal resolution letter, etc., sent in Spanish **Evidence as Submitted by the MCO:** HPN_WRHCO 346 – Member and Provider Communication Policy HPN_Member Requests for Alternative Formats HPN_Medicaid QI Prog Eval Section 3: pages 2-3 HPN_Medicaid Member Linguistic Analysis 3.2021 HPN_Example Member Notice 1 HPN_Example Member Notice 2	

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
8. The MCO notifies its members: a. That oral interpretation is available for any language and written translation is available in prevalent languages; b. That auxiliary aids and services are available upon request and at no cost for members with disabilities; and c. How to access the services in §438.10(d)(5)(i) and (ii). 42 CFR §438.10(d)(5)(i-iii) Contract 3.6.1	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCO:** HPN_Member Handbook pgs. 2 - 4, 6	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
9. The MCO provides all written materials for potential members and members consistent with the following: a. Use easily understood language and format. b. Use a font size no smaller than 12 point. c. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or LEP, *in accordance with the requirements of the Americans with Disabilities Act of 1990.*	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook and member newsletter • Examples of member notices, such as an ABD notice, grievance resolution letter, appeal resolution letter, etc. • Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.10(d)(6)(i-iii) Contract 3.6.1	• Workflow and verification procedures for ensuring member materials are 508 compliant • Taglines included with member information	
	Evidence as Submitted by the MCO: HPN_Member Handbook pgs. 2 - 4, 6 HPN_NV_MemberHandbook-Eng_RGL_5.5 HPN_WRHCO 346 – Member and Provider Communication Policy HPN_Member Newsletter HPN_Medicaid Points of Care Flyer HPN_Health Plan ID Card Flyer HPN_Discover the Difference Flyer HPN_LanguageLine_Summary	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
Information for All Members With MCO—General Requirements		
10. The MCO must make a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider.	**HSAG Recommended Evidence:** • Policies and procedures • Example of a written notice to members of provider termination (include the effective date of the termination or receipt or issuance of the termination notice for this example)	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
a. Notice to the member must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice. 42 CFR §438.10(f)(1) Contract 3.6.1.1(D), 3.7.5.11(A)	• Tracking or reporting mechanisms (mailing date and effective date of the termination or receipt or issuance of the termination notice must be notated) **Evidence as Submitted by the MCO:** HPN_Medicaid Provider Termination Policy HPN_Provider Termination Spreadsheet_April 2021 HPN_Provider Term Letters to Members	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** Although the example provider termination notice was provided to members more than 30 calendar days prior to the effective date of the termination, and the Medicaid Provider Termination policy indicated that the MCO will provide notice to the member within 15 calendar days of receipt of issuance of the termination notice, HSAG strongly recommends that the MCO consider whether the more stringent time frame of 15 calendar days is always appropriate. HSAG further recommends that the MCO update its written documentation to align with federal requirements, which would allow the MCO more flexibility in providing notice to members.		
Required Actions: None.		
11. The MCO must make available, upon request, any physician incentive plans in place as set forth in 42 CFR §438.3(i). 42 CFR §438.3(i) 42 CFR §438.10(f)(3) Contract 3.7.6.6	**HSAG Recommended Evidence:** • Policies and procedures • Summary of physician incentive plans • Example of physician incentive plans provided to a member upon request (if an example is not available, please state so under the MCO Description of Process) **Evidence as Submitted by the MCO:** HPN_Member Handbook pg. 63 HPN_Medicaid Provider Incentive Program	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: HPN has never had a member request information about a physician incentive plan.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
Advance Directives		
12. Pursuant to Section 1902(w)(1) of the Social Security Act, the Patient Self-Determination Act, including advance directives, the MCO must have written policies and procedures with respect to all emancipated adult members receiving medical care through the MCO. 42 CFR §438.3(j)(1) Contract 3.6.1.2	**HSAG Recommended Evidence:** • Policies and procedures **Evidence as Submitted by the MCO:** HPN_WRHCO 286 Medicaid Advance Directive Policy	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
13. The MCO is required to provide written information to each member at the time of enrollment concerning: a. The member's rights, under State law, to make decisions concerning medical care, including the right to accept or refuse medical treatment and the right to formulate advance directives; b. The MCO's policies with regard to a member's right to execute an advance directive, including a requirement that the network provider present a statement of any limitations in	**HSAG Recommended Evidence:** • Policies and procedures • Written member informational materials • Tracking reports **Evidence as Submitted by the MCO:** HPN_Member Handbook pgs. 65, 66 and 78	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
the event the provider cannot implement an advance directive on the basis of conscience. c. *At a minimum, the MCO's statement of limitation, if any, must:* i. *Clarify any differences between institution-wide conscience objections and those that may be raised by individual network providers;* ii. *Identify the State legal authority pursuant to Nevada Revised Statute (NRS) 449.628 permitting such objections; and* iii. *Describe the range of medical conditions or procedures affected by the conscience objection.* 42 CFR §438.3(j)(3) Contract 3.6.1.2 (A)(1-2)	HPN_WRHCO 286 Medicaid Advance Directive Policy	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
Information for All Members With MCO—Member Handbook		
14. The MCO must provide each member a member handbook, *within five (5) business days* after receiving notice of the member's enrollment, which serves a similar function as the summary of benefits and coverage described in 45 CFR §147.200(a).	**HSAG Recommended Evidence:** • Policies and procedures • Tracking or reporting mechanisms (include the date the MCO received notice of the member's enrollment and the mailing date of the member handbook/member enrollment materials)	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
a. *The MCO must notify all members of their right to request and obtain this information at least once per year or upon request.* 45 CFR §147.200(a) 42 CFR §438.10(g)(1) Contract 3.6.1.1(B)	**Evidence as Submitted by the MCO:** HPN_Medicaid Welcome Kit TAT HPN_WRHCO 273 New Member Orientation Policy HPN_Member Newsletter	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
15. The content of the member handbook must include information that enables the member to understand how to effectively use the managed care program—Refer to the Member Handbook Checklist. 42 CFR §438.10(g)(2) Contract 3.6.1.1	**HSAG Recommended Evidence:** • Member handbook (provide handbook and link to website) • HSAG will also use the results of the Member Handbook Checklist. **Evidence as Submitted by the MCO:** HPN_Member Handbook pg. 6 (Link to main page of Medicaid site – pdf of handbook under dropdown under "I need help with")	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
16. Information required by 42 CFR §438.10(g) (member handbook) is considered to be provided by the MCO if the MCO: a. Mails a printed copy of the information to the member's mailing address;	**HSAG Recommended Evidence:** • Policies and procedures • Reporting or tracking mechanisms for providing the member handbook in paper form via mail	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
b. Provides the information by email after obtaining the member's agreement to receive the information by email; c. Posts the information on the website of the MCO and advises the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or d. Provides the information by any other method that can reasonably be expected to result in the member receiving that information. 42 CFR §438.10(g)(3) Contract 3.6.1.1	• Member enrollment materials **Evidence as Submitted by the MCO:** HPN_WRHCO 273 New Member Orientation Policy HPN_Medicaid Welcome Kit TAT HPN_Welcome Packet Contents HPN_Member Handbook pgs. 2 - 4, 6	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
17. The MCO must give each member notice of any change that DHCFP defines as significant in the information specified in 42 CFR §438.10(g) (member handbook), at least 30 days before the intended effective date of the change, *when there are material changes that will affect access to services and information about the Managed Care Program*. 42 CFR §438.10(g)(4) Contract 3.6.1.1(C)	**HSAG Recommended Evidence:** • Policies and procedures • Example of a member notice due to a significant change in the information in the member handbook, including the date of notice and date of change (if no significant change, please state so under the MCO Description of Process) • Tracking or reporting mechanisms for providing timely notice of a significant change	☐ Met ☒ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCO: HPN_Member Newsletter page 2	
MCO Description of Process: There was no significant change to the Member Handbook during the audit period. In general, should a notice of significant change occur, this would be included in the Member Newsletter in a dedicated space on the Contents page. In addition, an Addendum may be included in the New Member Kit outlining any changes.		
HSAG Findings: MCO staff members explained during the interview session that should a significant change occur, members would be notified of changes through the member newsletter. The member newsletter submitted for the review included a statement indicating, "Have you read your Member Handbook? It's a great source of information. It tells you how to use your health plan and includes changes to your plan benefits." This language implies that changes were made to the members' benefits without provision of notice to members prior to the update being made. Additionally, a formal document, such as a policy, SOP, or other guidance document outlining the MCO's process for member notification of significant changes was not provided.		
Required Actions: The MCO must ensure that it gives each member notice of any change that DHCFP defines as significant in the information specified in 42 CFR §438.10(g) (member handbook), at least 30 days before the intended effective date of the change, and when there are material changes that will affect access to services and information about the Managed Care Program per the State contract.		
Information for All Members of MCO—Provider Directory		
18. The MCO must make available in paper form upon request and electronic form, information about its network providers—Refer to the Provider Directory Checklist. 42 CFR §438.10(h) Contract 3.7.7, 3.14.7.2	**HSAG Recommended Evidence:** • Provider directory (provide excerpts of the directory and link to the website) • HSAG will also use the results of the Provider Directory Checklist. **Evidence as Submitted by the MCO:** HPN_Provider Directory *Link to online provider directory:* https://myhpnmedicaid.com	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: HPN is currently in a transition period from our previous online directory vendor – Talispoint – to the current directory managed by HealthSparq, which went live on 5/24/21. While Talispoint was up during the audit period, it is no longer available for review online.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
19. Information included in— a. A paper provider directory must be updated at least— i. Monthly, if the MCO does not have a mobile-enabled, electronic directory; or ii. Quarterly, if the MCO has a mobile-enabled, electronic provider directory. b. An electronic provider directory must be updated no later than 30 calendar days after the MCO receives updated provider information. 42 CFR §438.10(h)(3) Contract 3.14.7.4, 3.16.5	**HSAG Recommended Evidence:** • Policies and procedures • Verification of a mobile-enabled electronic provider directory • Workflow to update the paper and electronic provider directories • Evidence how updates to the paper and electronic provider directories are date stamped **Evidence as Submitted by the MCO:** HPN_Online Directories Policy: pg. 1 HPN_Online Directories SOP HPN_Provider Directory Scheduling and Process Overview: pg. 1-2 https://myhpnmedicaid.com	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
20. Provider directories must be made available on the MCO's website in a machine-readable file and format as specified by the Secretary. 42 CFR §438.10(h)(4) Contract 3.16.5	**HSAG Recommended Evidence:** • Policies and procedures • Provider directory (provide a link to the website) • Verification that the provider directory is available in a machine-readable file and format **Evidence as Submitted by the MCO:** HPN_Provider Directory Screenshot_HPNMedicaidSN *Link to online provider directory:* https://myhpnmedicaid.com	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
Information for All Members of MCO—Preferred Drug List		
21. The MCO must make available in electronic or paper form the following information about its formulary: a. Which medications are covered (both generic and name brand). b. What tier each medication is on.	**HSAG Recommended Evidence:** • Policies and procedures • Formulary (provide a link to the website and excerpts of the formulary) • Verification that the electronic formulary is available in a machine-readable file and format	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
c. Formulary drug lists must be made available on the MCO's website in a machine-readable file and format as specified by the Secretary. 42 CFR §438.10(i)(1-3) Contract 3.14.7.1(D)	**Evidence as Submitted by the MCO:** HPN_Medicaid Member PDL 412021 Eng HPN_Formulary-Machine Readable (JSON) Medicaid PDL	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
Information for all Members of MCO—Member Newsletter		
22. *The MCO, subject to the prior review and approval of DHCFP, must publish a newsletter for enrolled members at least twice per year.* a. *The newsletter focuses on topics of interest to enrolled members;* b. *The newsletter must be written at an eighth (8th)-grade level of understanding reflecting cultural competence and linguistic abilities.* c. *The MCO must provide a copy of all newsletters to the DHCFP. Additionally, these newsletters and announcements regarding provider workshops must be published on the MCO's website.* Contract 3.7.8.4	**HSAG Recommended Evidence:** • Policies and procedures • Examples of member newsletters published during fiscal year (FY) 21 • Documentation of DHCFP's approval of member newsletters • Evidence that member newsletters are written at the required reading grade level • Screen shot of the MCO's website where member newsletters are posted **Evidence as Submitted by the MCO:** HPN_Newsletter Online Availability HPN_Newsletter State Approval GL HPN_For Acknowledgement – HPN Provider Newsletter https://myhpnmedicaid.com/Provider/Provider-Newsletter	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		

Standard II—Member Rights and Member Information						
Met	=	20	X	1	=	20
Not Met	=	2	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	22	Total Score		=	20
Total Score ÷ Total Applicable					=	91%

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Definitions		
1. The MCO defines "emergency medical condition" as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. b. Serious impairment to bodily functions. c. Serious dysfunction of any bodily organ or part. 42 CFR §438.114(a)	**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:** HPN_Member Handbook: pg. 32 HPN_PCP FFS Template: pg. 2, Article 1.I HPN_Consulting Provider Template: pg. 2, Article 1.K HPN_Provider Summary Guide: pg. 5, sec 8.7 HPN_WRHCO 132 Out-of-Area and Non Contracted Services HPN_UM Policy HCO100 pg 23 HPN_Reviewer Guidelines of Emergent Condition HPN_Claims Emergency Services Policy pg 1 HPN_UM Prog Desc pg 10	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
2. The MCO defines "emergency services" covered inpatient and outpatient services that are as follows: a. Furnished by a provider that is qualified to furnish these services under this Title.	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual	☒ Met ☐ Not Met ☐ NA

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
b. Needed to evaluate or stabilize an emergency medical condition. 42 CFR §438.114(a)	**Evidence as Submitted by the MCO:** HPN_Member Handbook: pg. 32	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
3. The MCO defines "poststabilization care services" as covered services, related to an emergency medical condition, that are provided after a member is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR §438.114(e), to improve or resolve the member's condition. 42 CFR §438.114(a)	**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:** HPN_Member Handbook: pg. 32	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** HSAG recommends that the MCO review the member handbook and further define "under the circumstances" or consider removing this language from the definition.		
Required Actions: None.		

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Coverage and Payment		
4. The MCO must cover and pay for emergency services, *both in and out of state,* regardless of whether the provider that furnishes the services has a contract with the MCO. a. *No prior or post-authorization can be required for emergency care provided by either network or out-of-network providers.* 42 CFR §438.114(c)(1)(i) Contract 3.4.9.2(A-B)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim algorithm for emergency services **Evidence as Submitted by the MCO:** HPN_Member Handbook: pg. 28 and 34 HPN_WRHCO 132 Out-of-Area and Non Contracted Services HPN_Provider Summary Guide: pg. 6, sec 8.9 HPN_UM Policy HCO100 page 23 HPN_Medicaid Claims Processing Policy page 5	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
5. The MCO may not deny payment for treatment obtained under either of the following circumstances: a. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in (1), (2), and (3) of the definition of "emergency medical condition" in 42 CFR §438.114(a). b. A representative of the MCO instructs the member to seek emergency services.	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim algorithm for emergency services **Evidence as Submitted by the MCO:** HPN_WRHCO 132 Out-of-Area and Non Contracted Services	☒ Met ☐ Not Met ☐ NA

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.114(c)(1)(ii)(A-B) Contract 3.4.9.2(B)	HPN_UM Policy HCO100 page 23 HPN_Medicaid Claims Processing Policy page 5-6 HPN_UM Prog Desc pg 10	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
Additional Rules for Emergency Services		
6. The MCO may not: a. Limit what constitutes an "emergency medical condition" with reference to 42 CFR §438.114(a), on the basis of lists of diagnoses or symptoms; and b. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, MCO, or DHCFP of the member's screening and treatment within 10 calendar days of presentation for emergency services. 42 CFR §438.114(d)(1)(i-ii) Contract 3.4.9.2(C)	**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:** HPN_UM Policy HCO100: pg. 23 HPN_2021 UM Prog Desc: pg. 10 HPN_WRHCO 132 Out-of-Area and Non Contracted Services	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
7. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member. 42 CFR §438.114(d)(2) Contract 3.4.9.2(D)	**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:** HPN_WRHCO 132 Out-of-Area and Non Contracted Services HPN_Medicaid Claims Processing Policy page 6	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
8. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in 42 CFR §438.114(b) as responsible for coverage and payment. 42 CFR §438.114(d)(3) Contract 3.4.9.2(D)	**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:** HPN_WRHCO 132 Out-of-Area and Non Contracted Services	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** HSAG strongly recommends that the MCO review and update its written documentation (e.g., provider manual) to specifically indicate that the treating provider is responsible for determining when the member is stabilized for transfer or discharge. Implementation of these recommendations will be further assessed during future compliance reviews.		
Required Actions: None.		

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Coverage and Payment: Poststabilization Care Services		
9. Poststabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR §422.113(c). The MCO: a. Is financially responsible (consistent with 42 CFR §422.214) for poststabilization care services obtained within or outside the MCO that are pre-approved by a plan provider or other organization representative; b. Is financially responsible for poststabilization care services obtained within or outside the MCO that are not pre-approved by a plan provider or other MCO representative, but administered to maintain, improve, or resolve the member's stabilized condition if— i. The MCO does not respond to a request for pre-approval within one (1) hour; ii. The MCO cannot be contacted; or iii. The MCO representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the member until a plan physician is reached or one of the criteria in 42 CFR §422.113(c)(3) is met; and c. Must limit charges to members for poststabilization care services to an amount no greater than what the MCO would charge the member if he or she had obtained the services through the MCO. For purposes of cost sharing,	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Workflow for claims review process for poststabilization services **Evidence as Submitted by the MCO:** HPN_Member Handbook: pg. 40 HPN_WRHCO 132 Out-of-Area and Non Contracted Services HPN_Medicaid Claims Processing Policy page 6	☒ Met ☐ Not Met ☐ NA

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
poststabilization care services begin upon inpatient admission. 42 CFR §422.113(c)(2)(i-iv) 42 CFR §422.214 42 CFR §438.114(e) Contract 3.4.10(A-C), (E)		
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
10. The MCO's financial responsibility for poststabilization care services it has not pre-approved ends when— a. A plan physician with privileges at the treating hospital assumes responsibility for the member's care; b. A plan physician assumes responsibility for the member's care through transfer; c. An MCO representative and the treating physician reach an agreement concerning the member's care; or d. The member is discharged. 42 CFR §422.113(c)(3)(i-iv) 42 CFR §438.114(e) Contract 3.4.10(D)	**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:** HPN_UM Policy HCO100 pg 24 HPN_WRHCO 132 Out-of-Area and Non Contracted Services HPN_Medicaid Claims Processing Policy page 6	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		

Standard III—Emergency and Poststabilization of Services						
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 IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Delivery Network		
1. The MCO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities. 42 CFR §438.206(b)(1) Contract 3.4.2.7	**HSAG Recommended Evidence:** • Provider contract • Analysis of provider network linguistic capabilities • Analysis of provider network capabilities to serve members with special health care needs **Evidence as Submitted by the MCO:** HPN_Medicaid QI Prog Eval Section 3_Linguistic Analysis: pgs. 2-3 HPN_PCP FFS Template: pgs. 16-19 HPN_Consulting Provider Template: pgs. 17-20 HPN_Provider Directory HPN_Online Directory Screenshot ABA Provider HPN_Access and Availability Policy: pg.3 HPN_402 Network Adequacy_2nd Q 2021 HPN_402 Network Adequacy_3rd Q 2021	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
2. The MCO provides female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Claims algorithm **Evidence as Submitted by the MCO:** HPN_Member Handbook: pg. 28, 43, 78	☒ Met ☐ Not Met ☐ NA

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.206(b)(2) Contract 3.4.2.8(E)	HPN_Provider Summary Guide: pg. 4, section 8.7	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
3. The MCO provides for a second opinion from a network provider or arranges for the member to obtain one outside the network, at no cost to the member. 42 CFR §438.206(b)(3) Contract 3.4.2.10	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Second opinion tracking/analysis **Evidence as Submitted by the MCO:** HPN_Member Handbook: pg. 27 and 78 HPN_WRHCO 354 Second Opinion HPN_Provider Summary Guide: pg. 5, sec 8.7	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
4. If the provider network is unable to provide necessary services, covered under the contract, to a particular member, the MCO must adequately and timely cover these services out of network for the member, for as long as the MCO's provider network is unable to provide them. 42 CFR §438.206(b)(4) Contract 3.4.2.9	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Tracking/analysis of services unavailable in network/provider out of network **Evidence as Submitted by the MCO:** HPN_Member Handbook: pg. 20, 78 HPN_Letters of Agreement Policy	☒ Met ☐ Not Met ☐ NA

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	HPN_Provider Summary Guide: pg. 5, sec 8.7 HPN_LOA Example	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
5. The MCO requires out-of-network providers to coordinate with the MCO for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network. a. *The MCO must exhaust all out-of-network providers located within 25 miles of the member's address before contracting with out-of-network providers located over 25 miles from the member's address.* 42 CFR §438.206(b)(5) Contract 3.4.2.9	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • One example of an executed single case agreement **Evidence as Submitted by the MCO:** HPN_Member Handbook: pg. 20 HPN_Letters of Agreement Policy HPN_LOA Example HPN_WRHCO 132 Out of Area and Non Contracted pg 3 HPN_PA-022 Out of Area Outreach HPN_PA-023 Local Out of Plan Outreach	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
6. The MCO demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. 42 CFR §431.51(b)(2) 42 CFR §438.206(b)(7)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Network analysis of family planning providers, including a comparison of family planning providers enrolled in Nevada Medicaid and family planning providers contracted with the MCO • Claims algorithm **Evidence as Submitted by the MCO:** HPN_Member Handbook: pg. 41, 47, 51 HPN_PCP FFS Template: pg. 18, Article III.7a-b HPN_Consulting Provider Template: pg. 19, Article III.7a-b HPN_Family Planning Utilization by Provider	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
Timely Access		
7. The MCO must do the following: a. Meet and require its network providers to meet DHCFP standards for timely access to care and services, taking into account the urgency of the need for services. i. *The MCO has written policies and procedures regarding appointment standards and disseminated the standards to all network providers*—Refer to the Access Standards: Appointment Times Checklist.	**HSAG Recommended Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Network analysis (e.g., appointment standards) • Results of provider monitoring (e.g., secret shopper surveys) • One example of corrective action when a provider failed to meet access standards	☒ Met ☐ Not Met ☐ NA

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
ii. *The MCO must assign a specific staff member of its organization to ensure compliance with these standards by the network.* b. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service (FFS), if the provider serves only Medicaid members. c. Make services included in the contract available 24 hours a day, seven days a week, when medically necessary. d. Establish mechanisms to ensure compliance by network providers. e. Monitor network providers regularly to determine compliance. f. Take corrective action if there is a failure to comply by a network provider. 42 CFR §438.206(c)(1)(i-vi) Contract 3.4.2.13	• HSAG will also use the results of the Access Standards: Appointment Times Checklist. **Evidence as Submitted by the MCO:** HPN_Access and Availability Policy: pg. 8 and pgs. 19-23 HPN_PCP FFS Template: pg. 17, Article III.1-3 HPN_Consulting Provider Template: pg. 18, Article III.1-3 HPN_Provider Summary Guide: pg. 4, sec 8.7 and pgs. 13-14, sec 8.13 HPN_NV Access & Availability Secret Shopper Results HPN_Secret Shop QQ Analysis HPN_Access Standards Postcard HPN_Non-Compliant SShop letter HPN_Dir Prov Svc JD	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Steps to Assure Accessibility of Services		
8. *The MCO must have written policies and procedures describing how members and providers can obtain urgent coverage after business hours and on weekends. Policies and procedures must include provision of direct contact with qualified clinical staff. Urgent coverage means those problems which, though not life-threatening, could result in serious injury or disability unless medical attention is received.* Contract 3.4.2.14	**HSAG Recommended Evidence:** • Policies and procedures **Evidence as Submitted by the MCO:** HPN_Member Handbook: pg. 26 HPN_Access and Availability Policy: pg. 20 HPN_Provider Summary Guide: pg.4, sec 8.7 and pg. 14, sec 8.13	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
Access and Cultural Considerations		
9. The MCO participates in DHCFP's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex. 42 CFR §438.206(c)(2) Contract 3.4.2.15	**HSAG Recommended Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Cultural competency plan • Analysis of provider network linguistic capabilities • Analysis of provider network cultural competence **Evidence as Submitted by the MCO:** HPN_Member Handbook: pg. 2 HPN_WRHCO 357 Cultural Competency Policy HPN_2021 HPN Cultural Div and Sens Prog Overview	☒ Met ☐ Not Met ☐ NA

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	HPN_Provider Summary Guide: pgs. 14-15, sec 8.15 HPN_PCP FFS Template: pg. 16, Article II.C HPN_Consulting Provider Template: pg. 17, Article II.C HPN_Access and Availability Policy: pgs.9-10 HPN_Medicaid QI Prog Eval Section 3_Linguistic Analysis: pgs. 2-3 & 4-5 HPN_Site Visit Form HPN_100-03 Site Visit Policy: pg.3	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
Accessibility Considerations		
10. The MCO must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. 42 CFR §438.206(c)(3) Contract 3.10.16.7(A-B), 3.14.7.2	**HSAG Recommended Evidence:** • Policies and procedures • Provider materials such as the provider manual and provider contract • Analysis of provider network capability to provide services to members with physical or mental disabilities **Evidence as Submitted by the MCO:** HPN_CR 300 Cred-Recred Policy: pgs. 34-36 HPN_Online Directory Screenshot_Accessibility	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		

Standard IV—Availability of Services						
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 V—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
Basic Rule		
1. The MCO gives assurances to DHCFP and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with DHCFP's standards for access to care under 42 CFR §438.207, including the standards at §438.68 and §438.206(c)(1). a. Each MCO must submit documentation to DHCFP, in a format specified by DHCFP, to demonstrate that it complies with the following requirements: i. Offers an appropriate range of preventive, primary care, specialty services, and long-term services and supports (LTSS) that is adequate for the anticipated number of members for the service area. ii. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. 42 CFR §438.207(a);(b)(1-2) Contract 3.7; 3.7.2.11	**HSAG Recommended Evidence:** • Policies and procedures • Time/distance analysis • Member/provider ratio analysis • Exceptions approved by DHCFP • HSAG will also use the results of the Access Standards: Time/Distance Checklist. **Evidence as Submitted by the MCO:** HPN_Access and Availability Policy: pgs. 11-15 HPN_402_Network Adequacy_2nd Q 2021 2-9-21 402 Upload into Folder HPN Inbound Confirmed HPN_402_Network Adequacy_3rd Q 2021 5-7-21 402 Upload into Folder HPN Inbound Confirmed	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		

Standard V—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
Timing of Documentation		
2. Each MCO must submit the documentation described in 42 CFR §438.207(b) as specified by DHCFP, but no less frequently than the following: a. At the time it enters into a contract with DHCFP. b. On an annual basis. c. At any time there has been a significant change (as defined by DHCFP) in the MCO's operations that would affect the adequacy of capacity and services, including— i. Changes in MCO services, benefits, geographic service area, composition of or payments to its provider network; or ii. Enrollment of a new population in the MCO. d. *Upon request by the DHCFP, the MCO must confirm the network adequacy and accessibility of its provider network and any subcontractor's provider network.* 42 CFR §438.207(c)(1-3) Contract 3.7.2.11; 3.7.7; 3.16.5	**HSAG Recommended Evidence:** • Policies and procedures • Most recent annual assurances of adequate capacity and services submission to DHCFP • Assurances of adequate capacity and services submission to DHCFP due to a significant change (if no significant change, indicate in the MCO Description of Process) **Evidence as Submitted by the MCO:** HPN_ Notice of Significant Network Change NV2020-21_NAV_Report_D2	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		

Standard V—Assurances of Adequate Capacity and Services						
Met	=	2	X	1	=	2
Not Met	=	0	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	2	Total Score		=	2
Total Score ÷ Total Applicable					=	100%

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Care and Coordination of Services for All MCO Members		
1. The MCO must ensure that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. The member must be provided information on how to contact their designated person or entity. a. *For members with case management needs, the designated PCP is the physician who will manage and coordinate the overall care for the member.* 42 CFR §438.208(b)(1) Contract 3.6.1.1(B)(2); 3.6.3.1, and 3.10.20.2(F)	**HSAG Recommended Evidence:** • Policies and procedures • Screen shot of assigned PCP in system • ID card with assigned PCP **Evidence as Submitted by the MCO:** HPN_WRHCO 279 Assignment of PCP for Medicaid and NCU Members HPN_Provider Summary Guide: pgs. 10-11, sec 8.11 HPN_PCP Assignment from OPC HPN_Member Handbook pg 20	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Note: PCP Assignment is not included on the Member ID.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
2. The MCO must coordinate the services the MCO furnishes to the member: a. Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays; b. With the services the member receives from any other MCO, PIHP, or PAHP; c. With the services the member receives in FFS Medicaid; and d. With the services the member receives from community and social support providers.	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use results from the Care Management File Review. **Evidence as Submitted by the MCO:** HPN_WRHCO 279 Assignment of PCP for Medicaid and NCU Members HPN_Complex Case Management Policy: page 1, section 1.1; page 2, section 4.1; page 3, section 6.1.3; page 4, section 8.4.4;	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.208(b)(2)(i-iv) Contract 3.4.14	page 5, sections 8.4.5, 8.4.6, 8.4.8, and 8.4.9; page 7, section 8.5.11 HPN_Coordination Acute to SNF Example HPN_Coordination with Liberty Dental Example HPN_Coordination with Community Resource Example HPN_Coordination with County Example HPN_Coordination with Law Example HPN_Coordination with State Agency Example	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
3. The MCO must ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards. 42 CFR §438.208(b)(5) Contract 3.7.3.1(F); 3.8	**HSAG Recommended Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Oversight of provider medical record practices, such as audits, site visits, etc. **Evidence as Submitted by the MCO:** HPN_Provider Summary Guide: pgs. 11-13, section 8.12 HPN_PCP FFS Template: pg. 18 HPN_Consulting Provider Template: pg. 19 HPN_Example of Medical Record Review during Site Visit	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** The MCO provided only an excerpt of a medical record review (MRR) tool which was not dated; therefore, HSAG requested that the complete copy be submitted. However, after the interview session, the MCO provided a narrative that suggested it had inadvertently submitted an MRR snapshot that was completed outside of the review period. The MCO further explained that MRRs are completed during credentialing site visits, which were suspended by the National Committee for Quality Assurance (NCQA) due to coronavirus disease 2019 (COVID-19); however, this information was not relayed to HSAG reviewers by MCO staff members during the interview session. As such, HSAG recommends that the MCO reinstate site reviews, and therefore MRRs, when appropriate. The MCO should also conduct desk reviews of medical records in lieu of site visits. Implementation of these recommendations will be further assessed during future compliance reviews.		
Required Actions: None.		
Health Needs Assessment Screening		
4. *The MCO must have mechanisms in place to screen and identify members potentially eligible for case management services. These mechanisms include:* *a. Administrative data review (e.g., diagnosis, cost threshold, and/or service utilization) and may also include:* *i. Telephone interviews;* *ii. Mail surveys;* *iii. Provider/self-referrals; or* *iv. Home visits.* Contract 3.10.20.2(A)	**HSAG Recommended Evidence:** • Policies and procedures • Tracking and reporting mechanisms for the method of identification of members who are potentially eligible for case management services **Evidence as Submitted by the MCO:** HPN_Complex Case Management Policy: page 2, section 5.0; page 3, sections 6.1 and 6.2 HPN_Risk Scoring Tool HPN_Member Profile HPN_Health Risk Survey Outreach Policy HPN_Medicaid HRA Survey Template HPN_WRHCO 161 Health Survey Screening and Assessments HPN_HRA Monthly Statistic Report HPN_HRA Survey-Detail Report	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
5. The MCO must make a best effort to conduct an initial screening of each member's needs within ninety (90) days of the effective date of enrollment for all new members. a. *Screening assessment for pregnant women, children with special health care needs, and adults with special health care needs must be conducted within thirty (30) days*; b. *The MCO must document at least three (3) attempts to conduct the screen. If unsuccessful the MCO must document the barrier(s) to completion and how the barriers shall be overcome so that the Health Needs Assessment can be accomplished with in the first one hundred and twenty (120) days*. c. *Face-to-face assessments shall be conducted, as necessary. The goals of the assessment are to identify the member's existing and/or potential health care needs and assess the member's need of case management services*. d. *The MCO will submit their Health Needs Assessment Screening form/s and data to the DHCFP upon request.* 42 CFR §438.208(b)(3) Contract 3.10.20.2(B)(1)(a-b)	**HSAG Recommended Evidence:** • Policies and procedures • Initial Health Needs Assessment Screening tool template • Internal tracking mechanisms • HSAG will also use results from the Care Management File Review. **Evidence as Submitted by the MCO:** HPN_Health Risk Survey Outreach Policy HPN_Medicaid HRA Survey Template HPN_WRHCO 161 Health Survey Screening and Assessments HPN_HRA Monthly Statistic Report HPN_HRA Survey-Detail Report HPN_Tracking Mechanism for Timely Completion of Care Plan	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: Initial screening outreach is performed to engage members within 90 days of enrollment in the plan, per the documentation provided. Unless a member self identifies, or we happen to call a member who is pregnant or has other special needs, there is no way HPN would know who these members are to perform initial screening activities within the first 30 days of enrollment. This information is not provided on the enrollment file		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
from the DHCFP. The one exception to that is if a member transitions from another MCO and a transition of care form is submitted to HPN identifying the pregnancy/special need. Those members receive outreach once HPN receives notice via the TOC form. However, that would not necessarily be the initial screening, it would be from the pertinent care management team (HROB, CM, DM, etc.)		
HSAG Findings: The case file review did not consistently demonstrate that the MCO conducted three attempts to complete the initial health risk screening. After the interview session, the MCO submitted a narrative response related to the health risk assessment (HRA) for each of the cases reviewed. For one case, the MCO explained it was unable to locate the HRA activity or attempts, but an unable to contact (UTC) letter was sent. The MCO further explained that it appears to be a possible documentation error if the representative did not document the attempts; however, the documentation provided did not meet the intent of this requirement. For a second case, the MCO explained that the member was showing a name change which may have impacted rotation into the survey report as there was no HRA activity; however, the documentation provided also did not meet the intent of the requirement. For a third case, the MCO explained that a call was attempted, and the phone number was no longer in service and an UTC letter was sent. As the MCO is required to address and overcome barriers to completing the initial screening, HSAG reviewers inquired how the MCO attempted to mitigate the barrier of not having a current phone number for this member. MCO staff members explained that research is conducted to locate any other phone number for the member. After the interview session, the MCO submitted a tracking sheet with examples of members who had no phone number listed on the enrollment file from DHCFP and any phone numbers identified through LexisNexis. However, this tracking sheet did not include the member from the case in question; therefore, it is unknown what was completed by the MCO in an attempt to locate other contact information for this member. **Recommendations:** HSAG recommends that the MCO consult with DHCFP regarding the 834-enrollment file and if it includes indicators for members who are identified as pregnant or having a special health care need. Additionally, HSAG recommends that the MCO enhance processes for ensuring all attempted contacts with a member to complete the initial health risk screening are documented, including actions taken in efforts to mitigate barriers such as the research completed to identify current contact information for members. Further, HSAG recommends that the MCO investigate how a member name change may impact the survey rotation, as this scenario may impact other members in the same situation.		
Required Actions: The MCO must make a best effort to conduct an initial screening of each member's needs within 90 days of the effective date of enrollment for all new members. Screening assessment for pregnant women, children with special health care needs, and adults with special health care needs must be conducted within 30 days. The MCO must document at least three attempts to conduct the screening. If unsuccessful, the MCO must document the barrier(s) to completion and how the barriers shall be overcome so that the Health Needs Assessment can be accomplished within the first 120 days.		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
6. The MCO must share with DHCFP or other MCOs, PIHPs, and PAHPs serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities. 42 CFR §438.208(b)(4) Contract 3.4.14.1(b)(4)	**HSAG Recommended Evidence:** • Policies and procedures • Two case examples of the MCO sharing assessment results: one with another MCE serving the member and one with DHCFP **Evidence as Submitted by the MCO:** HPN_WRHCO 276 Transition of Care HPN_PA_FILE_ANT_Jan 2021 Transfers HPN_PA_FILE_SSH_Nov 2020 Transfers HPN_ANT TOC HPN_TOC Email with State	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: During the last week of the month, the DHCFP provides a "transfer list" of members switching between each of the three MCOs. The MCOs are required to review the list of members transferring out of their plan, and determine if there is information that the new MCO would find valuable in the coordination of care. HPN reviews the transfer list for members who have prior authorizations (PA) on file, who are in the disease or case management programs, who may be locked-in to a particular pharmacy, or who are receiving Mental Health/Substance Abuse services, etc. As needed, HPN sends each MCO two types of documents each month: A PA list, with many members, and Transfer of Care (TOC) forms, with individualized information. Samples are included. The documents are sent via a secured FTP that has been set up between each MCO. The DHCFP has not set up a process to provide member information when a transition between FFS and HPN occurs. Although outside of the audit period, included in the documentation is an email with the State regarding the TOC process for FFS members, as context.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** HSAG recommends that the MCO continue to collaborate with DHCFP to develop a process to share information when a member transitions to or from fee-for-service; for example, sharing transition-of-care forms and open authorizations.		
Required Actions: None.		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Comprehensive Assessment		
7. The MCO must implement mechanisms to comprehensively assess each Medicaid member identified by DHCFP and identified to the MCO by DHCFP as needing LTSS or having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. a. *The assessment was completed by a physician, physician's assistant, registered nurse (RN), licensed practical nurse, licensed social worker, or a graduate of a two- or four-year allied health program.* b. *If the assessment was completed by another medical professional, there was documented oversight and monitoring by either a RN or physician.* 42 CFR §438.208(c)(1) Contract 3.10.20.2(C)	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use results from the Care Management File Review. **Evidence as Submitted by the MCO:** HPN_Complex Case Management Policy: page 4, section 8.4; Page 5, section 8.5 through 8.5.12 HPN_Assessment Template	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
8. *The comprehensive assessment evaluated all the following for the member.* a. *Physical health* b. *Comorbid conditions* c. *Behavioral health*	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use results from the Care Management File Review • Comprehensive Assessment Template	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
d. *Psycho-social* e. *Environmental* f. *Community support needs* Contract 3.10.20.2(C)	**Evidence as Submitted by the MCO:** HPN_Complex Case Management Policy: page 5, section 8.5.1; page 5, sections 8.5.4 and 8.5.5, page 7, section 8.5.11 HPN_Assessment Template	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
9. *The MCO provided information to members and their PCP that they have been identified as meeting the criteria for case management, including their enrollment into case management services.* Contract 3.10.20.2.1(C); 3.10.20.2(C)	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use results from the Care Management File Review • Notification and/or welcome letter template **Evidence as Submitted by the MCO:** HPN_Complex Case Management Policy: page 4, section 8.2; page 8, section 8.5.17.2 HPN_Care Plan Sent to PCP HPN_ Welcome Letter Template	☐ Met ☒ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: The case file review confirmed that the MCO did not send a communication to a member's primary care provider (PCP) informing the PCP that the member has been enrolled into care management services. MCO staff members explained that they do not send a communication to the PCP due to the provisions of the Nevada Revised Statutes (NRS) 433A.360 Clinical records: Contents; confidentiality. However, NRS 433A.360 does allow for the disclosure of information to a provider of health care to assist with treatment provided to a member. Additionally, according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), health care providers are permitted to disclose to other health providers any protected health information (PHI) contained in the medical record about an individual for treatment, case management, and coordination of care and, with few exceptions,		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
treats mental health information the same as other health information. HIPAA generally does not limit disclosures of PHI between health care providers for treatment, case management, and care coordination, except that covered entities must obtain individuals' authorization to disclose separately maintained psychotherapy session notes for such purposes. **Recommendations:** HSAG recommends that the MCO provide updated guidance to care managers for when PHI related to mental health information can be shared with health care providers for the purposes of treatment, case management, and coordination of care (i.e., when a member's consent is or is not required). Additionally, if a member's condition requires consent from a member to share PHI (e.g., substance use disorder), the MCO should be encouraging integrated care with the member and obtaining the member's consent or documenting the member's refusal.		
Required Actions: The MCO must provide information to members and their PCPs that they have been identified as meeting the criteria for case management, including their enrollment into case management services (including the circumstances when a member's consent is or is not required).		
Care Plan		
10. *Based on the assessment, the MCO coordinated the placement of the member into case management and developed a person-centered care plan within ninety (90) calendar days of membership.* Contract 3.10.20.2(E)(1)	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use results from the Care Management File Review • Tracking and reporting mechanisms for timely completion of the care plan **Evidence as Submitted by the MCO:** HPN_Complex Case Management Policy Section 8.5 HPN_Care Plan Template	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
11. *There is evidence that the following individuals were actively involved in the development of the care plan*: a. *Member* b. *Member's designated formal and informal supports* c. *Member's PCP* Contract 3.10.20.2(E)(1)	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use results from the Care Management File Review. **Evidence as Submitted by the MCO:** HPN_Complex Case Management Policy: page 7, section 8.5.13; page 8, section 8.5.17.2 HPN_Care Plan Sent to PCP HPN_Care Plan Signed by PCP	☐ Met ☒ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: While the MCO's process was to send written communication of the care plan/self-management plan to a member's PCP, the case file review confirmed that the MCO did not actively involve a member's PCP in the development of the care plan for members enrolled in behavioral health care management. MCO staff members explained that they do not send the care plan to the PCP due to the provisions of the NRS 433A.360 Clinical records: Contents; confidentiality. However, NRS 433A.360 does allow for the disclosure of information to a provider of health care to assist with treatment provided to a member. Additionally, according to HIPAA, health care providers are permitted to disclose to other health providers any PHI contained in the medical record about an individual for treatment, case management, and coordination of care and, with few exceptions, treats mental health information the same as other health information. HIPAA generally does not limit disclosures of PHI between health care providers for treatment, case management, and care coordination, except that covered entities must obtain individuals' authorization to disclose separately maintained psychotherapy session notes for such purposes. **Recommendations:** HSAG recommends that the MCO provide updated guidance to care managers for when PHI related to mental information can be shared with health care providers for the purposes of treatment, case management, and coordination of care (including the circumstances when a member's consent is or is not required). Additionally, if a member's condition requires consent from a member to share PHI (e.g., substance use disorder), the MCO should be encouraging integrated care with the member and obtaining the member's consent or documenting the member's refusal.		
Required Actions: The MCO must actively involve members' PCPs in the development of the care plan.		

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Requirement	**Supporting Documentation**	**Score**
12. *The care plan reflects the member's*: a. *Primary medical diagnosis and other health conditions.* b. *Psychological and community support needs.* c. *Specific individualized interventions to meet the member's assessed needs.* Contract 3.10.20.2(E)(3) Contract 3.10.20.2(D)(1)	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use results from the Care Management File Review. **Evidence as Submitted by the MCO:** HPN_Complex Case Management Policy: page 7, section 8.5.13; page 5, section 8.5 HPN_Care Plan Template	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
13. *Development and implementation of a care plan includes coordination with State and county agencies, such as Aging and Disability Services Division (ADSD), Division of Child and Family Services (DCFS), Governor's Office of Consumer Health Assistance (GovCHA), Division of Public and Behavioral Health (DPBH), Division of Welfare and Supportive Services (DWSS), and Substance Abuse Prevention and Treatment Agency (SAPTA) as well as other public assistance programs, such as the Women, Infants, and Children (WIC) program; teen pregnancy programs; parenting programs; and child welfare programs.* Contract 3.10.20.1(D)(2)	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use results from the Care Management File Review. **Evidence as Submitted by the MCO:** HPN_Complex Case Management Policy: page 5, section 8.4.8; page 7, section 8.5.11 HPN_Coordination with State Agency Example HPN_Coordination with County Example HPN_Coordination with Law Example	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
14. *The MCO continuously monitors the member's progress, reevaluates the member's care needs, and adjusts the level of case management services accordingly.* Contract 3.10.20.2(D)(1)(c)(f)	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use results from the Care Management File Review. **Evidence as Submitted by the MCO:** HPN_Complex Case Management Policy: page 8, section 8.5.18; page 9, section 8.5.19.3	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
15. *The MCO identified gaps between care recommended and actual care provided, and proposed and implemented interventions to address gaps in care.* Contract 3.10.20.2(D)(1)(d-e)	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use results from the Care Management File Review. **Evidence as Submitted by the MCO:** HPN_Complex Case Management Policy: page 6, section 8.5.10; page 8, section 8.5.15; page 7, section 8.5.11 HPN_Addressing Gaps in Care Example	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
16. *The MCO*: a. *Has ongoing communication regarding the status of the care plan with the PCP or designee (such as a qualified health professional).* b. *Made revisions to the clinical portion of the care plan in consultation with the PCP.* Contract 3.10.20.2(E)(1)	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use results from the Care Management File Review. **Evidence as Submitted by the MCO:** HPN_Complex Case Management Policy: page8, sections 8.5.17.2 and 8.5.18 HPN_Care Plan Sent to PCP HPN_Care Plan Signed by PCP	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** The MCO's policy lacked specificity in processes for ensuring ongoing communication regarding the status of the care plan with the PCP and making revisions to the clinical portion of the care plan in consultation with the PCP. HSAG recommends that the MCO update its policy and/or procedure to identify criteria or guidelines for care managers as it relates to the requirements of this element. Further, processes should be updated to ensure that ongoing communication with PCPs occur for their members who may have a behavioral health or substance use disorder as allowed under HIPAA.		
Required Actions: None.		
Direct Access to Specialists		
17. For members with special health care needs determined through an assessment (consistent with 42 CFR §438.208[c][2]) to need a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.	**HSAG Recommended Evidence:** • Policies and procedures **Evidence as Submitted by the MCO:** HPN__Standard VI Item 17 supporting documentation HPN_MCD-01 Medicaid Review Process	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.208(c)(4) Contract 3.4.7.2		
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		

Standard VI—Coordination and Continuity of Care						
Met	=	14	X	1	=	14
Not Met	=	3	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	17	Total Score		=	14
Total Score ÷ Total Applicable					=	82%

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Coverage		
1. The MCO must ensure that services identified in 42 CFR §438.210(a)(1) be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to members under FFS Medicaid, as set forth in §440.230, and for members under the age of 21, as set forth in subpart B of Part 441. 42 CFR §438.210(a)(1-2) 42 CFR §440.230 42 CFR Part 441 Contract 3.4.2.1	**HSAG Recommended Evidence:** • Policies and procedures **Evidence as Submitted by the MCO:** HPN_Member Handbook: Benefits Section pgs. 38-59 HPN_2021 UMPD NV Addendum pg 8 HPN_VII_HCO100 pg 10 HPN_MCD-01 Medicaid Review Process page 2	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
2. The MCO— 1. Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. 2. May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. 42 CFR §438.210(a)(3)(i-ii) Contract 3.4.2.1–3.4.2.2	**HSAG Recommended Evidence:** • Policies and procedures • Utilization management plan **Evidence as Submitted by the MCO:** HPN_Member Handbook: Benefits Grid pgs. 38-59 HPN_2021 UMPD NV Addendum pg 8-10 HPN_VII_HCO100 pg 6 HPN_MCD-01 Medicaid Review Process page 2 HPN_PA-010 PA Routine Requests	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
3. The MCO may place appropriate limits on a service— a. On the basis of criteria applied under the State plan, such as medical necessity; or b. For the purpose of utilization control, provided that— i. The services furnished can reasonably achieve their purpose, as required in 42 CFR §438.210(a)(3)(i); ii. The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports (LTSS) are authorized in a manner that reflects the member's ongoing need for such services and supports; and iii. Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20. 42 CFR §438.210(a)(4)(i-ii) Contract 3.4.2.3	**HSAG Recommended Evidence:** • Policies and procedures • Utilization management plan • Member materials, such as the member handbook **Evidence as Submitted by the MCO:** HPN_Member Handbook: pgs. 41, 47, 51 HPN_2021 UMPD NV Addendum pg 7-8 HPN_VII_HCO100 pg 6, 10, 36, HPN_MCD-01 Medicaid Review Process page 1 HPN_PA-010 PA Routine Requests	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
4. The MCO specifies what constitutes "medically necessary services" in a manner that— a. Is no more restrictive than that used in the DHCFP Medicaid program, including quantitative and nonquantitative treatment limits, as indicated in DHCFP statutes and regulations, the DHCFP Plan, and other DHCFP policy and procedures; and b. Addresses the extent to which the MCO is responsible for covering services that address: i. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. ii. The ability for a member to achieve age-appropriate growth and development. iii. The ability for a member to attain, maintain, or regain functional capacity. iv. The opportunity for a member receiving LTSS to have access to the benefits of community living, achieve person-centered goals, and live and work in the setting of their choice. 42 CFR §438.210(a)(5)(i-ii) Contract 3.4.2.4	**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:** HPN_Member Handbook: pg. 38-58 HPN_PCP FFS Template: pg. 1 HPN_Consulting Provider Template: pgs. 1-2 HPN_2021 UMPD NV Addendum pg 8 HPN_VII_HCO100 pg 10 HPN_MCD-01 Medicaid Review Process page 2	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** HSAG recommends the MCO enhance member and provider documentation (e.g., member and provider handbooks) to include a definition of *medically necessary services*, along with examples of the types of services that may be medically necessary. For example, services that pertain to the prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability; services		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
that support the member's ability to achieve age-appropriate growth and development; services that provide the member the ability to attain, maintain, or regain functional capacity; and LTSS that supports the member's independence.		
Required Actions: None.		
Authorization of Services		
5. For the processing of requests for initial and continuing authorizations of services, the MCO shall— a. Have in place, and follow, written policies and procedures. b. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions. c. Consult with the requesting provider for medical services when appropriate. d. Authorize LTSS based on a member's current needs assessment and consistent with the person-centered service plan. e. Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical, behavioral health, or LTSS needs. 42 CFR §438.210(b)(1-2) Contract 3.4.2.5	**HSAG Recommended Evidence:** • Policies and procedures • Results of interrater reliability (IRR) activities • One case example of a peer-to-peer (P2P) consult • Workflow to authorize LTSS consistent with the person-centered service plan (PCSP) • HSAG will also use the results of the service authorization denial file review. **Evidence as Submitted by the MCO:** HPN_IRR Assessment Report 2020: all pages HPN_2021 UMPD NV Addendum pg 7-8 HPN_VII_HCO100, page 6, 10, 15-16, 22, 38 HPN_MCD-01 Medicaid Review Process page 1-2 HPN_ADT-01 Denial Process page 1-2 HPN_Member Handbook page 64 HPN_PA Workflow HPN_P2P Case Example HPN_Medicaid Denial Letter Template HPN_P2P Offer and Medicaid Denial Letter Template	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
Notice of Adverse Benefit Determination		
6. The MCO must notify the requesting provider, and give the member written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The member's notice must meet the requirements of §438.404. The notice must explain the following: a. The adverse benefit determination (ABD) the MCO has made or intends to make. b. The reasons for the ABD, including the right of the member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's ABD. Such information includes medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits and *the specific regulations that support, or the change in federal or State law that requires the action.* c. The member's right to request an appeal of the MCO's ABD, including information on exhausting the MCO's one level of appeal described at 42 CFR §438.402(b) and the right to request a State fair hearing consistent with 42 CFR §438.402(c). d. The procedures for exercising the rights specified in 42 CFR §438.404(b). e. The circumstances under which an appeal process can be expedited and how to request it.	**HSAG Recommended Evidence:** • Policies and procedures • ABD notice template • HSAG will also use the results of the service authorization denial file review. **Evidence as Submitted by the MCO:** HPN_VII_HCO100 page 30, 39-40 HPN_ADT-01 Denial Process page 1-2 HPN_P2P Case Example HPN_Medicaid Denial Letter Template HPN_P2P Offer and Medicaid Denial Letter Template	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
f. The member's right to have benefits continue pending resolution of the appeal; how to request that benefits be continued; and the circumstances, consistent with DHCFP policy, under which the member may be required to pay the costs of these services. 42 CFR §438.402(b-c). 42 CFR §438.404(b)(1-6) Contract 3.13.4.3		
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** HSAG recommends that the MCO remove language from its ABD notices that require a written, signed appeal as this requirement has been removed from federal rule. Implementation of this recommendation will be further assessed during future compliance reviews.		
Required Actions: None.		
Timing of Notice of Adverse Benefit Determination		
7. For termination, suspension, or reduction of previously authorized Medicaid-covered services, the MCO must mail the notice at least ten (10) days before the date of action. Additionally, the MCO must mail the notice no later than the date of the action when: a. The MCO has factual information confirming the death of a member; b. The MCO receives a clear written statement signed by a member that: i. No longer wishes services; or	**HSAG Recommended Evidence:** • Policies and procedures • ABD template(s) • Tracking and reporting mechanism(s) • HSAG will also use the results of the service authorization denial file review. **Evidence as Submitted by the MCO:** HPN_VII_HCO100 page 26-27, 32, 40 HPN_Member Discontinue Request Example HPN_Member Discontinue Request Example 2	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
ii. Gives information that requires termination or reduction of services and indicates that the member understands that this must be the result of supplying that information; c. The member has been admitted to an institution where the member is ineligible under the plan for further services; d. The member's whereabouts are unknown, and the post office returns agency mail directed the member indicating no forwarding address; e. The MCO establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth; f. A change in the level of medical care is prescribed by the member's physician; g. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Social Security Act; or h. The date of action will occur in less than ten (10) days, in accordance with 42 CFR §483.15(b)(4)(ii) and (b)(8), which provides exceptions to the 30-day notice requirements of 42 CFR §483.15(b)(4)(i) of this chapter. 42 CFR §431.211 42 CFR §431.213 42 CFR §438.404(c)(1) Contract 3.13.4.4-5		
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** Although the HCO 100.00.00 Utilization Management Policy included language to support this requirement, examples submitted as evidence under this element and the cases reviewed during the case file review did not support that the MCO had a firm understanding of what constitutes a		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
termination, reduction, or suspension of previously authorized services, or that an ABD notice must be sent in those circumstances. Further discussion with the MCO, however, indicated a misunderstanding in the terminology being used by the MCO and the terminology under federal rule. As such, HSAG strongly recommends that the MCO review and refine its current processes to ensure that all terminations, suspensions, and reductions of previously authorized services result in an ABD notice. Implementation of these recommendations will be further assessed during future compliance reviews.		
Required Actions: None.		
8. The MCO may shorten the period of advance notice to five (5) days before the date of action if: a. The MCO has facts indicating that action should be taken because of probable fraud by the member; and b. The facts have been verified, if possible, through secondary sources. 42 CFR §431.214 42 CFR §438.404(c)(1) Contract 3.13.4.4	**HSAG Recommended Evidence:** • Policies and procedures • ABD template(s) • Tracking and reporting mechanism(s) **Evidence as Submitted by the MCO:** HPN_VII_HCO100 page 40	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
9. For the denial of payment, the MCO must mail the notice at the time of any action affecting the claim. 42 CFR §438.404(c)(2) Contract 3.13.4.6	**HSAG Recommended Evidence:** • Policies and procedures • ABD template(s) • Tracking and reporting mechanism(s) • Workflow for payment denial on a claim to trigger an ABD notice	☐ Met ☒ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• One case example of an ABD notice sent to a member for the denial of payment on a claim **Evidence as Submitted by the MCO:** HPN_VII_HCO100 page 27	
MCO Description of Process:		
HSAG Findings: Although the HCO 100.00.00 Utilization Management Policy indicated notice of action must be provided on the date of action when the action is a denial of payment, MCO staff members confirmed during the interview session that members are not receiving an ABD notice for denial of claim payment. **Recommendations:** HSAG recommends that the MCO's utilization management and claims staff members review the Federal Register from 2002 related to the denial of payment adverse benefit determination requirement and outline the criteria and process for sending the member an ABD notice for denials of payment. As part of this collaboration, HSAG further recommends staff members determine and then document the process for ensuring the ABD notice is provided to the member simultaneous to the claim decision/claim adjudication occurring.		
Required Actions: For the denial of payment, the MCO must mail the notice at the time of any action affecting the claim.		
10. For service authorization decisions not reached within the applicable time frame for standard or expedited requests (which constitutes a denial and is thus an ABD), the MCO must provide notice on the date that the time frames expire. 42 CFR §438.404(c)(5) Contract 3.13.4.7	**HSAG Recommended Evidence:** • Policies and procedures • ABD template(s) • Tracking and reporting mechanism(s) • One case example of an ABD notice sent to a member due to the MCO's failure to make a timely service authorization decision • HSAG will also use the results of the service authorization denial file review. **Evidence as Submitted by the MCO:** HPN_VII_HCO100 page 27	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	HPN_MCD-01 Medicaid Review Process page 3 HPN_Case Notes for case# 210210214 26 day TAT HPN_Denial Letter for case# 210210214 26 day TAT HPN_Pend Letter for case# 210210214 26 day TAT HPN_Report of Aging Standard PA Requests Feb 2021	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** Although the HCO 100.00.00 Utilization Management Policy included language to support the requirement, HSAG strongly recommends that the MCO develop a clear process or procedure for sending an ABD notice when authorizations are not resolved timely. HSAG also recommends that the MCO develop an ABD notice template to ensure the template is readily available for use by staff members should a standard or expedited authorization not be determined in accordance with time frame requirements. Implementation of these recommendations will be further assessed during future compliance reviews.		
Required Actions: None.		
Standard Authorization Decisions		
11. For standard authorization decisions, the MCO must provide notice as expeditiously as the member's condition requires and within DHCFP-established time frames that may not exceed 14 calendar days following receipt of the request for service. 42 CFR §438.210(d)(1)(i-ii) Contract 3.13.3.1	**HSAG Recommended Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Service authorization log • HSAG will also use the results of the service authorization denial file review. **Evidence as Submitted by the MCO:** HPN_VII_HCO100 page 25, 32 HPN_MCD-01 Medicaid Review Process page 3 HPN_ADT-01 Denial Process page 3	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	HPN_Report of Aging Standard PA Requests Feb 2021	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
Expedited Authorization Decisions		
12. For cases in which a provider indicates, or the MCO determines, that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service. 42 CFR §438.210(d)(2)(i-ii) Contract 3.13.3.2	**HSAG Recommended Evidence:** • Policies and procedures • Tracking and reporting mechanisms • HSAG will also use the results of the service authorization denial file review. **Evidence as Submitted by the MCO:** HPN_VII_HCO100 page 24-25, 32 HPN_MCD-01 Medicaid Review Process page 3 HPN_ADT-01 Denial Process page 3 HPN_Example of Stat dashboard HPN_Pop up message for Stat cases HPN_Expedited Example page 2, 5, 20, 21, 24	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** Although the MCO determined that all expedited cases included as part of the case file were reviewed within 72 hours, the PA-004 Extension Process for Prior Authorization Cases policy indicated that all expedited cases are processed within three days. As such, HSAG recommends that the MCO update its policy to include the appropriate time frame for expedited authorization requests.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Extension of Time Frames		
13. The MCO may extend the review of a standard or expedited service authorization time frame up to 14 additional calendar days if— a. The member, or the provider, requests extension; or b. The MCO justifies (to DHCFP upon request) a need for additional information and how the extension is in the member's interest. 42 CFR §438.404(c)(4)(i-ii) Contract 3.13.5.3(b)	**HSAG Recommended Evidence:** • Policies and procedures • Extension notice template(s) • One redacted copy of an extension notice and the corresponding benefit determination notice **Evidence as Submitted by the MCO:** HPN_VII_HCO100 page 29, 32 HPN_MCD-01 Medicaid Review Process page 3 HPN_PA-004 Extension Process for PA HPN_Case Notes Example pg 2-3 HPN_Example of Extension Letter	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
14. If the MCO meets the criteria set forth for extending the time frame for standard or expedited service authorization decisions, it must: a. 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; and	**HSAG Recommended Evidence:** • Policies and procedures • Extension notice template(s) • One redacted copy of an extension notice and the corresponding benefit determination notice **Evidence as Submitted by the MCO:** HPN_VII_HCO100 page 29 HPN_MCD-01 Medicaid Review Process page 3	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
b. Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 CFR §438.404(c)(4)(i-ii) Contract 3.13.5.3(b)	HPN_ADT-01 Denial Process page 3 HPN_PA-004 Extension Process for PA HPN_Case Notes Example pg 2-3 HPN_Example of Extension Letter	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
Compensation for Utilization Management Activities		
15. The MCO must provide that, consistent with 42 CFR §§438.3(i), and 422.208, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member. 42 CFR §438.210(e) Contract 3.10.19.3 (H)	**HSAG Recommended Evidence:** • Policies and procedures • New hire and ongoing training for staff • One example of a staff attestation **Evidence as Submitted by the MCO:** HPN_VII_HCO100 page 18 HPN_Medicaid_Website_12Tips: page 2 HPN_PCP FFS Template: pg. 10 HPN_Consulting Provider Template: pg. 10 HPN_Affirmative Statements Regarding Incentives HPN_Incentive Read Receipt HPN_Member Handbook page 64	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services						
Met	=	14	X	1	=	14
Not Met	=	1	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	15	Total Score		=	14
Total Score ÷ Total Applicable					=	93%

Appendix B. Corrective Action Plan

Following this page is a document HSAG developed for **HPN** to use in preparing its CAP. For each of the requirements listed as *Not Met*, identify the following:

- Intervention(s) planned by your organization to achieve compliance with the requirement, including how the MCE will measure the effectiveness of the intervention.
- Individual(s) responsible for ensuring that the planned interventions are completed.
- Proposed timeline for completing each planned intervention.
- Evidence of compliance. This could include proposed revisions to policies and procedures, report templates, or other documentation, as needed.

This plan is due to DHCFP and HSAG no later than 30 calendar days following receipt of this final *State Fiscal Year 2021 Compliance Review* report.

Appendix B. Corrective Action Plan
Nevada Division of Health Care Finance and Policy
State Fiscal Year 2021 MCE Compliance Review
for Health Plan of Nevada

SFY 2020–21 Compliance With Standards Review Tool CAP Template

Standard II—Member Rights and Member Information			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
Language and Format			
42 CFR §438.10(d)(3) Contract 3.6.1	6. The MCO makes its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its particular service area. a. Written materials that are critical to obtaining services must also be made available in alternative formats upon request of the potential member or member at no cost, include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and include the toll-free and Telecommunications Device for the Deaf/TeleTYpewriter (TTY/TDY) telephone number of the MCO's member/customer service unit.	**Evidence as Submitted by the MCO:** HPN_Member Handbook pages 3-4 HPN_Member Handbook Spanish (in drop down) HPN_Provider Directory Spanish_(Link) HPN_WRHCO 346 – Member and Provider Communication Policy HPN_Member Requests for Alternative Formats	☐ 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 II—Member Rights and Member Information			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
	b. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost.		
	MCO Description of Process:		
	HSAG Findings: The WRHCO 346 Member and Provider Communication Policy specified that taglines must be written in at least 12-point font. Although the MCO included taglines for most written critical materials in what appears to be 12-point font, the taglines, however, were not in a conspicuously visible font size in accordance with federal regulations. Additionally, taglines were not included in either the landing page for the online provider search tool or the printable version of the provider directory. **Recommendations:** HSAG recommends that the MCO define "conspicuously visible" font size to be greater than a 12-point font to ensure the taglines are clearly visible and stand out from the other text.		
	Required Actions: The MCO must ensure that written materials that are critical to obtaining services, include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided.		
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 II—Member Rights and Member Information			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
Information for All Members With MCO—Member Handbook			
42 CFR §438.10(g)(4) Contract 3.6.1.1(C)	17. The MCO must give each member notice of any change that DHCFP defines as significant in the information specified in 42 CFR §438.10(g) (member handbook), at least 30 days before the intended effective date of the change, *when there are material changes that will affect access to services and information about the Managed Care Program*.	**Evidence as Submitted by the MCO:** HPN_Member Newsletter page 2	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: There was no significant change to the Member Handbook during the audit period. In general, should a notice of significant change occur, this would be included in the Member Newsletter in a dedicated space on the Contents page. In addition, an Addendum may be included in the New Member Kit outlining any changes.		
	HSAG Findings: MCO staff members explained during the interview session that should a significant change occur, members would be notified of changes through the member newsletter. The member newsletter submitted for the review included a statement indicating, "Have you read your Member Handbook? It's a great source of information. It tells you how to use your health plan and includes changes to your plan benefits." This language implies that changes were made to the members' benefits without provision of notice to members prior to the update being made. Additionally, a formal document, such as a policy, SOP, or other guidance document outlining the MCO's process for member notification of significant changes was not provided.		
	Required Actions: The MCO must ensure that it gives each member notice of any change that DHCFP defines as significant in the information specified in 42 CFR §438.10(g) (member handbook), at least 30 days before the intended effective date of the change, and when there are material changes that will affect access to services and information about the Managed Care Program per the State contract.		

Standard II—Member Rights and Member Information			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**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

Standard VI—Coordination and Continuity of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Health Needs Assessment Screening			
42 CFR §438.208(b)(3) Contract 3.10.20.2(B)(1)(a-b)	5. The MCO must make a best effort to conduct an initial screening of each member's needs within ninety (90) days of the effective date of enrollment for all new members. a. *Screening assessment for pregnant women, children with special health care needs, and adults with special health care needs must be conducted within thirty (30) days*; b. *The MCO must document at least three (3) attempts to conduct the screen. If unsuccessful the MCO must document the barrier(s) to completion and how the barriers shall be overcome so that the Health Needs Assessment can be accomplished with in the first one hundred and twenty (120) days.* c. *Face-to-face assessments shall be conducted, as necessary. The goals of the assessment are to identify the member's existing and/or potential health care needs and assess the member's need of case management services.* d. *The MCO will submit their Health Needs Assessment Screening form/s and data to the DHCFP upon request.*	**Evidence as Submitted by the MCO:** HPN_Health Risk Survey Outreach Policy HPN_Medicaid HRA Survey Template HPN_WRHCO 161 Health Survey Screening and Assessments HPN_HRA Monthly Statistic Report HPN_HRA Survey-Detail Report HPN_Tracking Mechanism for Timely Completion of Care Plan	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: Initial screening outreach is performed to engage members within 90 days of enrollment in the plan, per the documentation provided. Unless a member self identifies, or we happen to call a member who is pregnant or has other special needs, there is no way HPN would know who these members are to perform initial screening activities within the		

Standard VI—Coordination and Continuity of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	first 30 days of enrollment. This information is not provided on the enrollment file from the DHCFP. The one exception to that is if a member transitions from another MCO and a transition of care form is submitted to HPN identifying the pregnancy/special need. Those members receive outreach once HPN receives notice via the TOC form. However, that would not necessarily be the initial screening, it would be from the pertinent care management team (HROB, CM, DM, etc.)		
	HSAG Findings: The case file review did not consistently demonstrate that the MCO conducted three attempts to complete the initial health risk screening. After the interview session, the MCO submitted a narrative response related to the health risk assessment (HRA) for each of the cases reviewed. For one case, the MCO explained it was unable to locate the HRA activity or attempts, but an unable to contact (UTC) letter was sent. The MCO further explained that it appears to be a possible documentation error if the representative did not document the attempts; however, the documentation provided did not meet the intent of this requirement. For a second case, the MCO explained that the member was showing a name change which may have impacted rotation into the survey report as there was no HRA activity; however, the documentation provided also did not meet the intent of the requirement. For a third case, the MCO explained that a call was attempted, and the phone number was no longer in service and an UTC letter was sent. As the MCO is required to address and overcome barriers to completing the initial screening, HSAG reviewers inquired how the MCO attempted to mitigate the barrier of not having a current phone number for this member. MCO staff members explained that research is conducted to locate any other phone number for the member. After the interview session, the MCO submitted a tracking sheet with examples of members who had no phone number listed on the enrollment file from DHCFP and any phone numbers identified through LexisNexis. However, this tracking sheet did not include the member from the case in question; therefore, it is unknown what was completed by the MCO in an attempt to locate other contact information for this member. **Recommendations:** HSAG recommends that the MCO consult with DHCFP regarding the 834-enrollment file and if it includes indicators for members who are identified as pregnant or having a special health care need. Additionally, HSAG recommends that the MCO enhance processes for ensuring all attempted contacts with a member to complete the initial health risk screening are documented, including actions taken in efforts to mitigate barriers such as the research completed to identify current contact information for members. Further, HSAG recommends that the MCO investigate how a member name change may impact the survey rotation, as this scenario may impact other members in the same situation.		
	Required Actions: The MCO must make a best effort to conduct an initial screening of each member's needs within 90 days of the effective date of enrollment for all new members. Screening assessment for pregnant women, children with special health care needs, and adults with special health care needs must be conducted within 30 days. The MCO must document at least three		

Standard VI—Coordination and Continuity of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	attempts to conduct the screening. If unsuccessful, the MCO must document the barrier(s) to completion and how the barriers shall be overcome so that the Health Needs Assessment can be accomplished within the first 120 days.		
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 VI—Coordination and Continuity of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Comprehensive Assessment			
Contract 3.10.20.2.1(C); 3.10.20.2(C)	9. *The MCO provided information to members and their PCP that they have been identified as meeting the criteria for case management, including their enrollment into case management services.*	**Evidence as Submitted by the MCO:** HPN_Complex Case Management Policy: page 4, section 8.2; page 8, section 8.5.17.2 HPN_Care Plan Sent to PCP HPN_ Welcome Letter Template	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process:		
	HSAG Findings: The case file review confirmed that the MCO did not send a communication to a member's primary care provider (PCP) informing the PCP that the member has been enrolled into care management services. MCO staff members explained that they do not send a communication to the PCP due to the provisions of the Nevada Revised Statutes (NRS) 433A.360 Clinical records: Contents; confidentiality. However, NRS 433A.360 does allow for the disclosure of information to a provider of health care to assist with treatment provided to a member. Additionally, according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), health care providers are permitted to disclose to other health providers any protected health information (PHI) contained in the medical record about an individual for treatment, case management, and coordination of care and, with few exceptions, treats mental health information the same as other health information. HIPAA generally does not limit disclosures of PHI between health care providers for treatment, case management, and care coordination, except that covered entities must obtain individuals' authorization to disclose separately maintained psychotherapy session notes for such purposes. **Recommendations:** HSAG recommends that the MCO provide updated guidance to care managers for when PHI related to mental health information can be shared with health care providers for the purposes of treatment, case management, and coordination of care (i.e., when a member's consent is or is not required). Additionally, if a member's condition requires consent from a member to share PHI (e.g., substance use disorder), the MCO should be encouraging integrated care with the member and obtaining the member's consent or documenting the member's refusal.		
	Required Actions: The MCO must provide information to members and their PCPs that they have been identified as meeting the criteria for case management, including their enrollment into case management services (including the circumstances when a member's consent is or is not required).		

Standard VI—Coordination and Continuity of Care			
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

Standard VI—Coordination and Continuity of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Care Plan			
Contract 3.10.20.2(E)(1)	11. *There is evidence that the following individuals were actively involved in the development of the care plan*: a. *Member* b. *Member's designated formal and informal supports* c. *Member's PCP*	**Evidence as Submitted by the MCO:** HPN_Complex Case Management Policy: page 7, section 8.5.13; page 8, section 8.5.17.2 HPN_Care Plan Sent to PCP HPN_Care Plan Signed by PCP	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process:		
	HSAG Findings: While the MCO's process was to send written communication of the care plan/self-management plan to a member's PCP, the case file review confirmed that the MCO did not actively involve a member's PCP in the development of the care plan for members enrolled in behavioral health care management. MCO staff members explained that they do not send the care plan to the PCP due to the provisions of the NRS 433A.360 Clinical records: Contents; confidentiality. However, NRS 433A.360 does allow for the disclosure of information to a provider of health care to assist with treatment provided to a member. Additionally, according to HIPAA, health care providers are permitted to disclose to other health providers any PHI contained in the medical record about an individual for treatment, case management, and coordination of care and, with few exceptions, treats mental health information the same as other health information. HIPAA generally does not limit disclosures of PHI between health care providers for treatment, case management, and care coordination, except that covered entities must obtain individuals' authorization to disclose separately maintained psychotherapy session notes for such purposes. **Recommendations:** HSAG recommends that the MCO provide updated guidance to care managers for when PHI related to mental information can be shared with health care providers for the purposes of treatment, case management, and coordination of care (including the circumstances when a member's consent is or is not required). Additionally, if a member's condition requires consent from a member to share PHI (e.g., substance use disorder), the MCO should be encouraging integrated care with the member and obtaining the member's consent or documenting the member's refusal.	
	Required Actions: The MCO must actively involve members' PCPs in the development of the care plan.		

Standard VI—Coordination and Continuity of Care			
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

Standard VII—Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Timing of Notice of Adverse Benefit Determination			
42 CFR §438.404(c)(2) Contract 3.13.4.6	9. For the denial of payment, the MCO must mail the notice at the time of any action affecting the claim.	**Evidence as Submitted by the MCO:** HPN_VII_HCO100 page 27	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process:		
	HSAG Findings: Although the HCO 100.00.00 Utilization Management Policy indicated notice of action must be provided on the date of action when the action is a denial of payment, MCO staff members confirmed during the interview session that members are not receiving an ABD notice for denial of claim payment. **Recommendations:** HSAG recommends that the MCO's utilization management and claims staff members review the Federal Register from 2002 related to the denial of payment adverse benefit determination requirement and outline the criteria and process for sending the member an ABD notice for denials of payment. As part of this collaboration, HSAG further recommends staff members determine and then document the process for ensuring the ABD notice is provided to the member simultaneous to the claim decision/claim adjudication occurring.		
	Required Actions: For the denial of payment, the MCO must mail the notice at the time of any action affecting the claim.		
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