Division of Health Care Financing and Policy
Nevada Medicaid Managed Care

State Fiscal Year 2021
Compliance Review

for

SilverSummit Healthplan, Inc.

October 2021

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

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 **SilverSummit Healthplan, Inc.** (**SilverSummit**) staff members as well as file reviews conducted during the desk review and virtual interviews, the reviewers assigned **SilverSummit** 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 **SilverSummit** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards. Table 1-2 presents a summary of **SilverSummit**'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	17	5	0	**77%**
III	Emergency and Poststabilization Services	10	10	10	0	0	**100%**
IV	Availability of Services	10	10	9	1	0	**90%**

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
V	Assurances of Adequate Capacity and Services	2	2	2	0	0	**100%**
VI	Coordination and Continuity of Care	17	17	12	5	0	**71%**
VII	Coverage and Authorization of Services	15	15	10	5	0	**67%**
Total		**83**	**83**	**67**	**16**	**0**	**81%**

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

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

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

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

SilverSummit demonstrated compliance in 67 of 83 elements, with an overall compliance score of 81 percent, indicating that many program areas had the necessary policies, procedures, and initiatives in place to carry out 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*, **SilverSummit** 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 14, 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 **SilverSummit** 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. **SilverSummit** must use this template to submit its CAP to bring any elements scored *Not Met* into compliance with the applicable standard(s). **SilverSummit**'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 **SilverSummit** in its submitted CAP.

Appendix A. Review of the Standards

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

Standard 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:** *Element 1 bullets 1-5:* • NV.ELIG.02 Eligibility Guidelines for Disenrollment Requests *Plan Initiated Disenrollment Requests of Members* section (pp. 3 – 4) • 2021 SSHP Member Handbook *Involuntary Disenrollment for Cause* section (p. 56)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SSHP's NV.ELIG.02 Eligibility Guidelines for Disenrollment Requests *Plan Initiated Disenrollment Requests of Members* section describes the process for health plan-initiated disenrollment. The 2021 SSHP Member Handbook informs our members of the reasons that SSHP may ask for a member to be disenrolled involuntarily. SSHP does not request disenrollment of members for the reasons listed in this requirement and as described in contract section 3.5.2, 3.5.7.4 (C) (1-7).		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations**: While the NV.ELIG.02 Eligibility Guidelines for Disenrollment Requests policy included the requirements for this element, the member handbook included reasons the MCO may not request disenrollment of the member which did not align with the reasons listed in policy. HSAG		

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
strongly recommends that the MCO review its policy and member handbook to ensure the documents contain consistent information regarding reasons an MCO may not request disenrollment of a member. Implementation of this recommendation will be further assessed during future compliance reviews.		
Required Actions: None.		
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:** *Elements 2, 2a, 2b:* • NV.ELIG.02 Eligibility Guidelines for Disenrollment Requests *Plan Initiated Disenrollment Requests of Members* section (pp. 3 – 4)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SSHP's *NV.ELIG.02 Eligibility Guidelines for Disenrollment Requests* describes the process for health plan-initiated disenrollment, including the plan's notification of the DHCFP by using the State-provided Disenrollment Form. SSHP does not request disenrollment for reasons other than those permitted under the contract. We do take reasonable measures, as determined by DHCFP, to correct member behavior prior to requesting disenrollment, including providing education and counseling regarding the offensive acts or behaviors. SSHP has not requested any member disenrollment.		
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**
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 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)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCO:** *Element 3ai:* • NV.ELIG.02 Eligibility Guidelines for Disenrollment Requests *Member Procedures to Request Disenrollment with Cause* section and *Plan Procedures to Request Disenrollment of a Member* section (pp. 3 – 4) • 2021 SSHP Member Handbook *How to Disenroll* section (p. 55) • DHCFP Disenrollment Form • Disenrollment Notice of Decision template *Elements 3bi, 3bii, 3biii, 3biv:* • NV.ELIG.02 Eligibility Guidelines for Disenrollment Requests *Member Initiated Disenrollment Requests without Cause* section (p. 2)	☒ Met ☐ Not Met ☐ NA

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: The *NV.ELIG.02 Eligibility Guidelines for Disenrollment Requests* policy describes the process and criteria for Member- and Plan-initiated disenrollment. The *2021 SSHP Member Handbook* informs our members of the reasons for, and timelines when, they can disenroll or change their health plan, as well as the process to do so. The *DHCFP Disenrollment Form* is the state form we use to document a member's request for disenrollment and what SSHP uses to notify the DHCFP if we approve the member's request. The *Disenrollment Notice of Decision* template is the document SSHP uses to create the member notification of an adverse decision. SSHP does not restrict our members' right to disenroll in any way; members can request disenrollment for cause or without cause in alignment with the contractual guidelines.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
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:** *Element 4:* • NV.ELIG.02 Eligibility Guidelines for Disenrollment Requests *Member Procedures to Request Disenrollment without Cause during the First 90 Days of Enrollment with the Plan* section, *Member Initiated Disenrollment Requests with Cause after the First 90 Days of Enrollment* section, and	☒ Met ☐ Not Met ☐ NA

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
	Member Procedures to Request Disenrollment with Cause section (pp. 2 – 3) • 2021 SSHP Member Handbook *How to Disenroll* section (p. 55) • GCD Disenrollment Request sample form	
MCO Description of Process: The *NV.ELIG.02 Eligibility Guidelines for Disenrollment Requests* policy describes the process and criteria for Member- and Plan-initiated disenrollment. The *2021 SSHP Member Handbook* informs our members of the process for disenrollment. The *GCD Disenrollment Request sample form* provides an example of a member disenrollment request. Our members or their representatives can request disenrollment orally or in writing by calling our member services department or by sending a written request to our office.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
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	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCO:** *Elements 5, 5a, 5b, 5c, 5d, 5e:* • NV.ELIG.02 Eligibility Guidelines for Disenrollment Requests *Member Initiated Disenrollment Requests with Cause after the First 90 Days of Enrollment* section (p.2)	☒ Met ☐ Not Met ☐ NA

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
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)	• 2021 SSHP Member Handbook *Change health plans after the first 90 days of enrollment* sub-section (p. 54)	
MCO Description of Process: The *NV.ELIG.02 Eligibility Guidelines for Disenrollment Requests* policy describes the process and criteria for Member-initiated disenrollment. The *2019 SSHP Member Handbook* informs our members of the reasons for, and timelines when, and process for a member to request to disenroll from the MCO for good cause. SSHP's members can request to disenroll for good cause at any time for all of the reasons listed in this requirement and in contract section 3.5.7.3(F)(1).		
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**
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:** *Elements 6, 6a, 6b:* • NV.ELIG.02 Eligibility Guidelines for Disenrollment Requests General Provisions section (p. 1) • Member GCD Request Grievance Record sample • Grievance Resolution Letter sample • Grievance Acknowledgment Letter sample • Disenrollment Tracking Report	☒ Met ☐ Not Met ☐ NA

MCO Description of Process: The *NV.ELIG.02 Eligibility Guidelines for Disenrollment Requests* policy describes how the member's request is addressed through SSHP's grievance process.

The *Member GCD Request Grievance Record* provides an overview of how SSHP's Grievance & Appeals department assists in the management of a member's request for good cause disenrollment.

The *Grievance Acknowledgment Letter sample* provides an example of a letter a member receives from SSHP's Grievance & Appeals department when they request good cause disenrollment

The *Grievance Resolution Letter sample* provides an example of a letter a member receives from SSHP's Grievance & Appeals department when their request is resolved.

The *Disenrollment Tracking Report* provides a summary of all requests for good cause disenrollment during the audit period and the actions taken.

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
SSHP submits all requests for disenrollment through our grievance system before making a determination. We complete our grievance process in time for disenrollments, if approved, to be effective no later than the first day of the second month following the month in which the member files the request. If we cannot make a determination, we refer the request to DHCFP.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
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:** *Element 7:* • NV.ELIG.02 Eligibility Guidelines for Disenrollment Requests *Member Procedures to Request Disenrollment with Cause* section (p. 3) • Member Request for Disenrollment sample • Notice of Decision letter sample • Disenrollment Tracking Report *Element 7a:* • DHCFP email forwarding member request sample	☒ Met ☐ Not Met ☐ NA

Standard I—Disenrollment: Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: The *NV.ELIG.02 Eligibility Guidelines for Disenrollment Requests* policy describes how the member's request is processed when the request is denied for lack of good cause. The *Member Request for Disenrollment* sample shows a member request to disenroll because their provider was leaving the MCO's network. The *Notice of Decision* letter sample shows the MCO's denial of the member's request, and includes information about the member's appeal rights. The *Disenrollment Tracking Report* provides a summary of all requests for good cause disenrollment during the audit period, the actions taken, and the dates of those actions. The *DHCFP email* provides an example of the DHCFP forwarding a member request for disenrollment to SHHP for follow-up and resolution. If SSHP denies a member's request for disenrollment for lack of good cause, we send a notification of our decision (NOD) to the member no later than 14 days of receipt of the member's request. We include the date of our decision as well as the member's right to appeal directly with us in the NOD. In addition, we include information on how the member can request and obtain a State Fair Hearing. When we received disenrollment requests forwarded to us from DHCFP, we manage those requests as if the member had contacted us directly.		
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:** • NV.MBRS.25 Member Rights and Responsibilities	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: *NV.MBRS.25 Member Rights and Responsibilities* is SSHP's written policy regarding our member rights as specified; the policy is reviewed annually and updated as needed.		
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:** • 2021 SSHP Member Handbook *Member Rights* section (pp 66-67) • 2021 SSHP Provider Manual *Member Rights* section (pp 29-30). • Member Services Rep New Hire Training *Agenda (Day 4)*	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• NV.MBRS.25 Member Rights and Responsibilities *Policy* items 6, 7, 8 (pp 1-2)	
MCO Description of Process: It is SSHP's policy to advise members of their rights and how they will be protected in accordance with the Centers for Medicare & Medicaid Services (CMS) and state regulations. All members received a Member Handbook upon enrollment, which contains and describes their rights. We train all new staff on member rights during new hire training. We also inform our providers of our members' rights by providing them with a Provider Manual during provider orientation; our member rights are included in the Provider Manual. If members' rights are violated, we would follow our standard grievance process. We have not received any grievances regarding violation of members' rights during this review period.		
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:** • 2021 SSHP Member Handbook *Member Rights* section (pp 66, 67) • NV.MBRS.25 Members Rights and Responsibilities *Policy* section (p.1); *Procedure* section (p.1) • SSHP website *Members Rights and Responsibilities* page: https://www.silversummithealthplan.com/members/medicaid/resources/member-rights.html	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: As described in *NV.MBRS.25 Members Rights and Responsibilities*, our members are informed of their member rights at least yearly and when changes occur. Our members receive the current year's *SSHP Member Handbook*, which contains and describes their rights. Additionally, members may review their rights on our website.		
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, 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)	**HSAG Recommended Evidence:** • Policies and procedures • Model member handbook and notice templates, as applicable • Member materials, such as the member handbook • Member notice templates, such as ABD, grievance, and appeal letter templates **Evidence as Submitted by the MCO:** *Element 4a:* • NV.MRKT.01 Member Materials and Marketing Materials Guidelines: *Policy* section (p 1) • 2021 SSHP Member Handbook • Final Adverse Determination Letter template • Grievance Resolution Letter template	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: SSHP uses clarifying definitions for managed care terminology throughout our member handbook. Our written materials are presented in easily understandable language, not exceeding the eighth grade reading level.		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
While SSHP does not have a model Member Handbook, our corporate team provided us with a template Member Handbook prior to implementation, which was used to create a Nevada-specific SSHP Member Handbook for Medicaid members. Our Member Handbook is reviewed at least annually and when material changes occur.		
HSAG Findings: Although the member handbook and the adverse benefit determination and grievance letter templates included definitions for nine of the 32 required definitions for managed care terminology, the majority of required managed care terms were not defined by the MCO. **Recommendations**: HSAG recommends that the MCO develop a listing of managed care definitions that are available in member-facing documents, such as the member handbook. HSAG further recommends that the MCO consult with DHCFP to determine whether the model member handbook and notices can be developed to comply with federal rule.		
Required Actions: The MCO must ensure that it defines and uses all required managed care terminology as identified in this element.		
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; 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)	**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 **Evidence as Submitted by the MCO:** Element 5a-5e: • CC.MRKT.14 Website 508 Compliance *Purpose* section (p. 1) • Mailed Member Materials Tracking Report • 2021 SSHP Member Handbook *Over-the-Counter (OTC) Drug Formulary section* (p. 18)	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	Online Preferred Drug List: https://www.silversummithealthplan.com/members/medicaid/benefits-services/pharmacy.html	
MCO Description of Process: As noted in *CC.MRKT.14 Website 508 Compliance*, SSHP ensures that our electronic information is compliant with section 508/WCAG 2.0. All of our secure and non-secure web functionality is accessible to and usable by people with sensory, cognitive, and manual-dexterity type disabilities. SSHP provides electronic information to members in paper form, free of charge and within five business days. An example is our Preferred Drug List (PDL), which is provided electronically; members are informed in our Member Handbook on how they can access the PDL. Members may also request a printed copy of the PDL which will be mailed to them.		
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 information provided, information on how to request auxiliary aids and services, and include the toll-free and	**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:** *Elements 6a-6b:* • 1557 Language Taglines	☐ Met ☒ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
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	• 2021 SSHP Member Handbook (EN SP Combined) *Other Formats and Languages* section (p. 2); *Translation and Interpreter Services* section (p. 3); *Other Translation Information* section (p. 4) • 2021 SSHP Member Handbook (Spanish) online: https://www.silversummithealthplan.com/members/medicaid/resources/handbooks-forms.html • 2021 SSHP Provider Directory • CC.MBRS.02 Member Materials Readability and Translation	
MCO Description of Process: SSHP ensures that vital materials are made available upon request for the top fifteen (15) non-English prevalent languages. We also provide in-language versions or translate non-vital documents into threshold and prevalent languages on request. In addition, we will provide oral interpretation of vital and non-vital materials, for non-threshold, non-prevalent languages upon request at no cost to our members. SSHP also includes taglines in our member mailings, explaining the availability of written translation or oral interpretation to understand the information provided.		
HSAG Findings: Although the MCO included taglines in the member handbook and grievance and appeal notices, the printable version of the provider directory did not include taglines as required. Additionally, the taglines were not in a conspicuously visible font size as required by federal rule.		
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:** *Element 7:* • 2021 SSHP Member Handbook *Other Formats and Languages section, Translation and Interpreter Services,* and *Other Translation Information* sections (pp 2-4) • NV.MBRS.16 Hearing Impaired/Language Specific Interpreter Services *Policy* section (pp 1-2) *Element 7a, 7b-biii, 7c:* • CC.MBRS.02 Member Materials Readability and Translation *Purpose* and *Policy* sections (p. 1) • Language Services Data • Language Usage Report (audit period) • NV.MRKT.01 Member Materials *Requirements for Materials* section (p. 2) • OMNI Screenshot of Member Profile and Member Preferences • OMNI Work Process for Member Material Requests • English Spanish Member Notification Postcard	

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: As noted in our policy, we ensure participation in State and Federal 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 pursuant to MSM Chapter 100. The State has identified the prevalent non-English language in Nevada to be Spanish.		
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:** *Element 8a:* • CC.MBRS.02 Member Materials Readability and Translation *Purpose* and *Policy* sections (p. 1) • NV.MBRS.16 Hearing Impaired/Language Specific Interpreter Services *Policy* section (p. 1) *Elements 8b-8c:* • 2021 SSHP Member Handbook (EN SP Combined) *Other Formats and Languages* section (p. 2); *Translation and Interpreter Services* section (p. 3); *Other Translation Information* section (p. 4) • Work Process: *In-Person Interpreter Request*	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SSHP offers our members interpretive services for languages other than English and for members who are deaf or hearing impaired; services are available for any service where the member may have interaction with us either telephonically or in person. It is also our policy that all written materials are translated for prevalent languages and provided to members upon request and at no cost. Additionally, we provide auxiliary aids and services upon request and at no cost for our members with disabilities, as outlined in the *SSHP Member Handbook*.		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
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.* 42 CFR §438.10(d)(6)(i-iii) Contract 3.6.1	**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 • Workflow and verification procedures for ensuring member materials are 508 compliant • Taglines included with member information **Evidence as Submitted by the MCO:** • 1557 Language Taglines • 2021 SSHP Member Handbook (EN SP Combined) *Other Formats and Languages* section (p. 2); *Translation and Interpreter Services* section (p. 3); *Other Translation Information* section (p. 4) • CC.MBRS.02 Member Materials Readability and Translation *Purpose, Policy*, and *Translation of Member Materials* sections (pp. 1 – 2)	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• CC.MRKT.14 Website 508 Compliance *Purpose* and *Procedure* sections (pp 1-2), and *Accessibility Checks* section (p. 3) • Grievance Resolution Letter (sample) • Language Services Data	
MCO Description of Process: SSHP ensures that member and potential member educational materials developed are written in a clear and culturally appropriate manner including reading level and availability of alternate language translation for threshold and prevalent non-English languages as required by CMS and State specific requirements. Additionally, we provide auxiliary aids and services upon request and at no cost for our members with disabilities as outlined in our member handbook.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendation:** Although the MCO staff members were able to identify the process that ensures member materials are written in a font size no smaller than 12 point, the CC.MBRS.02 Member Materials Readability and Translation policy did not specifically identify a font size. HSAG strongly recommends that the MCO clearly indicate in the policy the required font size for member materials. Implementation of these recommendations will be further assessed during future compliance reviews.		
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. 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.	**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) • Tracking or reporting mechanisms (mailing date and effective date of the termination or receipt or issuance of the termination notice must be notated)	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.10(f)(1) Contract 3.6.1.1(D), 3.7.5.11(A)	**Evidence as Submitted by the MCO:** *Element 10a:* • 2021 SSHP Member Handbook (EN SP Combined) *What to Do If Your PCP Leaves Our Network* section (p. 37) • Notice of Termination for Dignity Health • Member Notification of Provider Termination • NV.PRVR.23 Provider Termination *State-Initiated Termination* section (p. 3)	
MCO Description of Process: All provider terminations are processed in an expedient manner to ensure timely inter-departmental communication, to include provider and member notifications adherence. SSHP provides member notification for non-renewal contract as well as provider initiated terminations. We provide written notice of termination of a terminating provider within fifteen (15) calendar days of receipt of issuance of the termination notice to each member who receives primary care from or was seen on a regular basis by the terminated provider.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** Although the example provider termination notices were provided to members within 30 calendar days prior to the effective date of termination, and the NV.PRVR.23 Provider Termination policy indicates 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 if 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.		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
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:** • CC.FINC.15 Reinsurance for Provider Risk Contracts • Physician Incentive Plans (overview) • Model 1 Provider Monthly Review • Model 1 Provider Performance Review • Model 1 Shared Risk Agreement • Pay for Performance Amendment • Quality Risk Program Amendment	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: As evidenced by our provider contracts and training materials, SSHP offers a variety of value based contracts to our providers. Providers receive training on each of these programs and are encouraged to discuss with their members. At this time SSHP does not have any materials to share with members as related to these contracts other than our overview of the plans.		
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**
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:** *Element 12:* • CC.CM.10 Advance Directives policy • 2021 SSHP Member Handbook (EN SP Combined) *Advance Directives* section (p. 60) • 2021 SSHP Provider Manual *Advance Directives* section (pp 20-21) • SSHP website *Advanced Directives* Page: https://www.silversummithealthplan.com/members/medicaid/resources/advance-directive.html	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SSHP provides and/or ensures that network practitioners are providing written information to all adult members receiving medical cared with respect to their rights under State law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. We include education related to advance directives in our member handbook and on our website.		
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;	**HSAG Recommended Evidence:** • Policies and procedures • Written member informational materials • Tracking reports	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
b. The MCO's policies with regard to a member's right to execute an advance directive, including a requirement that the network provider present a statement of any limitations in the event the provider cannot implement an advance directive on the basis of conscience. c. *At a minimum, the MCO's statement of limitation, if any, must:* *i. Clarify any differences between institution-wide conscience objections and those that may be raised by individual network providers;* *ii. Identify the State legal authority pursuant to 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)	**Evidence as Submitted by the MCO:** *Elements 13a and 13b:* • 2021 SSHP Member Handbook *Advanced Directives* section (p. 60), and *Member Rights* section (p. 66) • CC.CM.10 Advance Directives *Policy* and *Procedure* sections (pp 1-2) • New Member Welcome Packet Mailing Report • NV.MBRS.25 Member Rights and Responsibilities *Policy* and *Procedures* sections (p. 1) • Website *Advance Directives* Page: https://www.silversummithealthplan.com/members/medicaid/resources/advance-directive.html *Element 13c:* • 2021 SSHP Provider Manual *Advance Directives* section (pp 20-21)	
MCO Description of Process: SSHP provides and/or ensures that network practitioners are providing written information to all adult members receiving medical care with respect to their rights under State law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. We include education related to advance directives in the *SSHP Member Handbook* and on our website. We also include advance directive requirements in our provider manual.		
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**
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). 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)	**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) **Evidence as Submitted by the MCO:** *Element 14:* • NV.ELIG.11 Eligibility Guidelines *Procedure* section (p. 2, last sentence) • New Member Welcome Packet Mailing Report *Element 14a:* • 2021 SSHP Member Handbook *Member Services Can Help* section (p. 7) and *Member Rights* section (p. 67)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SSHP mails new member welcome packets, which includes the SSHP Member Handbook, within five (5) business days after receiving notice of member's enrollment on the 834 file. Our members have the right to request this information at any time during the year.		
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.	**HSAG Recommended Evidence:** • Member handbook (provide handbook and link to website) • HSAG will also use the results of the Member Handbook Checklist.	☐ Met ☒ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.10(g)(2) Contract 3.6.1.1	**Evidence as Submitted by the MCO:** *Element 15:* • 2021 SSHP Member Handbook • SSHP website: *Member Handbooks and Forms* page: https://www.silversummithealthplan.com/	
MCO Description of Process: The SSHP Member Handbook includes information that enables our members to understand how to effectively use their benefits and services. Our member handbook also informs members on how they can contact us if they need additional assistance.		
HSAG Findings: The MCO demonstrated compliance with the elements of the member handbook checklist, with the exception of one sub-element. The MCO did not include the address of the MCO's fraud and abuse unit in the member handbook as required by State contract.		
Required Actions: The MCO must ensure that information (including hotlines, email addresses, and the address and telephone number of the MCO's fraud and abuse unit) on how to report suspected fraud or abuse is included in the member handbook.		
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; 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.	**HSAG Recommended Evidence:** • Policies and procedures • Reporting or tracking mechanisms for providing the member handbook in paper form via mail • Member enrollment materials **Evidence as Submitted by the MCO:** *Element 16a:* • NV.ELIG.11 Eligibility Guidelines *Procedure* section (p. 2, last sentence) • New Member Welcome Packet Mailing Report *Element 16b:* • While there is no evidence, we will send a copy of our member handbook by email upon member's request.	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.10(g)(3) Contract 3.6.1.1	*Element 16c-16d:* • 2021 SSHP Member Handbook *About Your Member Handbook* section, *Other Formats, Languages, Translation, Interpreter Services*, and *Other Translation Information* sections (pp 2-4) • SSHP Website: *Member Handbook and Forms* page: https://www.silversummithealthplan.com/members/medicaid/resources/handbooks-forms.html • Member Enrollment Materials	
MCO Description of Process: SSHP's Member Handbook includes information that enables our members to understand how to effectively use their benefits and services. We mail our member handbook in our new member welcome packet within five (5) business days of being notified of member's enrollment with us. The *SSHP Member Handbook* also informs members on how they can contact us if they need additional assistance.		
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 **Evidence as Submitted by the MCO:** *Element 17:*	☐ Met ☒ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• 2021 SSHP Member Handbook *Member Services Can Help* Section (p. 7) • NV.MRKT.01 Marketing Materials Guidelines *Requirements for Materials* section (p. 2, bullet F) *Example of Change:* • Member Postcard Notification *Disenrollment Process Update* • Q1 2021 Member Newsletter *Information About Disenrollment Process Change* (p. 7) • SSHP website: *Member Handbook and Forms - Disenrollment Update*: https://www.silversummithealthplan.com/members/medicaid/resources/handbooks-forms.html • Invoice for Member Postcard Notification	
MCO Description of Process: SSHP notifies its members of any changes that DHCFP defines as significant, at least 30 days before the effective date of the change. We notify members of changes by mail and online in our member newsletter.		
HSAG Findings: The MCO provided its member newsletter, a postcard, and the link to its website, indicating changes to the disenrollment process had been made. Since the MCO provided the disenrollment updates as a significant change, the MCO did not comply with the requirement to notify the members at least 30 days before the effective date of the change as the documentation indicated changes were already in effect. Additionally, the documents provided to support this element did not confirm that the MCO was aware of the 30-day notification time frame requirement.		
Required Actions: The MCO must ensure that each member receives notice of any significant change 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 MCO's contract with the State.		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
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:** • 2021 SSHP Provider Directory (hard copy version) *Find a Provider Online Directory excerpts* • FAP PCP Excerpt • FAP Pharmacy Excerpt • FAP Hospital Excerpt • SSHP website: *Find A Provider*: https://findaprovider.silversummithealthplan.com/location	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Our provider directory is available electronically via our website as well as in paper form upon request. Excerpts of our provider directory can also be printed from our website after a search has been completed.		
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**
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:** *Elements 19a-19b:* • NV.PRVR.19 Provider Directory – Portico *Procedure* section (p. 2, bullets 4-5) • CC.PDM.13.01 Real Time Repository to Directory Display • *Find A Provider Online Directory* Mobile Phone screenshot • Date Stamped Provider Directory Updates	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Print directories are updated according to regulatory requirements. Our provider data management team updates our provider directory database (Portico) when they receive information from a practitioner or facility that requires a change to any provider directory element. Updates are made to Portico within 30 calendar days of receiving the information. Updates to Portico are reflected in our *Find A Provider* online directory within two (2) calendar days.		
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:** *Element 20:* • CC.MRKT.14 Website 508 Compliance • NV.PRVR.19 Provider Directory Portico *Purpose and Policy* sections (p. 1) • SSHP website: *Find A Provider*: https://findaprovider.silversummithealthplan.com/location • Find A Provider How to Print screenshot • Find A Provider PCP Excerpt	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: SSHP is compliant with section 508/WCAG 2.0 and ensure that our secure and non-secure web functionality is accessible to and usable by people with sensory, cognitive, and manual–dexterity type disabilities. All of our electronic information will also be available in paper form.		
HSAG Findings: Although the MCO posted the provider directory in a portable document format (PDF) format on the MCO's website, the MCO did not verify that the PDF format of the provider directory was in a machine-readable file and format.		
Required Actions: The MCO must ensure that the provider directory is made available on the MCO's website in a machine-readable file and format.		

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
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. 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)	**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 **Evidence as Submitted by the MCO:** *Elements 21-21a:* • CC.PHAR.10 Preferred Drug List *Procedure* section (p. 2, procedure 1) • 2021 SSHP Member Handbook *Pharmacy Services* section (p. 18). *Element 21c:* • SSHP website: *Pharmacy* page: https://www.silversummithealthplan.com/members/medicaid/benefits-services/pharmacy.html • SSHP website *Preferred Drug List* (.pdf): https://pharmacy.envolvehealth.com/content/dam/centene/envolve-pharmacy-solutions/pdfs/PDL/FORMULARY-SilverSummitHealthPlan_Nevada.pdf • SSHP Preferred Drug List	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Our Preferred Drug List (PDL) is updated monthly on our website. The tier level is located on the second column of our PDL. The link to our machine-readable file is on our website's pharmacy page.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** Although the MCO maintains a machine-readable format of its PDL under the Provider Pharmacy section of the MCO's website, HSAG strongly recommends that the MCO also include the machine-readable PDL under the Member Pharmacy section for members to have easier access to the information. Implementation of these recommendations will be further assessed during future compliance reviews.		
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:** *Element 22a-22c:* • NV.MRKT.01 Member Materials and Marketing Materials Guidelines *Member Newsletter* section (p. 5) • SSHP website: *Newsletters* page: https://www.silversummithealthplan.com/members/medicaid/resources/newsletters.html	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• SSHP Member Newsletters website screenshot • SSHP Q1 2021 Member Newsletter • SSHP Q2 2021 Member Newsletter • DHCFP E-Mail Approval of Member Newsletter	
MCO Description of Process: SSHP publishes a newsletter for members on a quarterly basis. The newsletter focuses on topics of interest to members and is written at an eighth (8th) grade level of understanding reflecting cultural competence and linguistic abilities. We provide copies of all newsletters to the DHCFP and obtain their approval prior to posting to our website.		
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	=	17	X	1	=	17
Not Met	=	5	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	22	Total Score		=	17
Total Score ÷ Total Applicable					=	77%

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:** • 2021 SSHP Member Handbook *Emergency Care* section (p. 30) • 2021 SSHP Provider Handbook *Emergency Care Services* section (p.59) • NV.UM.01 UM Program Description *Emergency Services* section (pg. 28, 29) • NV.UM.01.01 Covered Benefits and Services Work Process • NV.UM.12 Emergency Services – No PLP Process *Definitions* (p. 3)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The purpose of the *NV.UM.12 Emergency Services* policy is to promote timely member access to needed emergency services. The policy provides a definition of an emergency medical condition and what prudent layperson could reasonably expect in the absence of immediate medical attention. Examples to promote timely access to needed emergency services are provided in the Member Handbook and the Provider Manual.		
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**
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. b. Needed to evaluate or stabilize an emergency medical 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:** • 2021 Member Handbook *Provider Network*, *Quality Improvement*, and *Prior Auth for Services* sections (p. 27, 28, 59) • 2021 Provider Manual *Welcome, 24-Hour Access, Hospital Responsibilities, Network Development*, and *Emergency Care Services* sections (p. 5, 17, 27, 43, 59) • NV.UM.01 UM Program Description *Emergency Services* section (pg. 28, 29) • NV.UM.01.01 Covered Benefits and Services Work Process • NV.UM.12 Emergency Services – No PLP Process *Coverage of Emergency Medical Services* section (p. 2)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The *NV.UM.12 Emergency Services* policy describes that emergency services are furnished by a provider that is qualified to furnish those services, and needed to stabilize an emergent medical condition. This is also defined in both the Provider Manual and Member Handbook as well. Prior authorization is not required for a member's emergency medical condition until it is stabilized and only if a decision has been made for inpatient admission.		
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**
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:** • 2021 Member Handbook *Post Stabilization Services* (p. 32) • 2021 Provider Manual *PCP Responsibilities* and *Prior Authorizations* sections (pg. 25, 61) • NV.UM.01 UM Program Description *Emergency Services* section (pg. 24, 29) • NV.UM.01.01 Covered Benefits and Services Work Process • NV.UM.12 Emergency Services – No PLP Process *Post-Stabilization Services* (p. 2)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The NV.UM.12 policy describes that the plan shall cover and pay for post-stabilization care and services, and those services are covered whether they are obtained in or out of network. These services are defined as well in the provider and the member handbooks		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
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.	**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**
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)	**Evidence as Submitted by the MCO:** • 2021 Member Handbook *Emergency Care, Out of Network Services,* and *Post-Stabilization Services* sections (p. 30, 31, 32) • 2021 Provider Manual *PCP Responsibilities, Referrals, Telephone Arrangements, Hospital Responsibilities, Emergency Care Services, OON Providers,* and *Key Provisions* sections (pp. 16, 25, 26, 27, 59, 61, 72, 73) • ARQ ER Services No Auth Required screenshot • ARQ Urgent Care and ER Services screenshot • Authorization Requirement Qualifier (ARQ) File (tab 1, column D, row 27) • NV.UM.01.01 Covered Benefits and Services Work Process • NV.UM.12 Emergency Services – No PLP Process *Policy* and *Procedure* sections (p.1, 2) • SSHP Website Pre-Auth Check Tool • Authorization Analysis Tool	
MCO Description of Process: The *NV.UM.12 Emergency Services – No PLP Process* policy defines that all emergency services are covered by the health plan when furnished by a qualified provider, including non-network providers, and will be covered until the member is stabilized. The policy also states that prior authorization is not required for emergency medical services and that SSHP does require pre-certification for hospital admissions, but only after the member is stabilized and when a decision has been made by the provider for an inpatient admission. Other examples of this are also provided in both the Provider Manual and Member Handbook. An example is attached showing that any provider is able to confirm that there are no authorization requirements for emergency services on the SSHP website.		
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**
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. 42 CFR §438.114(c)(1)(ii)(A-B) Contract 3.4.9.2(B)	**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:** • 2021 Member Handbook *Emergency Care* (pp. 30, 31) • 2021 Provider Manual *Emergency Care Services* (p. 59) • Authorization Analysis Tool OP L1 Summary • Authorization Analysis Tool OP L2 Summary • ARQ ER Services No Auth Required screenshot • Authorization Analysis Tool • Authorization Requirement Qualifier (ARQ) File (tab 1, row 27) • Emergency Services Claims Payments • NV.UM.01 UM Program Description *Emergency Services* section (pg. 28, 29) • NV.UM.01.01 Covered Benefits and Services Work Process • NV.UM.12 Emergency Services – No PLP Process *Policy, Procedure* and *Definitions* sections (pp. 1, 2, 3) • SSHP Website Pre-Auth Check Tool	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The *NV.UM.12 Emergency Services* policy indicates that SSHP will cover emergency services, when members are unsure as to the emergency situation, and if an authorized representative acting for the organization instructs the member to go to the emergency rooms. This is also defined in both the member handbook and the provider manual.		

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
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:** • 2021 Member Handbook *Making Appointments and Getting Care* and *Emergency Care* sections (pp. 30, 34) • 2021 Provider Manual *Emergency Care Services* (p. 59) • Authorization Requirement Qualifier (ARQ) File (tab 1, row 27) • NV.UM.12 Emergency Services – No PLP Process (p. 1, sec A.4.) • NV.UM.01 UM Program Description *Emergency Services* (pp. 28, 29)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The *NV.UM.12 Emergency Services* policy defines that the plan does not limit what constitutes and emergency medical condition. It also defines that the health plan will not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agency not notifying the member's PCP. This is defined as well in both the member handbook and the provider manual.		
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:** • 2021 Member Handbook *PA for Services, Getting Out of State Care, Post Stabilization Services* sections (p. 28, 29, 32) • 2021 Provider Manual Emergency Care Services, Prior Authorizations section (p. 59, 61) • Amysis Claim Emergency Room • NV.UM.01 UM Program Description *Timeliness of UM Decisions, Emergency Services* sections (p.24, 28, 29) • NV.UM.01.01 Covered Benefits and Services Work Process (p. 1) • NV.UM.12 Emergency Services – No PLP Process *Coverage of Emergency Medical Services* (p. 2)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The *NV.UM.12 Emergency Services* policy clearly defines that the member will not be held liable for payment of subsequent screening and treatment required to diagnose a specific condition or to stabilize the member. This is also defined in both the member handbook and the provider manual.		
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**
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:** • 2021 Member Handbook (does not address this requirement because this is provider-facing) • 2021 Provider Manual *Emergency Care Services* (p.59) • NV.UM.01 UM Program Description *Emergency Services* (p. 29) • NV.UM.01.01 Covered Benefits and Services Work Process (p. 2, item 1.) • NV.UM.12 Emergency Services – No PLP Process (p. 1, sec A.5.)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The *NV.UM.12 Emergency Services – No PLP Process* policy defines that the attending physician or the provider treating the member is responsible for determining when the member is sufficiently stabilized for transfer and/or discharge. This is also defined in the member handbook and the provider manual.		
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**
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:** • 2021 Member Handbook *Post Stabilization Service* and *Prior Authorization for Services* sections (p. 28, 32) • 2021 Provider Manual *Prior Authorizations* (p.61) • NV.UM.01 UM Program Description *Emergency Services* (p. 29) • NV.UM.01.01 Covered Benefits and Services Work Process (pp. 1, 2) • NV.UM.12 Emergency Services – No PLP Process *Post Stabilization Services* (p.2) • RE: Post Op Office Visit (email)	☒ 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: The NV.UM.12 policy clearly defines all elements in this standard and the evidence in the policy is bookmarked advising such. Additionally, the member handbook and the provider manual also define this element. The *Post-Op Office Visit* email demonstrates that SSHP will cover post-stabilization services to maintain, improve, or resolve the member's stabilized condition.		
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:** • 2021 Member Handbook (does not address this requirement because this is provider-facing) • 2021 Provider Manual *Emergency Care Services* and *Hospital Responsibilities sections* (pp. 27, 60) • NV.UM.01 UM Program Description *Emergency Services* and *Timeliness of UM Decisions* sections (pp. 24, 29) • NV.UM.12 Emergency Services – No PLP Process (p. 2 sec 6)	☒ Met ☐ Not Met ☐ NA

Standard III—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	• NV.UM.12 Post Emergency, Post Stabilization Work Process (pp. 1, 2)	
MCO Description of Process: The NV.UM.12 policy defines that the health plan will cover all post stabilization care services, and the emergency room has not pre-approved ends when the plan representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation.		
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:** • Participating Provider Agreement (sample) • NV.CONT.01 Network Adequacy Procedure (pp. 1-3, subsections 2, 3, and subsection 4 letter L) • 2021 SSHP Provider Manual *Cultural Competency* section (p. 18); *Provider Rights and Responsibilities* section (p. 32) **Analysis of Provider Network Capabilities** • BH and PH Chronic Conditions • Condition by Race report • Membership Demographics by Region • NV Chronic Condition Count update • Provider Medicaid Language Report	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SSHP enters into written agreements with all Medicaid provider types by region. Provider languages are compared to our member population to ensure sufficient provider access for members with limited English proficiency as demonstrated in the *Analysis of Provider Network Capabilities* evidence. Through claims data, we analyze our member conditions to ensure we have the appropriate provider types in our network.		
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**
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. 42 CFR §438.206(b)(2) Contract 3.4.2.8(E)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Claims algorithm **Evidence as Submitted by the MCO:** • 2021 SSHP Member Handbook *Family Planning* (pp. 12, 22, 34); *After Hours Appointments* section (p. 37); *Member Rights* section (p. 66 bullet 5) • 2021 SSHP Provider Manual *Women's Health Care* section (p. 42) • NV.CONT.01 Network Adequacy (letter F pg. 3) • Participating Provider Agreement *Primary Care Services* (p. 25 section 14.3) **Analysis** • OB/GYN Access Report 4/20/21 • Claims Report (Family Planning)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SSHP allows direct access to women's health and family planning services; this is stated in our *Participating Provider Agreement* as well our *NV.CONT.01 Network Adequacy* policy. SSHP contracts with Women's Health specialists to provide adequate access. This information is communicated to our members through the *SSHP Member Handbook*. SSHP analyzes our network to ensure appropriate coverage as evidenced in the *OB/GYN Access Report*. Our reporting demonstrates members are accessing OB/GYN and family planning services based on diagnosis. We do not deny preventive and wellness claims for OB/GYN and family planning services, as shown in the *Claims Report (Family Planning)*.		
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**
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:** • NV.CONT.01 Network Adequacy (p. 3, letter J) • CC.UM.01.08 Use of Out of Network Providers and Steerage *Special Considerations* section (p 4, subsection 3.c.) • SSHP Provider Manual *Second Opinion* section (p. 68); *Member Rights and Responsibilities* section (p. 29); *Provider Rights and Responsibilities* section (p. 32) • 2021 SSHP Member Handbook *Second Medical Opinion* section (p. 29); *Member Rights* section (p. 66 bullet 19)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SSHP allows for second opinions. For in network providers we do not require a prior authorization. Members can self-refer for these services. If a member needs to go outside of the network a second opinion may be requested through our medical management team. All second opinions are provided at no cost to the member.		
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:** • CC.UM.01.08 Use of Out of Network Providers and Steerage *Work Process* section (p. 1); *Special Consideration* section (p. 4)	☒ Met ☐ Not Met ☐ NA

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	• NV.CONT.01 Network Adequacy (letter K, p. 3) • 2021 SSHP Provider Manual (pp. 44, 45) • 2021 SSHP Member handbook *Provider Network* section (p. 27), *Second Medical Opinion* section (p. 29), *Out of Network Services* section (p. 31) • SCA Log (Jan 2021 – May 2021) • SCA Log (Nov 2020 – Dec 2020)	
MCO Description of Process: SSHP works with its contracted providers and Medical Management team to ensure members have access to adequate and timely care. If we find that we don't have a network available to provide these services, we will execute a Single Case Agreement as evidenced in our SCA tracking logs.		
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:** • 2021 SSHP Member Handbook *Getting Care Out of State* section (p. 29); *Out of Network Services* section (p. 31); *Access to Care* section (p. 42) • 2021 SSHP Provider Manual (pp. 44, 45) • SCA Logs (column K) • SCA Order of Operations • SCA Workflow • Single Case Agreement sample	☒ Met ☐ Not Met ☐ NA

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: SSHP works with out of network providers to ensure members have access to care if we cannot provide in the network. SSHP negotiates Single Case Agreements outlining the reimbursement for services with no cost share to the members. The SCA processes are followed to ensure we have exhausted all in-network options prior to sending to an out of network provider.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
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:** • NV.CONT.01 Network Adequacy (p. 3 letter g) • 2021 SSHP Provider Manual (pp. 24 and 42) • 2021 SSHP Member Handbook *Family Planning Services* section (p. 22) • OB GYN State File to Portico Medicaid	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SSHP provides access to a sufficient network of family planning providers through direct contracts. SSHP also allows members to seek out of network family planning services without an authorization required.		
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**
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. 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 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 • HSAG will also use the results of the Access Standards: Appointment Times Checklist. **Evidence as Submitted by the MCO:** • 2020 Annual Quality Program Evaluation *Access and Availability* section (pp. 27-28); *Network Adequacy* section (pp. 31 – 32) • 2021 SSHP Provider Manual *Appointment Availability and Access Standards* section (pp. 15, 17) • Network Analysis Report (2021 Q1) • NV.CONT.01 Network Adequacy *Procedure* and *Provider Network Maintenance* sections (pp. 1, 4) • NV.QI.01 Quality Operational Documents *Member Access to Care* section (pp. 35, 36) • Participating Provider Agreement, *Schedule A, Term 13 Access to Services (p. 24)* • Quality Improvement Committee Meeting Minutes *Practitioner Availability Report review* (p. 3)	☐ Met ☒ Not Met ☐ NA

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: SSHP contractually obligates its network providers to abide by the access DHCFP access standards in the contract. SSHP has processes in place to monitor the access of our providers. If providers are found to be outside of the standards, Provider Relations contacts the provider to let them know the findings and provides education for remediation.		
HSAG Findings: Although MCO staff members during the interview identified two teams assigned to ensuring the MCO's compliance with the availability of services standards, the MCO did not identify a specific staff member assigned to ensure compliance. The MCO provided in follow-up a job description for an Accreditation Specialist who is responsible for the MCO's submission of evidence to the National Committee for Quality Assurance (NCQA) for accreditation. While the job description listed information related to accreditation audits, it did not demonstrate responsibilities related to compliance with availability of service standards, such as timely access to care and services. Further, although the MCO described a process indicating that provider relations staff members contact network providers that fail to meet compliance standards, documentation that corrective action would occur for non-compliance was not provided.		
Required Actions: The MCO must assign a specific staff member of its organization to ensure compliance with availability of services standards. Additionally, the MCO must ensure that it has documented mechanisms in place to support that the MCO takes corrective action if there is a failure to comply by a network provider.		
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:** • 2020 Annual Quality Program Evaluation *Access and Availability* (p. 27) • 2021 SSHP Member Handbook *Urgent Care After-Hours* section (p. 30) • 2021 SSHP Provider Manual *24 Hour Access* section (p. 17); *Telephone Arrangements* section (p. 16) • NV.CONT.01 Network Adequacy (p. 2 section 4.A.) • NV.UM.12 Emergency Services *Accessing Emergency Medical Services* section (p. 1)	☒ Met ☐ Not Met ☐ NA

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	• Participating Provider Agreement, *Schedule A, Term 13 Access to Services (p. 24)*	
MCO Description of Process: SSHP has provider contracts in place that require the network providers to provide information on how to obtain urgent coverage for after hours and weekends. This information is also outlined in the *2021 SSHP Provider Manual* and monitored by the Provider Relations team.		
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:** • 2021 SSHP Provider Manual *Cultural Competency* section (p. 18) • Cultural Competency and Linguistics Assistance Services (CCLAS) Program Description (pages cover, 5- 6, 7, 8 and 12) • Cultural Competency Work Plan • Medicaid Language Report • NV.CONT.01 Network Adequacy *Cultural Diversity* section (p. 4, letter L) • NV.QI.26 Cultural Competency • Participating Provider Agreement, *Schedule A, Term 3. Cultural Competency (p. 24)*	☒ Met ☐ Not Met ☐ NA

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: The *NV.QI.26 Cultural Competency* plan and the *Cultural Competency and Linguistics Assistance Services Program Description* are the policies for cultural competency, including information regarding provider network linguistic capabilities and cultural competency. In addition, it provides the work plan details involved in evaluating the cultural competency program. SSHP has provider contracts in place that require the network providers to deliver services in a culturally competent manner in accordance with regulatory and contractual requirements.		
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:** • Cultural Competency and Linguistics Assistance Services (CCLAS) Program Description *CCLAS Work Plan* section (p. 14) • NV PAI Provider Self Reporting Form Report • NV.CONT.01 Network Adequacy (p. 2, letter c) • Participating Provider Agreement, *Article II, 2.11 Nondiscrimination* (p. 5) • Provider Accessibility Initiative (PR Training) • Provider Accessibility Initiative (Provider Notification)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SSHP conducts routine outreach to our provider network to ensure they provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities. Our outreach is continuous through our Provider Relations		

Standard IV—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
team. Our providers are trained on how to submit their compliance with requirements through our online portal and tracking mechanisms have been put in place to capture the provider's attestations.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		

Standard IV—Availability of Services						
Met	=	9	X	1	=	9
Not Met	=	1	X	0	=	1
Not Applicable	=	0				
Total Applicable	=	10	Total Score		=	9
Total Score ÷ Total Applicable					=	90%

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:** *Element a:* • NV.CONT.01 Network Adequacy *Procedure* (pp. 1 - 3) • Participating Provider Agreement *Access to Services*, *Laboratory Service Providers*, and *Appointment and Wait Times* sections (pp. 24 - 26) *Element a.ii* • 402 Network Adequacy Report • 2021 SSHP Provider Handbook *Network Development and Maintenance* section (p. 45); *IQAP Scope and Goals* section (p. 89)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SilverSummit Healthplan has processes in place to monitor network adequacy to ensure we have the appropriate capacity to serve our members. In addition, we run monthly adequacy reports supported by Geonetwork analysis to ensure members have access to care. Any categories that fall out of compliance are researched to determine if there is a provider available and attempts are made to contract.		
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:** *Element b:* • 402 Network Adequacy Report • NV.CONT.01 Network Adequacy *Procedure* section p.1 *Element c:* • Notice of Termination for Dignity Health • State Notification of Dignity Termination *Element d:* • NV.CONT.01 Network Adequacy *Procedure* section p.1	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SilverSummit Healthplan follows the contract requirements for network adequacy. Monthly reports are run to confirm adequacy is met on a continual basis. Quarterly reports are submitted to the State as required by the contract. If a significant change occurs, we notify the DHCFP and send member communications to the affected members.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** In follow up to the interview session, the MCO provided a Provider Termination Report that included instructions on informing DHCFP's Provider Enrollment Unit within five business days if a provider is decredentialed, terminated, or disenrolled as evidence of its process for notifying DHCFP of significant changes. While this meets the intent of this requirement, HSAG strongly recommends that the MCO consider developing a guidance document that details the steps to take if a major change in the MCO's network should occur outside of provider terminations, including notification time frames. Implementation of these recommendations will be further assessed during future compliance reviews.		
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:** *Element 1a* • NV.CM.02 Care Coordination Care Management (pp. 3, 15) • Screenshot of assigned PCP in system • ID Card with Assigned PCP	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The *NV.CM.02 Care Coordination Care Management* policy describes the process of coordinating a plan of care with the member's PCP. An example of a member with an assigned *PCP in the system* is included, along with a copy of a *member's ID card* showing an assigned PCP.		
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	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use results from the Care Management File Review. **Evidence as Submitted by the MCO:** *Element 2a* • NV.UM.01.09 Discharge Planning (pp. 1, 2)	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
d. With the services the member receives from community and social support providers. 42 CFR §438.208(b)(2)(i-iv) Contract 3.4.14	• Discharge Planning (Short Term Hospital) • Coordination Between Settings (SNF) *Element 2b* • NV.CM.02 Care Coordination Care Management (p. 3) • HPN PA Transfer File • HPN Transition of Care File • SSHP PA Transfer File • SSHP Transfer of Care File *Element 2c* • NV.CM.02 Care Coordination Care Management (p. 1) *Element 2d* • NV.CM.02 Care Coordination Care Management (pp. 1, 2, 17) • Community and Social Service Support Providers (CM Notes)	
MCO Description of Process: The *NV.UM.01.09 Discharge Planning* policy describes the process of coordinating the discharge plan between SSHP and the various settings of care. The *Discharge Planning (Short Term Hospital)* notes provide an example of communication between SSHP and the acute facility, along with communication between SSHP and the SNF (between settings). The *NV.CM.02 Care Coordination Care Management* policy describes the process of communicating with the other MCOs about the services the member had received. The *PA Transfer File* template and the *Transition of Care File* template are the forms that NV Medicaid MCOs use to identify members who have transferred to another MCO and include any current prior authorizations that need to be honored and any current case management services. The *NV.CM.02 Care Coordination Care Management* policy also describes the process of communicating with any FFS case manager. To date there has been no communication from the State regarding members with FFS Medicaid who are transitioning to the MCO.		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
The *NV.CM.02 Care Coordination Care Management* policy describes the process of how SSHP coordinates services the member receives or could receive from community and social service programs. The Community and Social Service Support Providers (CM Notes) provide an example of such communication for a member.		
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:** • NV.Q1.13 Medical Record Review (pp. 1-2) • Medical Records Review Checklist Tool • Medical Records Review Letter (Passing Score) • PCP Audit Medicaid Q4 2020 • Participating Provider Agreement (p. 7) • 2021 SSHP Provider Manual (pp. 7-8)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The *NV.Q1.13 Medical Record Review* policy describes SSHP's standards for practitioner documentation and maintenance of medical records. It also outlines how SSHP will access network medical record keeping practices by conducting audits and the required passing score. The *2021 SSHP Provider Manual* describes the Provider Portal where records can be shared securely. The *Participating Provider Agreement* outlines how each contracted provider shall maintain medical records. The *Medical Records Review Checklist Tool* is an example of a provider's medical records review audit.		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
The *PCP Audit Medicaid Q4 2020* provides an example pull of providers who were requested for a medical records audit. The *Medical Records Review Letter* demonstrates communication post audit to the provider with their passing score.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
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:** *Element 4a* • NV.CM.02 Care Coordination Care Management (pp. 4-5) • Case Management Prioritization Report	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The *NV.CM.02 Care Coordination Care Management* policy describes the process of identification of appropriate candidates for care management. It also outlines the various resources SSHP has in place to assist in the identification of these members, which includes claims based, pharmacy based, and ER high utilization based data. The *CM Prioritization Report* is pulled weekly from our data warehouse and managed by the department's non-clinical staff who conduct outreach calls, complete screenings, and submit referrals to case management should the members agree to enroll.		
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**
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:** *Element 5a, 5b, 5c* • NV.CM.02 Care Coordination Care Management (p. 5) *Element 5d* • CC.COMP.33 Compliance Reporting Program (p. 1) *Other Evidence* • Health Risk Assessment Template • Health Risk Screening Template • State Required HRA Reporting • NV Medicaid New Members • NV Medicaid New Pregnant Members	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: The *NV.CM.02 Care Coordination Care Management* policy describes the process of conducting an initial comprehensive assessment on newly enrolled members to determine the need for CM services within 90 days of enrollment. It further describes the need to complete this assessment within 30 days of enrollment on members who are pregnant or have special healthcare needs. The policy includes how many attempts must be made and addresses conducting face to face assessments as necessary. To date, SSHP has not received a request to submit a Health Needs Assessment Screening to the DHCFP, however in the event of such a request, the *CC.Comp.33 Compliance Reporting Program* policy does reference what SSHP will do.		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
SSHP's Data Analytics Team submits two weekly reports to the Case Management department, both of which list newly enrolled members to SSHP. These are the *Medicaid New Members Report* and the *Medicaid New Pregnant Members Report*. The State does submit these initial lists to SSHP, however, to date, SSHP is not receiving a list of newly enrolled adults or children with special needs. The two reports are used to begin outreach attempts to complete the initial comprehensive assessments and screenings. SSHP submits a monthly report to the DHCFP showing the success of outreach attempts on newly enrolled Medicaid members.		
HSAG Findings: The case file review confirmed that the MCO did not consistently conduct three attempts to complete the initial health risk screening or the screening was not completed timely. **Recommendations:** For one case, all three attempts to complete the initial health risk assessment occurred on the same day. HSAG recommends that the MCO implement standardized procedures to ensure that attempts occur on different days and at different times of the day. Additionally, MCO staff members explained that the 834-enrollment file received from DHCFP includes a pregnancy indicator, but there was no indicator for special health care needs. HSAG recommends that the MCO consult with DHCFP regarding the possibility of including the identification of members with a special health care need in the file.		
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.		
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:** • NV.CM.02 Care Coordination Care Management (p. 3) • Transition of Care File to HPN • Transition of Care File to Anthem	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: The *NV.CM.02 Care Coordination Care Management* policy states that SSHP, upon request, will communicate with other vendors serving the recipient, the results of any identification and assessment to ensure services are not duplicated. The evidence submitted includes a transition of care (TOC) file from SSHP to HPN (MCO) and one to Anthem (MCO). To date there has been no requests from the DHCFP to share results or an assessment.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** HSAG recommends that the MCO consult with DHCFP regarding processes for the exchange of information between the MCO and DHCFP when a member transitions to or from fee-for-service; for example, sharing of transition-of-care forms and open authorizations.		
Required Actions: None.		
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:** • NV.CM.02 Care Coordination Care Management (pp. 4, 5)	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: The *NV.CM.02 Care Coordination Care Management* policy describes the various mechanisms and data resources the Healthplan has in place to help identify members with potential special health care needs. To date the Healthplan is not managing any members needing LTSS. The policy also indicates that the State may supply data to help identify potential candidates for care management, but to date, this is not occurring.		
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* d. *Psycho-social* e. *Environmental* f. *Community support needs* Contract 3.10.20.2(C)	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use results from the Care Management File Review • Comprehensive Assessment Template **Evidence as Submitted by the MCO:** • NV.CM.02 Care Coordination Care Management (pg. 5) • Comprehensive Assessment Template (pgs. 1,3,5,7,8)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The *NV.CM.02 Care Coordination Care Management* policy outlines the required components of the comprehensive assessment. The *Comprehensive Assessment Template* included as evidence has been bookmarked and highlighted to show these components.		
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.*	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use results from the Care Management File Review • Notification and/or welcome letter template	☐ Met ☒ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Contract 3.10.20.2.1(C); 3.10.20.2(C)	**Evidence as Submitted by the MCO:** • NV.CM.02 Care Coordination Care Management (pgs. 13, 14) • Adult Welcome Letter • Provider Welcome Letter	
MCO Description of Process: The *NV.CM.02 Care Coordination Care Management* policy describes the process of sending a welcome letter to the member upon completion of the initial assessment and enrollment in care management. The policy also goes on to describe that for members in complex care management, the member's assigned PCP will also be sent a letter informing them that the member is enrolled in care management. The evidence includes a sample of both the member and provider notification letters.		
HSAG Findings: Although the MCO indicated that it adhered to this requirement through the mailing of welcome letters to the member and his or her primary care provider (PCP), the case file review confirmed that the MCO did not consistently send welcome letters to the member and/or the member's PCP when a member was enrolled in care management services. **Recommendations:** In some instances, while the provider welcome letter was not sent, the member welcome letter was sent to the PCP. MCO staff members explained that this issue has been addressed with the care managers. As such, HSAG recommends that the MCO continue to monitor and audit care management files to ensure that the correct letters are being generated and sent to PCPs. Additionally, with the exception of the obstetrics (OB) care management member welcome letters, the member welcome letters provided to the member included a number to call to disenroll from the care management program; however, the letters did not provide the member with the name and contact number of his or her assigned care manager. HSAG recommends that the MCO revise the care management enrollment welcome letter to be more member-centric and specifically include the member's care manager name and contact information.		
Required Actions: The MCO must provide information to members and their PCPs that they have been identified as meeting the criteria for care management, including their enrollment into care management services.		
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.*	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use results from the Care Management File Review	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Contract 3.10.20.2(E)(1)	• Tracking and reporting mechanisms for timely completion of the care plan **Evidence as Submitted by the MCO:** • NV.CM.02 Care Coordination Care Management (pgs. 4, 11) • Case Detail Dossier Report (columns H and Q)	
MCO Description of Process: The *NV.CM.02 Care Coordination Care Management* policy describes the process of developing a person-centered care plan. The policy further outlines that this care plan will be initiated no later than 30 days from initial identification / referral to care management. The *Case Detail Dossier Report* is a tracking mechanism used by SSHP and includes if a care plan exists and the latest update to an existing care plan. This report is pulled monthly and sent to each case manager. SSHP's documentation system also allows the case managers to set tasks to complete the care plans.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
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:** • NV.CM.02 Care Coordination Care Management (pg. 15)	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: The *NV.CM.02 Care Coordination Care Management* policy states that SSHP will collaborate with members, treating providers, member's family / guardians or care givers to develop and individualized care management plan.		
HSAG Findings: The case file review confirmed that the MCO did not consistently implement processes to involve the member's PCP in the development of the initial care plan. For example, evidence that the care plan was sent to the PCP was not located in the record, or a care plan letter was located in the record but did not include the actual care plan. After the interview session, the MCO explained that there has been an issue identified in which the care plan was not attached to the letters during the printing process and that this issue will be reviewed by the MCO's corporate team.		
Required Actions: The MCO must actively involve the member's PCP in the development of the care plan.		

Standard VI—Coordination and Continuity of Care		
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:** • NV.CM.02 Care Coordination Care Management (pg. 8)	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: The *NV.CM.02 Care Coordination Care Management* policy describes how the care management screening and or assessment will use the member's physical, behavioral and or psycho-social conditions, along with environmental and community needs identified, to help determine an effective care plan.		
HSAG Findings: The case file review identified two care plans with a lack of specific, individualized, and meaningful goals and interventions. MCO staff members explained that these care plans were created by the same care manager who is no longer employed by the MCO. **Recommendations:** While the care manager is no longer employed by the MCO, HSAG recommends that the MCO continue to conduct ongoing training to care managers on the development of member-centric, individualized, and measurable goals and interventions and conduct regular review of member records for adherence.		
Required Actions: The MCO must ensure that a care plan includes specific individualized interventions to meet the member's assessment needs.		
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,*	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use results from the Care Management File Review. **Evidence as Submitted by the MCO:** • NV.CM.02 Care Coordination Care Management (pgs. 2-3)	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Infants, and Children (WIC) program; teen pregnancy programs; parenting programs; and child welfare programs. Contract 3.10.20.1(D)(2)		
MCO Description of Process: The *NV.CM.02 Care Coordination Care Management* policy describes how SSHP's care managers will work with other MCOs, other health systems, and State and County Agencies, such as ADSD, DCFS, GovCHA, DPBH, DWSS, SAPTA, and WIC, to coordinate care and ensure continuity of services for those with special needs.		
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:** • NV.CM.02 Care Coordination Care Management (pg. 4)	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: The *NV.CM.02 Care Coordination Care Management* policy describes the care manager's role in continuous monitoring of the progress of the member, re-evaluation of the member's care needs, and adjusting the level of CM services as appropriate.		
HSAG Findings: The case file review confirmed that the MCO did not consistently conduct timely outreach to members, which is necessary to monitor a member's progress and re-evaluate a member's care needs. Several gaps in outreach were identified and the MCO's recommended contact frequency was not consistently followed. It should be noted that after the interview session, the MCO was able to provide an explanation or additional documentation that resolved this initial concern for some, but not all, of the cases.		
Required Actions: The MCO must continuously monitor the member's progress, re-evaluate the member's care needs, and adjust the level of case management services accordingly.		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
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:** • NV.CM.02 Care Coordination Care Management (pg. 4)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The *NV.CM.02 Care Coordination Care Management* policy speaks to the case manager's role in identifying gaps between care recommended and actual care provided, and the role to propose new measures to address the gaps.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** While not a trend, one case identified a member who was having issues with obtaining diabetic testing strips from the pharmacy. While the community health representative instructed the member to call member services, there was no communication with the member's care manager or follow-up to ensure any barriers were remediated. As such, HSAG recommends that the MCO complete additional education with its staff members to ensure identified member needs are adequately and timely addressed.		
Required Actions: None.		
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:** • NV.CM.02 Care Coordination Care Management (pg. 20)	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: The *NV.CM.02 Care Coordination Care Management* policy describes how the care manager will ensure members are involved in the care plan on an ongoing basis and any updates or revisions are based on consultation with the member and the involved physicians.		
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 to identify criteria or guidelines for care managers related to the requirements of this element.		
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. 42 CFR §438.208(c)(4) Contract 3.4.7.2	**HSAG Recommended Evidence:** • Policies and procedures **Evidence as Submitted by the MCO:** • NV.CM.02 Care Coordination Care Management (pg. 21)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The *NV.CM.02 Care Coordination Care Management* policy describes the ongoing assessment and applicable revisions to the care plan and how the care manager will facilitate referrals to specialists when identified for needed services. The policy also states that prior authorization is required for a limited number of specialist referrals, which indicates that most referrals to specialists actually do not require a prior auth. This applies to all members and not just those who have special health care needs in care management.		
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	=	12	X	1	=	12
Not Met	=	5	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	17	Total Score		=	12
Total Score ÷ Total Applicable					=	71%

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:** • 2021 SSHP Member Handbook *Member Satisfaction*, *Your Covered Benefits*, *How Your Health Plan Works* sections (pp. 11 – 13, 66) • 2021 SSHP Provider Manual *Member Rights, Covered Services* sections (pp. 29, 40) • NV.UM.01.01 Covered Benefits and Services *Process* (p. 1) • NV.UM.01 UM Program Description *Scope, Medical Necessity Review* sections (pp. 4, 16)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SSHP, at a minimum, provides benefits and services that are reasonable, medically necessary and covered under the Title XIX and Title XXI State Plans for the diagnosis or treatment of an illness or injury. Preventive care and certain screening tests are also covered under the benefit plan. Plan benefits shall not be less in amount, duration, and scope than under the current FFS program, can be reasonably be expected to achieve the purpose for which the services are furnished and are covered under the respective State Plans for Title XIX and XXI programs and the Nevada Medicaid Service Manual, but may be more than stated therein. Benefits are subject to authorization requirements (as applicable). The Plan may utilize different authorization requirements than what is used by the State, as long as they are not more restrictive. SSHP covers those services which are medically necessary, pursuant to the applicable state and federal requirements. Medically necessary services shall include covered services related to the prevention, diagnosis and treatment of health impairments; the ability to achieve age appropriate growth and development; and the ability to attain, maintain, or regain functional capacity in a manner that is no more restrictive than that used in the State Medicaid and CHIP programs as indicated in State statutes and regulations, the Title XIX and Title XXI State Plans, and other State policy and procedures, including the Medicaid Services Manual (MSM). The Plan does not cover experimental medical and surgical procedures, equipment, medications, investigational or cosmetic procedures under the benefit plan. Experimental procedures and items are those items and procedures determined by our plan not to be generally accepted by the medical community. Phase I and Phase II trials are considered experimental. Phase III and Phase IV are not considered experimental. Medical necessity determinations are made on a case-by-case basis in situations where there are no viable non-experimental treatment options or all other treatment options have been exhausted.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
SSHP does 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 recipient; SSHP may place appropriate limits on a service on the basis of criteria applied under the Title XIX and Title XXI State plans, such as medical necessity, or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose; and Specific covered benefits and services are subject to prior authorization. As allowed under contract; the Plan authorization requirements may differ from those used by the State, are no more restrictive than those used by the State, and are State approved.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		
2. The MCO— a. Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. b. May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. 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:** • CC.UM.02.01 Medical Necessity Review • NV.UM.01 Utilization Management Program Description • NV.UM.01.01 Covered Benefits and Services *Process* section (pp. 1, 2) • NV.UM.02 Clinical Decision Criteria and Application	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SSHP, at a minimum, provides benefits and services that are reasonable, medically necessary and covered under the Title XIX and Title XXI State Plans for the diagnosis or treatment of an illness or injury. Preventive care and certain screening tests are also covered under the benefit plan. Plan benefits shall not be less in amount, duration, and scope than under the current FFS program, can be reasonably be expected to achieve the purpose for which the services are furnished and are covered under the respective State Plans for Title XIX and XXI programs and the Nevada Medicaid Service Manual, but may be more than stated therein. Benefits are subject to authorization requirements (as applicable). SSHP may utilize different authorization requirements than what is used by the State, as long as they are not more restrictive.		
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**
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:** • Authorization Requirement Qualifier (ARQ) spreadsheet • CC.UM.02.01 Medical Necessity Review • Family Planning Services No PA (screenshot) • NV.UM.01 UM Program Description *Medical Necessity Review* (p. 15) • NV.UM.01.01 Covered Benefits and Services Work Process *Process* and *Family Planning Services* sections (pp. 2, 6) • NV.UM.06.03 Women's Health, Family Planning and Abortion Services *Procedure* section (p. 2)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: LTSS Services are not covered at this time. SSHP does 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 recipient; we may place appropriate limits on a service on the basis of criteria applied under the Title XIX and Title XXI State plans, such as medical necessity, or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose. Family Planning Services and Supplies do not require an authorization for both in and out of network providers ensuring members the freedom to choose the method of family planning to be used consistent with 42 CFR §441.20. Family planning services are furnished on a voluntary and confidential basis, even if the member is less than 18 years of age. Specific covered benefits and services are subject to prior authorization. As allowed under contract; the Plan authorization requirements may different from those used by the State, are no more restrictive than those used by the State, and are State approved.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** Based on the discussion during the interview session, MCO staff members confirmed responsibility for covering certain LTSS, such as personal care and home health services when medically necessary for its membership. As such, HSAG recommends that the MCO review all LTSS-related		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
requirements indicated in federal rule under 42 CFR §438 to ensure its program documentation fully supports compliance. HSAG further recommends that the MCO train its staff members to ensure understanding of the MCO's responsibilities related to LTSS, even though the LTSS membership through waiver services is covered under Medicaid fee-for-service.		
Required Actions: None.		
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:** • 2021 SSHP Member Handbook *Your Covered Benefits* section (p. 11-13); *Out of Network Services* section (p. 31) • 2021 SSHP Provider Manual *Medical Necessity* (p.60) • 416 CMS EPSDT Quarterly Report • Authorization Requirement Qualifier (ARQ) spreadsheet • CC.UM.02.01 Medical Necessity Review • NV.UM.02 Clinical Decision Criteria and Application • Pre Auth Check Tool (screenshot)	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: LTSS Services are not covered at this time. SSHP covers those services which are medically necessary, pursuant to the applicable state and federal requirements. Medically necessary services shall include covered services related to the prevention, diagnosis and treatment of health impairments; the ability to achieve age appropriate growth and development; and the ability to attain, maintain, or regain functional capacity in a manner that is no more restrictive than that used in the State Medicaid and CHIP programs as indicated in State statutes and regulations, the Title XIX and Title XXI State Plans, and other State policy and procedures, including the Medicaid Services Manual (MSM).		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		
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:** • Authorization Requirement Qualifier (ARQ) spreadsheet • CC.UM.01.07 Concurrent Review Work Process • CC.UM.01.07 Next Review Date Work Flow • CC.UM.01.07 Referral Checklist Work Flow (RN to MD) • CC.UM.02.01 Medical Necessity Review *Purpose, Level II Review* sections (pp. 1, 2)	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• CC.UM.02.05 Interrater Reliability Work Process *Purpose* and *Work Process* sections (p. 1) • CC.UM.04 Appropriate UM Professionals *Policy* and *Licensed Health Professionals* sections (pp. 1, 2) • CC.UM.06 Clinical Info and Documentation • Interrater Reliability Testing Results • Interrater Reliability Testing Retake Results • NV.UM.02 Clinical Decision Criteria and Application *Consistency in Applying Criteria* and *Level I* sections (pp. 3, 4) • Pre Auth Check Tool (screenshot) • Prior Auth Form (Inpatient) • Prior Auth Form (Outpatient) • UM Nurse to MD Audit Tool Template	
MCO Description of Process: LTSS is not currently covered. All attached policies describe work flows/processes. All new employees, including temporary, contractor, or other individuals with decision making responsibilities, must be tested within 90 calendar days but not to exceed the 90th day of initial InterQual® or MCG Care Guidelines® (MCG) training. Testing will be assigned on the 60th day post the initial InterQual or MCG training. Best practice is to use the last 14 days of the 90 day window to complete the interrater reliability (IRR) process. This approach allows time to plan for testing that will support the business needs while allowing the end user to have sufficient time to prepare. In general, each assessment will require 90-120 minutes to complete. If this IRR testing coincides with the annual testing, it may be used for both. If there are more than 30 days separating the new employee and annual testing, it must be repeated. Successful demonstration of the UM process and proficient application of relevant medical necessity criteria including InterQual, MCG, American Society of Addiction Medicine (ASAM), Level Of Care Utilization/Child/Adolescents Of Care Utilization System, and/or Applied Behavioral Analysis must be validated through audits and testing prior to release from orientation. Managers and Clinical Trainers will receive scores for their respective staff. A score of less than 90% for any subset is considered failure.		
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**
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. 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	**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:** • 2021 SSHP Member Handbook *Appeals* section (p.62-63); *Continuing to Receive Services* section, *Fast Appeal Decisions* section, *State Fair Hearings* section (p. 64) • 2021 SSHP Provider Manual *Appeals* section, *Standard Appeals* section (p.35); *Expedited Appeals* section, *Extension of Grievance and Appeals Timeframe* section (p. 37) *State Fair Hearing* section (p.38); *Adverse Benefit Determination* section (p. 70-71); *Guidelines for Psychological /Neuropsychological Testing* section, *Advanced Diagnostic Imaging* section (p. 71) • CC.UM.01.07 Concurrent Review • CC.UM.02.01 Medical Necessity Review • CC.UM.07 Adverse Benefit Determination (Denial) Notices *Level II Review* section (p.2-3) • Adverse Benefit Determination (redacted sample)	☐ Met ☒ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
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: SSHP's ABD notices are structured to meet the content requirements of our MCO contract and applicable regulations. Both the member and requesting provider (and facility if applicable) receive a written notice of action regarding any denial, reduction, or termination of service, including behavioral health and pharmacy services. The notice of action letter is sent from the clinical documentation system and includes the member-specific reason for the denial, in easily understandable language; a reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based; notification that the member can request a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based; a description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal; an explanation of the appeal process, including the member's right to representation by anyone (including an attorney), contact information for the state Office of Health Insurance Consumer Assistance or ombudsman (if applicable), the time frames for filing and deciding appeals, and the circumstances under which additional external appeal rights are available and how to request them; and a description of the expedited appeal process including under what circumstances an expedited appeal can be requested, how to request an expedited appeal, and the timeframe for resolution of an expedited appeal.		
HSAG Findings: Although the Adverse Benefit Determination (Denial) Notices policy indicated that the ABD notice included information that the member can request a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based, the policy did not stipulate that the documentation can be requested free of charge. Additionally, results of the case file review indicated that two cases (#2 and #9) were missing language about the member's right to request copies of the documentation in which the denial decision was based. Further, for one case, the ABD notice was only sent to the provider and not to the member as required. **Recommendations:** Although the letters were generally written using easy-to-understand language, there were several ABD notices that included grammatical, spacing, font, and punctuation issues. To ensure ABD notices are professional and free from grammatical and other issues, HSAG recommends that the MCO develop a quality assurance process for its notices, which may include peer review or supervisory review of all notices prior to notices being mailed. Additionally, the MCO should update all member materials and notices requiring a written, signed appeal as this requirement has been removed from federal regulation. Implementation of these recommendations will be further assessed during future compliance reviews.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Required Actions: 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 42 CFR §438.404, and specifically must include the member's right to request and have reasonable access to, copies of all documents, records, and other information relevant to the ABD.		
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 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;	**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:** • 2021 SSHP Member Handbook *Individual Rights* section (p. 72) • Adverse Benefit Determination • Adverse Benefit Determination Previously Approved Service • Adverse Benefit Determination Reduction in Service • CC.UM.01.07 Concurrent Review • CC.UM.01.07 Next Review Date Work Flow • CC.UM.01.07 Referral Checklist Work Flow (RN to MD) • CC.UM.02.01 Medical Necessity Review • CC.UM.02.02 Inpatient Leveling of Care	☐ Met ☒ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
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	• CC.UM.05 Timeliness of UM Decisions and Notifications *NOA for Previously Approved Services* section (p. 4) • CC.UM.07 Adverse Benefit Determination Notices • Ineligible for Further Services (email notification to DHCFP) • Ineligible for Further Services (letter to member) • NV.UM.02 Clinical Decision Criteria and Application	
MCO Description of Process: When a service request for ongoing treatment(s) for a previously approved service request is received, SSHP reviews medical necessity criteria for the continuation and extent of these ongoing services (e.g. rehab therapy services, home health visits, etc.). If the determination results in a termination, suspension, or reduction of a previously approved treatment request, the UM designee notifies the member and provider in accordance with the notification standards as stated herein, and issue a written or electronic notification notice at least ten calendar days before the intended action.		
HSAG Findings: The MCO submitted its Timeliness of UM Decisions and Notifications policy as evidence for this element, which indicated that when a service request for ongoing treatments for a previously approved service is received, the plan reviews medical necessity criteria for the continuation and extent of these ongoing services. The policy further stated that if the determination results in a termination, suspension, or reduction of a previously approved treatment request, the MCO notifies the member and provider in accordance with the notification standards and issues a written or electronic notification notice at least 10 calendar days before the intended action. However, this documentation appeared to specifically relate to service authorizations that were going to expire versus the MCO's process for terminating, suspending, or reducing previously authorized services that were already in place. Additionally, although an ABD notice was provided that indicated "request was reduced," this was related to a partial denial/approval of a request for new services and not an ABD notice for previously authorized services that were being reduced by the MCO. Further, there was no language in the policy or in other documentation to support the exceptions to the 10-day advance notice. Finally, although the MCO presented a policy from 2019 that included termination, suspension, and reduction language, the policy had been updated more recently and this information had been removed.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Recommendations: HSAG recommends that the MCO review the requirements related to terminations, suspensions, and reductions of previously authorized services to better understand the expectations under federal rule. Based on this review, HSAG further recommends that the MCO update its written policies and procedures with the requirements related to terminations, suspensions, and reductions of previously authorized services, including the time frames associated with these actions, the exceptions under 42 CFR §431.213 and 42 CFR §431.214, and the steps the MCO will take should these actions be required. The MCO should conduct comprehensive training to its staff members to ensure awareness of these requirements and develop template ABD notices that are readily available should a termination, suspension, or reduction of services be required.		
Required Actions: For termination, suspension, or reduction of previously authorized Medicaid-covered services, the MCO must mail the notice at least 10 calendar days before the date of action. The MCO may mail the notice no later than the date of the action when the exceptions under 42 CFR §431.213 apply.		
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:** • CC.COMP.16.01 Attachment A: Market Service Verification • CC.COMP.16.01 Service Verification *Procedure* (p. 1) • CC.UM.05 Timeliness of UM Decisions and Notifications • CC.UM.07 Adverse Benefit Determination (Denial) Notices (p. 2) • Notice of Initial Adverse Action (ABD sample)	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: Suspected fraudulent member activity is monitored by the Compliance and Special Investigation Units, who evaluates for patterns of abuse, misuse, fraud. Monthly service verification is conducted with random sampling. Since plan inception, this process has not resulted in a shortened period of notice prior to the date of an action.		
HSAG Findings: The MCO did not provide evidence to support awareness of the advance notice exceptions, including the time frame for sending notice when services have been terminated, suspended, or reduced due to member fraud.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Required Actions: For termination, suspension, or reduction of previously authorized Medicaid-covered services, the MCO may mail the notice five days before the date of the action when the exception under 42 CFR §431.214 apply. The MCO's written documentation should support awareness of this requirement.		
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 • 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:** • Amysis Claims screenshot • CC.UM.05 Timeliness of UM Decisions and Notifications *Non-Urgent Preservice Decisions/Notifications* section (p. 2) • CC.UM.07 Adverse Benefit Determination (Denial) Notices *Policy* section (p. 1) • Member Letter and Claim Denial sample • Sample EOP Denial 1 • Sample EOP Denial 2	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: Both the member and requesting provider (and facility if applicable) receive a written notice of action regarding any denial, reduction, or termination of service, including behavioral health and pharmacy services. The notice of action letter is sent from the clinical documentation system and includes the member- specific reason for the denial, in easily understandable language; a reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based; notification that the member can request a copy of the actual benefit provision, guideline,		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
protocol or other similar criterion on which the denial decision was based; a description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal; an explanation of the appeal process, including the member's right to representation by anyone (including an attorney), contact information for the state Office of Health Insurance Consumer Assistance or ombudsman (if applicable), the time frames for filing and deciding appeals, and the circumstances under which additional external appeal rights are available and how to request them; and a description of the expedited appeal process including under what circumstances an expedited appeal can be requested, how to request an expedited appeal, and the timeframe for resolution of an expedited appeal.		
HSAG Findings: Although the MCO provided an ABD notice for a non-covered hospital stay, it did not specify that the notice was for a denial of payment. Additionally, during the interview session, staff members confirmed there was no process in place to send a member an explanation of payment or an ABD notice when a claim, in whole or in part, is denied. **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 that 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 ABD 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:** • CC.UM.05 Timeliness of UM Decisions and Notifications	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• *Non-urgent Preservice Decisions/Notification* section (p.2) • 214 Auth TAT Projection Report • 215 Backlog Aging Report	
MCO Description of Process: SSHP has several mechanisms to monitor timeliness including the 0215 Backlog Aging Reports, monitoring the urgency of requests via the TruCare UM Auth platform where clinicians can filter based on urgency levels to ensure we meet regulatory guidelines, and the 0214 Turnaround time report.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** The Timeliness of UM Decisions and Notifications policy included language to support this requirement; however, staff members confirmed and documentation supported that no cases were resolved outside of the standard and expedited time frame. HSAG strongly recommends that MCO staff members develop a detailed written procedure that would ensure that if an authorization is not resolved timely, that the MCO would send an ABD notice for untimely decision making. 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:** • 214 Auth TAT Projection Report • 215 Backlog Aging Report	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• CC.UM.05 Timeliness of UM Decisions and Notifications *Non-Urgent Decisions/Notifications* (p. 2) • Concurrent IP Request Monitoring (TruCare screenshot) • Retro Request Monitoring (TruCare screenshot) • Standard Request Monitoring (TruCare screenshot) • Timeliness and Auth Urgency Level (TruCare screenshot) • Urgent Request Monitoring (TruCare screenshot)	
MCO Description of Process: SSHP monitors the urgency of requests via our TruCare UM Auth platform where clinicians can filter based on urgency levels to ensure we meet regulatory guidelines. We also utilize the 0214 Turnaround Time report.		
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:** • 214 Auth TAT Projection Report • 215 Backlog Aging Report • CC.UM.05 Timeliness of UM Decisions and Notifications • *Urgent Preservice Decisions/Notification* section (p.2)	☐ Met ☒ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• Concurrent IP Request Monitoring (TruCare screenshot) • Timeliness and Auth Urgency Level (TruCare screenshot) • Urgent Request Monitoring (TruCare screenshot)	
MCO Description of Process: SSHP monitors the urgency of requests via TruCare UM Auth platform where clinicians can filter based on urgency levels to ensure we meet regulatory guidelines, 0214 Turnaround time report.		
HSAG Findings: As noted through the case file review, two expedited cases (#2 and #6) were not determined within the 72-hour time frame.		
Required Actions: 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 72 hours after receipt of the request for service.		
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:** • CC.UM.05 Timeliness of UM Decisions and Notifications Standard and Urgent requests (p. 2) • PA Missing Info 1st Attempt Letter • PA Missing Info 2nd Attempt Letter	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Two attempts are made to obtain additional clinical information to process requests for services.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Recommendations: During the interview session, although MCO staff members could identify the 14-day time frame allowance, they confirmed that they do not currently extend authorization time frames. After the site visit, the MCO provided the Plan Notice of Standard Auth Timeframe Extension and Plan Notice of Expedited Auth Timeframe Extension template letters, with language to support members would be notified of the reason for the extension and would be provided with grievance rights. Although these template letters support compliance, HSAG strongly recommends that the MCO's written documents (e.g., Timeliness of UM Decisions and Notifications policy) be updated with complete and accurate information for extending authorization time frames when in the member's interest and the steps taken to comply with federal rule. Additionally, the Plan Request for Expedited Auth Timeframe Extension letter indicated that the MCO is requesting an additional 48 hours to make an authorization determination; however, HSAG recommends that the MCO consider whether it would be more appropriate to indicate that the MCO may take an additional 14-calendar days to obtain necessary documentation and make an authorization determination. Further, HSAG recommends that the MCO consider when it would be appropriate to take an extension, and subsequently provide its utilization management staff members with training on the scenarios that would support a time frame extension, along with the processes staff members should take to ensure compliance with the extension requirements. Implementation of these recommendations will be further assessed during future compliance reviews.		
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 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)	**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:** • CC.UM.05 Timeliness of UM Decisions and Notifications	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: SSHP makes two attempts to obtain additional clinical information. Each request for additional information may extend that authorization by 7 days up to a total of 14 days. At which time a medically necessary decision may be made. However, if the medical director thinks that		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
extending the time is in the best interest of member's medical condition additional extensions will be allowed and the member will be notified IF an additional extension is made.		
HSAG Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** Refer to the recommendations provided under element 13.		
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:** • 2021 SSHP Member *Handbook Medically Necessary Services* section (p. 27) • CC.COMP.13 COI Disclosure Monitoring Report • CC.COMP.13 Conflicts of Interest *Personal COIs* (p. 2) • CC.UM.04 Appropriate UM Professionals *Affirmation Statement about Incentives* section (pp. 5 - 6) • CC.UM.04.01 Affirmative Statement About Incentives • CC.UM.04.01 Exhibit A Employee Affirmation • CC.UM.04.01 Exhibit B Tracking Form • CC.UM.04.01 Exhibit C Incentive Attestation • Close Personal Relationship COI Disclosure • COI Disclosure (sample)	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• COI Training Certificate • NV.UM.01 UM Program Description *Qualifications and Training* section (p. 10)	
MCO Description of Process: SSHP conducts yearly trainings and obtains annual employee attestations related to conflicts of interest and incentives. Individuals or entities that conduct utilization management activities are not incentivized to deny, limit, or discontinue medically necessary services to any member.		
HSAG Finding: HSAG has determined that the MCO has met the requirements for this element.		
Required Actions: None.		

Standard VII—Coverage and Authorization of Services						
Met	=	10	X	1	=	10
Not Met	=	5	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	15	Total Score		=	10
Total Score ÷ Total Applicable					=	67%

Appendix B. Corrective Action Plan

Following this page is a document HSAG developed for **SilverSummit** 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 SilverSummit Healthplan, Inc.

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 Requirements: Basic Rule			
42 CFR §438.10(c)(4)(i-ii)	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, 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.	**Evidence as Submitted by the MCO:** *Element 4a:* • NV.MRKT.01 Member Materials and Marketing Materials Guidelines: *Policy* section (p 1) • 2021 SSHP Member Handbook • Final Adverse Determination Letter template • Grievance Resolution Letter template	☐ 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**
	MCO Description of Process: SSHP uses clarifying definitions for managed care terminology throughout our member handbook. Our written materials are presented in easily understandable language, not exceeding the eighth grade reading level. While SSHP does not have a model Member Handbook, our corporate team provided us with a template Member Handbook prior to implementation, which was used to create a Nevada-specific SSHP Member Handbook for Medicaid members. Our Member Handbook is reviewed at least annually and when material changes occur.		
	HSAG Findings: Although the member handbook and the adverse benefit determination and grievance letter templates included definitions for nine of the 32 required definitions for managed care terminology, the majority of required managed care terms were not defined by the MCO. **Recommendations**: HSAG recommends that the MCO develop a listing of managed care definitions that are available in member-facing documents, such as the member handbook. HSAG further recommends that the MCO consult with DHCFP to determine whether the model member handbook and notices can be developed to comply with federal rule.		
	Required Actions: The MCO must ensure that it defines and uses all required managed care terminology as identified in this element.		
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**
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. b. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost..	**Evidence as Submitted by the MCO:** *Elements 6a-6b:* • 1557 Language Taglines • 2021 SSHP Member Handbook (EN SP Combined) *Other Formats and Languages* section (p. 2); *Translation and Interpreter Services* section (p. 3); *Other Translation Information* section (p. 4) • 2021 SSHP Member Handbook (Spanish) online: https://www.silversummithealthplan.com/members/medicaid/resources/handbooks-forms.html • 2021 SSHP Provider Directory • CC.MBRS.02 Member Materials Readability and Translation	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: SSHP ensures that vital materials are made available upon request for the top fifteen (15) non-English prevalent languages. We also provide in-language versions or translate non-vital documents into threshold and prevalent languages on request. In addition, we will provide oral interpretation of vital and non-vital materials, for non-		

Standard II—Member Rights and Member Information			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
	threshold, non-prevalent languages upon request at no cost to our members. SSHP also includes taglines in our member mailings, explaining the availability of written translation or oral interpretation to understand the information provided.		
	HSAG Findings: Although the MCO included taglines in the member handbook and grievance and appeal notices, the printable version of the provider directory did not include taglines as required. Additionally, the taglines were not in a conspicuously visible font size as required by federal rule.		
	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)(2) Contract 3.6.1.1	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.	**Evidence as Submitted by the MCO:** *Element 15:* • 2021 SSHP Member Handbook • SSHP website: *Member Handbooks and Forms* page: https://www.silversummithealthplan.com/	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: The SSHP Member Handbook includes information that enables our members to understand how to effectively use their benefits and services. Our member handbook also informs members on how they can contact us if they need additional assistance.		
	HSAG Findings: The MCO demonstrated compliance with the elements of the member handbook checklist, with the exception of one sub-element. The MCO did not include the address of the MCO's fraud and abuse unit in the member handbook as required by State contract.		
	Required Actions: The MCO must ensure that information (including hotlines, email addresses, and the address and telephone number of the MCO's fraud and abuse unit) on how to report suspected fraud or abuse is included in the member handbook.		
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:** *Element 17:* • 2021 SSHP Member Handbook *Member Services Can Help* Section (p. 7) • NV.MRKT.01 Marketing Materials Guidelines *Requirements for Materials* section (p. 2, bullet F) *Example of Change:* • Member Postcard Notification *Disenrollment Process Update* • Q1 2021 Member Newsletter *Information About Disenrollment Process Change* (p. 7) • SSHP website: *Member Handbook and Forms - Disenrollment Update*: https://www.silversummithealthplan.com/members/medicaid/resources/handbooks-forms.html • Invoice for Member Postcard Notification	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: SSHP notifies its members of any changes that DHCFP defines as significant, at least 30 days before the effective date of the change. We notify members of changes by mail and online in our member newsletter.		
	HSAG Findings: The MCO provided its member newsletter, a postcard, and the link to its website, indicating changes to the disenrollment process had been made. Since the MCO provided the disenrollment updates as a significant change, the MCO did not comply with the requirement to notify the members at least 30 days before the effective date of the change as the		

Standard II—Member Rights and Member Information			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
	documentation indicated changes were already in effect. Additionally, the documents provided to support this element did not confirm that the MCO was aware of the 30-day notification time frame requirement.		
	Required Actions: The MCO must ensure that each member receives notice of any significant change 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 MCO's contract with the State.		
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—Provider Directory			
42 CFR §438.10(h)(4) Contract 3.16.5	20. Provider directories must be made available on the MCO's website in a machine-readable file and format as specified by the Secretary.	**Evidence as Submitted by the MCO:** *Element 20:* • CC.MRKT.14 Website 508 Compliance • NV.PRVR.19 Provider Directory Portico *Purpose and Policy* sections (p. 1) • SSHP website: *Find A Provider*: https://findaprovider.silversummithealthplan.com/location • Find A Provider How to Print screenshot • Find A Provider PCP Excerpt	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: SSHP is compliant with section 508/WCAG 2.0 and ensure that our secure and non-secure web functionality is accessible to and usable by people with sensory, cognitive, and manual–dexterity type disabilities. All of our electronic information will also be available in paper form.		
	HSAG Findings: Although the MCO posted the provider directory in a portable document format (PDF) format on the MCO's website, the MCO did not verify that the PDF format of the provider directory was in a machine-readable file and format.		
	Required Actions: The MCO must ensure that the provider directory is made available on the MCO's website in a machine-readable file and format.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			

Standard II—Member Rights and Member Information			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard IV—Availability of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Timely Access			
42 CFR §438.206(c)(1)(i-vi) Contract 3.4.2.13	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. 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.	**Evidence as Submitted by the MCO:** • 2020 Annual Quality Program Evaluation *Access and Availability* section (pp. 27-28); *Network Adequacy* section (pp. 31 – 32) • 2021 SSHP Provider Manual *Appointment Availability and Access Standards* section (pp. 15, 17) • Network Analysis Report (2021 Q1) • NV.CONT.01 Network Adequacy *Procedure* and *Provider Network Maintenance* sections (pp. 1, 4) • NV.QI.01 Quality Operational Documents *Member Access to Care* section (pp. 35, 36) • Participating Provider Agreement, *Schedule A, Term 13 Access to Services (p. 24)* • Quality Improvement Committee Meeting Minutes *Practitioner Availability Report review* (p. 3)	☐ Met ☒ Not Met ☐ NA

Standard IV—Availability of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	f. Take corrective action if there is a failure to comply by a network provider.		
	MCO Description of Process: SSHP contractually obligates its network providers to abide by the access DHCFP access standards in the contract. SSHP has processes in place to monitor the access of our providers. If providers are found to be outside of the standards, Provider Relations contacts the provider to let them know the findings and provides education for remediation.		
	HSAG Findings: Although MCO staff members during the interview identified two teams assigned to ensuring the MCO's compliance with the availability of services standards, the MCO did not identify a specific staff member assigned to ensure compliance. The MCO provided in follow-up a job description for an Accreditation Specialist who is responsible for the MCO's submission of evidence to the National Committee for Quality Assurance (NCQA) for accreditation. While the job description listed information related to accreditation audits, it did not demonstrate responsibilities related to compliance with availability of service standards, such as timely access to care and services. Further, although the MCO described a process indicating that provider relations staff members contact network providers that fail to meet compliance standards, documentation that corrective action would occur for non-compliance was not provided.		
	Required Actions: The MCO must assign a specific staff member of its organization to ensure compliance with availability of services standards. Additionally, the MCO must ensure that it has documented mechanisms in place to support that the MCO takes corrective action if there is a failure to comply by a network provider.		
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:** *Element 5a, 5b, 5c* • NV.CM.02 Care Coordination Care Management (p. 5) *Element 5d* • CC.COMP.33 Compliance Reporting Program (p. 1) *Other Evidence* • Health Risk Assessment Template • Health Risk Screening Template • State Required HRA Reporting • NV Medicaid New Members • NV Medicaid New Pregnant Members	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: The *NV.CM.02 Care Coordination Care Management* policy describes the process of conducting an initial comprehensive assessment on newly enrolled members to determine the need for CM services within 90 days of enrollment. It further describes the need to complete this assessment within 30 days of enrollment on members who are		

Standard VI—Coordination and Continuity of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	pregnant or have special healthcare needs. The policy includes how many attempts must be made and addresses conducting face to face assessments as necessary. To date, SSHP has not received a request to submit a Health Needs Assessment Screening to the DHCFP, however in the event of such a request, the *CC.Comp.33 Compliance Reporting Program* policy does reference what SSHP will do. SSHP's Data Analytics Team submits two weekly reports to the Case Management department, both of which list newly enrolled members to SSHP. These are the *Medicaid New Members Report* and the *Medicaid New Pregnant Members Report*. The State does submit these initial lists to SSHP, however, to date, SSHP is not receiving a list of newly enrolled adults or children with special needs. The two reports are used to begin outreach attempts to complete the initial comprehensive assessments and screenings. SSHP submits a monthly report to the DHCFP showing the success of outreach attempts on newly enrolled Medicaid members.		
	HSAG Findings: The case file review confirmed that the MCO did not consistently conduct three attempts to complete the initial health risk screening or the screening was not completed timely. **Recommendations:** For one case, all three attempts to complete the initial health risk assessment occurred on the same day. HSAG recommends that the MCO implement standardized procedures to ensure that attempts occur on different days and at different times of the day. Additionally, MCO staff members explained that the 834-enrollment file received from DHCFP includes a pregnancy indicator, but there was no indicator for special health care needs. HSAG recommends that the MCO consult with DHCFP regarding the possibility of including the identification of members with a special health care need in the file.		
	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			
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**
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:** • NV.CM.02 Care Coordination Care Management (pgs. 13, 14) • Adult Welcome Letter • Provider Welcome Letter	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: The *NV.CM.02 Care Coordination Care Management* policy describes the process of sending a welcome letter to the member upon completion of the initial assessment and enrollment in care management. The policy also goes on to describe that for members in complex care management, the member's assigned PCP will also be sent a letter informing them that the member is enrolled in care management. The evidence includes a sample of both the member and provider notification letters.		
	HSAG Findings: Although the MCO indicated that it adhered to this requirement through the mailing of welcome letters to the member and his or her primary care provider (PCP), the case file review confirmed that the MCO did not consistently send welcome letters to the member and/or the member's PCP when a member was enrolled in care management services. **Recommendations:** In some instances, while the provider welcome letter was not sent, the member welcome letter was sent to the PCP. MCO staff members explained that this issue has been addressed with the care managers. As such, HSAG recommends that the MCO continue to monitor and audit care management files to ensure that the correct letters are being generated and sent to PCPs. Additionally, with the exception of the obstetrics (OB) care management member welcome letters, the member welcome letters provided to the member included a number to call to disenroll from the care management program; however, the letters did not provide the member with the name and contact number of his or her assigned care manager. HSAG recommends that the MCO revise the care management enrollment welcome letter to be more member-centric and specifically include the member's care manager name and contact information.		
	Required Actions: The MCO must provide information to members and their PCPs that they have been identified as meeting the criteria for care management, including their enrollment into care management services.		

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:** • NV.CM.02 Care Coordination Care Management (pg. 15)	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: The *NV.CM.02 Care Coordination Care Management* policy states that SSHP will collaborate with members, treating providers, member's family / guardians or care givers to develop and individualized care management plan.		
	HSAG Findings: The case file review confirmed that the MCO did not consistently implement processes to involve the member's PCP in the development of the initial care plan. For example, evidence that the care plan was sent to the PCP was not located in the record, or a care plan letter was located in the record but did not include the actual care plan. After the interview session, the MCO explained that there has been an issue identified in which the care plan was not attached to the letters during the printing process and that this issue will be reviewed by the MCO's corporate team.		
	Required Actions: The MCO must actively involve the member's PCP in the development of the care plan.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			

Standard VI—Coordination and Continuity of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard VI—Coordination and Continuity of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Care Plan			
Contract 3.10.20.2(E)(3) Contract 3.10.20.2(D)(1)	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.*	**Evidence as Submitted by the MCO:** • NV.CM.02 Care Coordination Care Management (pg. 8)	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: The *NV.CM.02 Care Coordination Care Management* policy describes how the care management screening and or assessment will use the member's physical, behavioral and or psycho-social conditions, along with environmental and community needs identified, to help determine an effective care plan.		
	HSAG Findings: The case file review identified two care plans with a lack of specific, individualized, and meaningful goals and interventions. MCO staff members explained that these care plans were created by the same care manager who is no longer employed by the MCO. **Recommendations:** While the care manager is no longer employed by the MCO, HSAG recommends that the MCO continue to conduct ongoing training to care managers on the development of member-centric, individualized, and measurable goals and interventions and conduct regular review of member records for adherence.		
	Required Actions: The MCO must ensure that a care plan includes specific individualized interventions to meet the member's assessment needs.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			

Standard VI—Coordination and Continuity of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard VI—Coordination and Continuity of Care			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Care Plan			
Contract 3.10.20.2(D)(1)(c)(f)	14. *The MCO continuously monitors the member's progress, reevaluates the member's care needs, and adjusts the level of case management services accordingly.*	**Evidence as Submitted by the MCO:** • NV.CM.02 Care Coordination Care Management (pg. 4)	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: The *NV.CM.02 Care Coordination Care Management* policy describes the care manager's role in continuous monitoring of the progress of the member, re-evaluation of the member's care needs, and adjusting the level of CM services as appropriate.		
	HSAG Findings: The case file review confirmed that the MCO did not consistently conduct timely outreach to members, which is necessary to monitor a member's progress and re-evaluate a member's care needs. Several gaps in outreach were identified and the MCO's recommended contact frequency was not consistently followed. It should be noted that after the interview session, the MCO was able to provide an explanation or additional documentation that resolved this initial concern for some, but not all, of the cases.		
	Required Actions: The MCO must continuously monitor the member's progress, re-evaluate the member's care needs, and adjust the level of case management services accordingly.		
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**
Notice of Adverse Benefit Determination			
42 CFR §438.402(b-c). 42 CFR §438.404(b)(1-6) Contract 3.13.4.3	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).	**Evidence as Submitted by the MCO:** • 2021 SSHP Member Handbook *Appeals* section (p.62-63); *Continuing to Receive Services* section, *Fast Appeal Decisions* section, *State Fair Hearings* section (p. 64) • 2021 SSHP Provider Manual *Appeals* section, *Standard Appeals* section (p.35); *Expedited Appeals* section, *Extension of Grievance and Appeals Timeframe* section (p. 37) *State Fair Hearing* section (p.38); *Adverse Benefit Determination* section (p. 70-71); *Guidelines for Psychological /Neuropsychological Testing* section, *Advanced Diagnostic Imaging* section (p. 71) • CC.UM.01.07 Concurrent Review • CC.UM.02.01 Medical Necessity Review • CC.UM.07 Adverse Benefit Determination (Denial) Notices *Level II Review* section (p.2-3) • Adverse Benefit Determination (redacted sample)	☐ Met ☒ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	e. The circumstances under which an appeal process can be expedited and how to request it. 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.		
	MCO Description of Process: SSHP's ABD notices are structured to meet the content requirements of our MCO contract and applicable regulations. Both the member and requesting provider (and facility if applicable) receive a written notice of action regarding any denial, reduction, or termination of service, including behavioral health and pharmacy services. The notice of action letter is sent from the clinical documentation system and includes the member- specific reason for the denial, in easily understandable language; a reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based; notification that the member can request a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based; a description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal; an explanation of the appeal process, including the member's right to representation by anyone (including an attorney), contact information for the state Office of Health Insurance Consumer Assistance or ombudsman (if applicable), the time frames for filing and deciding appeals, and the circumstances under which additional external appeal rights are available and how to request them; and a description of the expedited appeal process including under what circumstances an expedited appeal can be requested, how to request an expedited appeal, and the timeframe for resolution of an expedited appeal.		
	HSAG Findings: Although the Adverse Benefit Determination (Denial) Notices policy indicated that the ABD notice included information that the member can request a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based, the policy did not stipulate that the documentation can be requested free of charge. Additionally, results of the case file review indicated that two cases (#2 and #9) were missing language about the member's right to request copies of the documentation in which the denial decision was based. Further, for one case, the ABD notice was only sent to the provider and not to the member as required.		

Standard VII—Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Recommendations: Although the letters were generally written using easy-to-understand language, there were several ABD notices that included grammatical, spacing, font, and punctuation issues. To ensure ABD notices are professional and free from grammatical and other issues, HSAG recommends that the MCO develop a quality assurance process for its notices, which may include peer review or supervisory review of all notices prior to notices being mailed. Additionally, the MCO should update all member materials and notices requiring a written, signed appeal as this requirement has been removed from federal regulation. Implementation of these recommendations will be further assessed during future compliance reviews.		
	Required Actions: 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 42 CFR §438.404, and specifically must include the member's right to request and have reasonable access to, copies of all documents, records, and other information relevant to the ABD.		
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 §431.211 42 CFR §431.213 42 CFR §438.404(c)(1) Contract 3.13.4.4-5	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 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;	**Evidence as Submitted by the MCO:** • 2021 SSHP Member Handbook *Individual Rights* section (p. 72) • Adverse Benefit Determination • Adverse Benefit Determination Previously Approved Service • Adverse Benefit Determination Reduction in Service • CC.UM.01.07 Concurrent Review • CC.UM.01.07 Next Review Date Work Flow • CC.UM.01.07 Referral Checklist Work Flow (RN to MD) • CC.UM.02.01 Medical Necessity Review • CC.UM.02.02 Inpatient Leveling of Care • CC.UM.05 Timeliness of UM Decisions and Notifications *NOA for Previously Approved Services* section (p. 4) • CC.UM.07 Adverse Benefit Determination Notices • Ineligible for Further Services (email notification to DHCFP)	☐ Met ☒ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	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.	• Ineligible for Further Services (letter to member) • NV.UM.02 Clinical Decision Criteria and Application	
	MCO Description of Process: When a service request for ongoing treatment(s) for a previously approved service request is received, SSHP reviews medical necessity criteria for the continuation and extent of these ongoing services (e.g. rehab therapy services, home health visits, etc.). If the determination results in a termination, suspension, or reduction of a previously approved treatment request, the UM designee notifies the member and provider in accordance with the notification standards as stated herein, and issue a written or electronic notification notice at least ten calendar days before the intended action.		
	HSAG Findings: The MCO submitted its Timeliness of UM Decisions and Notifications policy as evidence for this element, which indicated that when a service request for ongoing treatments for a previously approved service is received, the plan reviews medical necessity criteria for the continuation and extent of these ongoing services. The policy further stated that if the determination results in a termination, suspension, or reduction of a previously approved treatment request, the MCO notifies the member and provider in accordance with the notification standards and issues a written or electronic notification notice at least 10 calendar days before the intended action. However, this documentation appeared to specifically relate to service authorizations that were going to expire versus the MCO's process for terminating, suspending, or reducing previously authorized services that were already in place. Additionally, although an ABD notice was provided that indicated "request was reduced," this was related to a partial denial/approval of a request for new services and not an ABD notice for previously authorized services that were being reduced by the MCO. Further, there was no language in the policy or in other documentation to support the exceptions to the 10-day advance notice. Finally, although the MCO presented a policy from 2019		

Standard VII—Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	that included termination, suspension, and reduction language, the policy had been updated more recently and this information had been removed. **Recommendations:** HSAG recommends that the MCO review the requirements related to terminations, suspensions, and reductions of previously authorized services to better understand the expectations under federal rule. Based on this review, HSAG further recommends that the MCO update its written policies and procedures with the requirements related to terminations, suspensions, and reductions of previously authorized services, including the time frames associated with these actions, the exceptions under 42 CFR §431.213 and 42 CFR §431.214, and the steps the MCO will take should these actions be required. The MCO should conduct comprehensive training to its staff members to ensure awareness of these requirements and develop template ABD notices that are readily available should a termination, suspension, or reduction of services be required.		
	Required Actions: For termination, suspension, or reduction of previously authorized Medicaid-covered services, the MCO must mail the notice at least 10 calendar days before the date of action. The MCO may mail the notice no later than the date of the action when the exceptions under 42 CFR §431.213 apply.		
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 §431.214 42 CFR §438.404(c)(1) Contract 3.13.4.4	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.	**Evidence as Submitted by the MCO:** • CC.COMP.16.01 Attachment A: Market Service Verification • CC.COMP.16.01 Service Verification *Procedure* (p. 1) • CC.UM.05 Timeliness of UM Decisions and Notifications • CC.UM.07 Adverse Benefit Determination (Denial) Notices (p. 2) • Notice of Initial Adverse Action (ABD sample)	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: Suspected fraudulent member activity is monitored by the Compliance and Special Investigation Units, who evaluates for patterns of abuse, misuse, fraud. Monthly service verification is conducted with random sampling. Since plan inception, this process has not resulted in a shortened period of notice prior to the date of an action.		
	HSAG Findings: The MCO did not provide evidence to support awareness of the advance notice exceptions, including the time frame for sending notice when services have been terminated, suspended, or reduced due to member fraud.		
	Required Actions: For termination, suspension, or reduction of previously authorized Medicaid-covered services, the MCO may mail the notice five days before the date of the action when the exception under 42 CFR §431.214 apply. The MCO's written documentation should support awareness of this requirement.		

Standard VII—Coverage and Authorization of Services			
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:** • Amysis Claims screenshot • CC.UM.05 Timeliness of UM Decisions and Notifications *Non-Urgent Preservice Decisions/Notifications* section (p. 2) • CC.UM.07 Adverse Benefit Determination (Denial) Notices *Policy* section (p. 1) • Member Letter and Claim Denial sample • Sample EOP Denial 1 • Sample EOP Denial 2	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: Both the member and requesting provider (and facility if applicable) receive a written notice of action regarding any denial, reduction, or termination of service, including behavioral health and pharmacy services. The notice of action letter is sent from the clinical documentation system and includes the member- specific reason for the denial, in easily understandable language; a reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based; notification that the member can request a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based; a description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal; an explanation of the appeal process, including the member's right to representation by anyone (including an attorney), contact information for the state Office of Health Insurance Consumer Assistance or ombudsman (if applicable), the time frames for filing and deciding appeals, and the circumstances under which additional external appeal rights are available and how to request them; and a description of the expedited appeal process including under what circumstances an expedited appeal can be requested, how to request an expedited appeal, and the timeframe for resolution of an expedited appeal.		

Standard VII—Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	HSAG Findings: Although the MCO provided an ABD notice for a non-covered hospital stay, it did not specify that the notice was for a denial of payment. Additionally, during the interview session, staff members confirmed there was no process in place to send a member an explanation of payment or an ABD notice when a claim, in whole or in part, is denied. **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 that 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 ABD 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

Standard VII—Coverage and Authorization of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Expedited Authorization Decisions			
42 CFR §438.210(d)(2)(i-ii) Contract 3.13.3.2	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.	**Evidence as Submitted by the MCO:** • 214 Auth TAT Projection Report • 215 Backlog Aging Report • CC.UM.05 Timeliness of UM Decisions and Notifications • *Urgent Preservice Decisions/Notification* section (p.2) • Concurrent IP Request Monitoring (TruCare screenshot) • Timeliness and Auth Urgency Level (TruCare screenshot) • Urgent Request Monitoring (TruCare screenshot)	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: SSHP monitors the urgency of requests via TruCare UM Auth platform where clinicians can filter based on urgency levels to ensure we meet regulatory guidelines, 0214 Turnaround time report.		
	HSAG Findings: As noted through the case file review, two expedited cases (#2 and #6) were not determined within the 72-hour time frame.		
	Required Actions: 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 72 hours after receipt of the request for service.		

Standard VII—Coverage and Authorization of Services			
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