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Department of Health and Human Services

Division of Medicaid and Long-Term Care

Contract Year 2021–2022 Compliance Review Report

for

Managed Care of North America, Inc.

January 2022

This report was produced for the Division of Medicaid and Long-Term Care by Health Services Advisory Group, Inc.

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

The State of Nebraska's Medicaid and Children's Health Insurance Program (CHIP) programs are administered by the Division of Medicaid and Long-Term Care (MLTC) within the Nebraska Department of Health and Human Services (DHHS). The current programs are full-risk, capitated managed care programs. Managed care in Nebraska was developed to improve the health and wellness of Nebraska's Medicaid and CHIP members by increasing access to comprehensive health care services in a cost-effective manner. DHHS contracts with three managed care organizations (MCOs) and one dental prepaid ambulatory health plan (PAHP) under the authority of a 1915(b) waiver from the Centers for Medicare & Medicaid Services (CMS) to provide physical health care, behavioral health care, pharmacy, and dental services for Nebraska's Medicaid and CHIP members. Notable features of Nebraska's Medicaid and CHIP programs include the integration of physical and behavioral health care for all 93 counties in the State of Nebraska.

To comply with Title 42 of the Code of Federal Regulations (42 CFR) §438.350, DHHS has contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO). Furthermore, this report documents the activities performed for one of Nebraska's contracted managed care entities (MCEs), Managed Care of North America, Inc. (MCNA), pursuant to 42 CFR §438.358(b)(1)(iii).

Reader's Guide

This report includes the following sections and appendices:

Section 1—Executive Summary

This section contains introductory comments; a reader's guide to the report; and a summary of compliance review results for each standard area reviewed, which includes summaries of findings, evidence of compliance, strengths, opportunities for improvement, and any corrective actions required to bring the MCE into full compliance with 42 CFR Part 438.

Section 2—Overview and Methodology

This section describes the background and methodology used for the contract year (CY) 2021–2022 compliance monitoring review activities, including a detailed description of HSAG's compliance review activities that are consistent with CMS external quality review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[1-1]

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity,* October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jul 13, 2021.

Appendices

Appendix A contains the completed compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the review of administrative records related to grievances, appeals, and denials of requests for services. Appendix C lists HSAG, MCE, and DHHS personnel who participated in some way in the compliance review process. Appendix D describes the corrective action plan (CAP) process that the MCE will be required to complete for CY 2021–2022 and the required template for submitting its plan to complete the required corrective actions.

Summary of Compliance Review Results

Based on conclusions drawn from the review activities, HSAG assigned each requirement in the compliance monitoring tool a score of *Met (M)*, *Not Met (NM)*, or *Not Applicable (NA)*. HSAG assigned required actions to any requirement receiving a score of *NM*. HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score.

Table 1-1 presents the scores for MCNA for each of the standards. Findings for all requirements are summarized in this section. Details of the findings for each requirement receiving a score of *NM* follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for Each Standard

Standard	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)*
I. Enrollment and Disenrollment	7	6	6	0	1	100%
II. Member Rights and Confidentiality	6	5	5	0	1	100%
III. Member Information	22	20	17	3	2	85%
IV. Emergency and Poststabilization Services	12	9	9	0	3	100%
V. Adequate Capacity and Availability of Services	14	12	12	0	2	100%
VI. Coordination and Continuity of Care	9	6	6	0	3	100%
VII. Coverage and Authorization of Services	19	17	14	3	2	82%
VIII. Provider Selection and Program Integrity	16	16	16	0	0	100%
IX. Subcontractual Relationships and Delegation	4	4	2	2	0	50%

Standard	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)*
X. Practice Guidelines	3	3	3	0	0	100%
XI. Health Information Systems	6	6	6	0	0	100%
XII. Quality Assessment and Performance Improvement	6	6	6	0	0	100%
XIII. Grievance and Appeal System	26	26	22	4	0	85%
Totals	**150**	**136**	**124**	**12**	**14**	**91%**

* The total score is calculated by dividing the total number of met elements by the total number of applicable elements.

Table 1-2 presents the scores for the review of MCNA's administrative records. Details of the findings for each record review are in Appendix B—Record Review Tools.

Table 1-2—Summary of Scores for the Record Reviews

Record Type	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Average Record Review Score (% of Met Elements)*
Grievances	50	32	30	2	18	94%
Appeals	70	60	60	0	10	100%
Denials	60	50	41	9	10	82%
Totals	**180**	**142**	**131**	**11**	**38**	**92%**

* The total score is calculated by dividing the total number of met elements by the total number of applicable elements.

Standard I—Enrollment and Disenrollment

Summary of Findings Resulting in Compliance or Strengths

MCNA's policies and procedures included all required provisions. MCNA provided system workflow diagrams that clearly described procedures to load 834 files into DentalTrac, MCNA's data processing and reporting system. Policies, procedures, and MCNA staff members articulated the policy to accept members for enrollment into MCNA in the order in which they appear in the enrollment file provided by the staff members. HSAG found no processes that would result in discriminatory enrollment. During the interview sessions, MCNA staff members described a variety of avenues to work with members who have challenging behaviors. Staff members also pointed out that MCNA is Nebraska's only dental benefit manager (DBM); therefore, commitment to work with all members is imperative.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Findings Resulting in Required Actions

HSAG identified no required corrective actions related to this standard.

Standard II—Member Rights and Confidentiality

Summary of Findings Resulting in Compliance or Strengths

MCNA published member rights and responsibilities within its member handbook, provider directory, and internal policies. During the interview, the compliance officer noted that staff members received training regarding member rights, Health Insurance Portability and Accountability Act of 1996 (HIPAA), and protecting personal health information (PHI) within 30 days of hire and annually thereafter. Contracted network providers received information about member rights during new provider orientation, including the requirement to post member rights in dental offices.

Due to the coronavirus disease 2019 (COVID-19), MCNA staff members were primarily working from home during the period under review. To ensure that privacy remained a high priority during this time, MCNA required that all staff members sign a telecommuter agreement and maintain a dedicated, confidential workspace. MCNA relied on employees using its Citrix enterprise software and virtual private network (VPN) to access and view member PHI securely. MCNA also discussed using a strong password to protect PHI in the Compliance Corner section of its employee newsletter, bizBUZZ.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Findings Resulting in Required Actions

HSAG identified no findings resulting in required actions for this standard.

Standard III—Member Information

Summary of Findings Resulting in Compliance or Strengths

MCNA had policies and processes to ensure that member materials and information were provided in an accessible manner, and in a format that is easily understood (at or below a 6.9 grade reading level). HSAG reviewed key sections of the member handbook and a few of the member materials available on MCNA's website using the Flesch-Kincaid reading level test which found the materials to be at or below the 6.9 grade reading level. HSAG used the WAVE Web accessibility evaluation tool (wave.webaim.org) to evaluate the MCNA website's compliance with Section 508 of the Rehabilitation Act. Using this tool, HSAG reviewed MCNA's landing page, provider directory, and formulary and found few accessibility errors, making these webpages highly readable with a machine reader device. Finally, HSAG reviewed MCNA's portable document format (PDF) member handbook using Adobe Pro, which identified few accessibility errors, making the large document highly readable with a machine reader device.

MCNA sent members a welcome packet following enrollment. The member welcome packet included contact information for the member's primary dental provider (PDP) and the member handbook, as well as instructions for members to access the member handbook online or to request the handbook in an alternative format. The member handbook and other vital member materials were published in both English and Spanish. Member materials were bright and engaging and covered a variety of topics including diabetes and oral health, pregnancy/baby oral health, Halloween candy alternatives, and check-up reminders. Member materials were developed as a joint effort between the communications department and the operational units. MCNA used feedback from member focus groups and Flesch-Kincaid grade level scores to ensure that materials were easy to understand. Draft versions of member materials were reviewed by the compliance department and DHHS prior to publication and then annually. MCNA also connected with its Nebraska members through its "Tooth Tribune" newsletter.

MCNA offered the member handbook on its website in English and Spanish. The MCNA website included a provider search function in English and Spanish, and search results were available for download. The member handbook included information about translation services, dental benefits and copayments, instructions for selecting a provider, prior authorization requirements, and what to do in a dental emergency. The member handbook included a toll-free member hotline number and described

how to use the hotline for assistance. MCNA tracked website traffic and calls to member services that pertained to questions about benefits to gauge members' understanding of materials and communication efforts.

Summary of Findings Resulting in Opportunities for Improvement

While HSAG found that the readability of MCNA's website was adequate for a machine reader, results of the WAVE tool noted a moderate number of contrast errors on the MCNA Nebraska website landing page and frequently asked questions (FAQ) page. HSAG recommends that MCNA work to reduce the number of contrast errors on its website to ensure that members with visual challenges and color blindness can view information on the website with ease.

While MCNA listed Americans with Disabilities Act (ADA) accessibility as a feature available with certain providers within its provider directory, the listing did not detail what about the provider's office made it accessible for members. During the interview, MCNA staff members described efforts that were underway to expand on the accessibility indicator to provide members with a more detailed view of a specific provider's accommodations. HSAG recommends that MCNA continue with these efforts as it will add clarity for members who may require certain types of accommodations.

Summary of Findings Resulting in Required Actions

Within its member handbook, MCNA did not include conspicuously visible taglines in its non-English prevalent language (Spanish). MCNA must update the member handbook to include conspicuously visible taglines in Spanish. HSAG recommends that MCNA use the same content used in its English tagline.

MCNA's website did not include a notice that the information found on the website is available in paper form without charge upon request and will be provided within five business days. MCNA must update its website to include a notice to the member that this information is available in paper form without charge upon request and will be provided within five business days.

Within its member handbook, MCNA did not include all required information about State fair hearings. MCNA must update its member handbook to include the following information:

- The availability of assistance to request a State fair hearing.
- The fact that, when requested by the member:
  - Benefits that the MCE seeks to reduce or terminate will continue if the member files a request for a State fair hearing within the time frames specified for filing.
  - If benefits continue during the appeal process, the member may be required to pay the cost of those services if the final decision is adverse to the member.

Standard IV—Emergency and Poststabilization Services

Summary of Findings Resulting in Compliance or Strengths

MCNA's policies and procedures defined "emergency medical condition," "emergency services," and "poststabilization care services" in a manner consistent with the federal definition. MCNA's member handbook described emergencies and emergency services in a way that members would easily understand and informed members that prior authorization is not required for emergency services. MCNA's policies and procedures included the required provisions, including payment of emergency services to out-of-network providers, that prior authorization is not needed, and that members may not be held liable for payment for subsequent care or when services were provided out of network. MCNA staff members described payment procedures for emergency services claims and staff responsibilities to work with out-of-network providers to ensure that members are not balanced billed for emergency services received. MCNA provided a letter of agreement used for out-of-network providers which included the provision that the provider may not seek payment from the member.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Findings Resulting in Required Actions

HSAG identified no required corrective actions related to this standard.

Standard V—Adequate Capacity and Availability of Services

Summary of Findings Resulting in Compliance or Strengths

MCNA's policies and procedures clearly outlined time and distance standards, appointment wait times, and procedural details related to monitoring and maintaining a provider network to ensure access to care for its members. To track and trend compliance with time and distance standards, MCNA used a time and distance spreadsheet and GeoAccess report. During the interview, MCNA's network development and provider engagement vice president described the network development and provider relations teams, which were responsible for building and ensuring an adequate network of providers, compliance with timely access standards, and routinely monitoring any service gaps. The network development team reviewed GeoAccess reports monthly, developed an action plan, and then brought the reports to the quality improvement committee meetings quarterly to discuss trends.

Despite some gaps identified with specialist providers, such as oral surgeons, specifically in deeply rural and frontier areas, MCNA described its Nebraska dental provider network as robust, evidenced by the network's significant growth since 2017. In November 2017 MCNA reported 287 unique providers in its Nebraska market and as of September 2021, MCNA reported 837 unique providers. MCNA attributed this immense growth to its work maintaining the current network and developing new relationships in Nebraska and neighboring states. To further its recruitment, MCNA is considering working with the Nebraska Dental Association and the two local dental schools in the State. To retain providers, MCNA is contemplating establishing an Elite Provider Program allowing providers who are consistently in good standing to forgo prior authorizations for standard procedures.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Findings Resulting in Required Actions

HSAG identified no findings resulting in required actions for this standard.

Standard VI—Coordination and Continuity of Care

Summary of Findings Resulting in Compliance or Strengths

During the interview, MCNA's director of utilization management and case management described two levels of care coordination services. One level was taken on by care coordinators who offered more engagement than member services and worked with members to find specific providers, obtain translation services, find transportation, find childcare, or navigate a specific barrier to dental care. Case managers offered continuous care for high-needs members that was ongoing for a longer time period, until a series of dental work was accomplished, and the member was engaged in routine prophylactic care or longer at the member's discretion. Members engaged in care management included those under the category "catastrophic" which involved treatment of 10 or more teeth concurrently, chronic or disabled members, members with mental or developmental disability support needs, and members with nonmedical special circumstances such as housing instability. Case managers, using PHI protocols, routinely met with other MCNA case managers, physical health plan case managers, and providers to support their goal in helping members stay in dental care. MCNA estimated that approximately 200 Nebraska members were in care coordination at a given time in CY 2020.

MCNA provided an oral health questionnaire upon enrollment during the initial member welcome call. Members were automatically assigned to a PDP which was indicated on their member identification (ID) card.

MCNA submitted coordination of care policies which described expectations for care management staff. Procedures included clear details regarding care management activities such as acting as a liaison, following up after dental appointments, reviewing treatment plans, and offboarding steps for members who no longer required care management assistance.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Findings Resulting in Required Actions

HSAG identified no findings resulting in required actions for this standard.

Standard VII—Coverage and Authorization of Services

Summary of Findings Resulting in Compliance or Strengths

MCNA had a variety of methods to ensure that services provided meet members' needs. Methods included use of quality metrics, the care coordination program, and thoughtful response to member grievances and appeals. MCNA had an organizational program designed to respond to member requests for services. Review of denial records demonstrated that utilization review (UR) determinations were made by individuals with the requisite clinical expertise, determinations were made within the required time frame, and notices of adverse benefit determination (NABDs) included the required information. MCNA developed UR criteria to use for review of requests for service and had effective processes for interrater reliability. MCNA provided policies and procedures which included an affirmative statement indicating that staff members who make UR decisions are not compensated in any way for limiting member access to services.

Summary of Findings Resulting in Opportunities for Improvement

While MCNA had processes to consult with the requesting provider when needed, the peer-to-peer and reconsideration processes described in policy and by staff members during the interview occurred following the member having received a NABD. HSAG recommends that when providers are notified of an overturn of the decision as a result of the reconsideration or peer-to-peer review, that members receive a copy of the notification, or an equivalent notification, as well. Since a resolution letter is not required for the informal processes and members do not receive the message of approval after they have received the NABD, they may be reluctant to schedule the care.

Summary of Findings Resulting in Required Actions

Although MCNA's Adverse Benefit Determination policy included the provision to send members notification of claims denials, during the interview, MCNA staff members stated that NABDs are not sent for claims denials. During the grievance record review, HSAG found several cases that were processed as grievances which should have been treated as appeals as they were related to claims denials. In absence of the NABD, staff processed the members' calls as grievances. Grievance resolution letters do not contain State fair hearing rights; therefore, it is important that members receive the appropriate notifications so that their subsequent communications can proceed correctly and afford members the appropriate due process. MCNA must develop a mechanism to send members an NABD at the time of any decision to deny payment for a service, in whole or in part.

MCNA did not submit a policy that included the requirement for a 10-day advance notice if MCNA proposes to terminate, reduce, or suspend services currently being received by the member. During the interview, MCNA staff members stated that once a service is authorized, MCNA would not seek to terminate the services prior to the end of the authorization period. HSAG recognizes that these situations may be rare for a DBM; however, MCNA must have processes in place if a situation such as this does occur. MCNA must revise policies and procedures and develop a mechanism to ensure that if MCNA proposes to terminate, suspend, or reduce previously authorized services prior to the end of the authorization period, it provides a 10-day advance notice of such termination or change to the service.

While MCNA consistently sent the NABD in writing in 10 of the 10 denial records reviewed, HSAG found that only one of the 10 NABDs reviewed was written at a 6.9 grade reading level as required by MCNA's contract with DHHS. MCNA must develop a mechanism to ensure that NABDs are written at a 6.9 grade reading level (to the extent possible) as required by MCNA's contract with DHHS.

Standard VIII—Provider Selection and Program Integrity

Summary of Findings Resulting in Compliance or Strengths

MCNA's Provider Network Development and Management Program described the selection and retention of network providers and included the discrimination provisions. The Provider Relations team handled many of the retention activities to maintain consistent contact with contracted providers.

MCNA screened all provider applicants against the Office of Inspector General (OIG) and System for Award Management (SAM) databases for exclusion from participation in federal health care programs as part of the credentialing process.

The Compliance Program description outlined the scope of the compliance program. During the interview, staff described the required components of the program, which included the following:

- Designation of a compliance officer and compliance committee

- Written policies and procedures
- Effective lines of communication
- Internal auditing and monitoring activities
- Effective education and training
- Enforcing standards through well-publicized disciplinary guidelines
- Prompt response and corrective action

MCNA had processes in place to report overpayments to the State, to notify the State promptly about changes in a member's circumstances, and a method to verify with members that they received services billed.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Findings Resulting in Required Actions

HSAG identified no required corrective actions related to this standard.

Standard IX—Subcontractual Relationships and Delegation

Summary of Findings Resulting in Compliance or Strengths

MCNA contracted with Fiserv, a printing vendor which printed and mailed new member materials, including the member handbook. Fiserv's agreement included a business associate agreement that included extensive details regarding HIPAA.

Summary of Findings Resulting in Opportunities for Improvement

HSAG did not identify opportunities for improvement other than those that resulted in required corrective actions for this standard.

Summary of Findings Resulting in Required Actions

HSAG reviewed a written delegation agreement in place with Fiserv. The agreement did not include required details regarding compliance with Medicaid laws and regulations, applicable subregulatory

guidance, or contract provisions. MCNA must update all written delegation agreements to include the required language from 42 CFR §438.230(c)(2).

Additionally, the Fiserv agreement did not include the language required by 42 CFR §438.230(c)(3). MCNA must update all written delegation agreements to include the following language:

- The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's MCE, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCE's contract with the State.
- The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to Medicaid members.
- The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

Standard X—Practice Guidelines

Summary of Findings Resulting in Compliance or Strengths

MCNA adopted practice guidelines that were based on valid and reliable clinical evidence. During the interview, staff described the process for reviewing, creating, and approving guidelines. Before the guidelines were approved, they passed through individuals and a committee for review. Minutes from the Quality Improvement Committee meeting, held on July 17, 2020, provided evidence of the guidelines being approved.

MCNA disseminated the guidelines to all providers, and upon request, to members and potential members. MCNA ensured that decisions regarding UM, member education, and coverage of services were applied consistently with the guidelines. MCNA provided interrater reliability testing results from 2020, and a Dental Record Review policy and audit tool were provided as evidence.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Findings Resulting in Required Actions

HSAG identified no required corrective actions related to this standard.

Standard XI—Health Information Systems

Summary of Findings Resulting in Compliance or Strengths

MCNA provided system structure and workflow diagrams that described the data flow for capturing and storing data, as well as for ensuring accurate reporting for quality management, provider network development, and organizational management and decisions. MCNA used its data system, DentalTrac, to ensure timely response to members' requests for services, grievances and appeals, claims and encounter data reporting, provider network development, credentialing and recredentialing, and reporting performance metrics. MCNA submitted documentation that described system edits to ensure compliance with HIPAA when accepting enrollment files and reporting encounter data to the State.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Findings Resulting in Required Actions

HSAG identified no required corrective actions related to this standard.

Standard XII—Quality Assessment and Performance Improvement

Summary of Findings Resulting in Compliance or Strengths

MCNA had implemented an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) program for services it furnished to members. MCNA's Quality Improvement Committee met quarterly and included an interdisciplinary group of attendees. As evidence, HSAG reviewed committee meeting minutes.

MCNA's program outlined activities such as performance improvement projects, performance measures, mechanisms to detect both under- and overutilization of services, and means of assessing the quality and appropriateness of care for members with special health care needs.

MCNA completed a quality improvement evaluation. The evaluation provided documentation of the effectiveness of the QAPI program, MCNA submitted the evaluation to the State annually.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Findings Resulting in Required Actions

HSAG identified no required corrective actions related to this standard.

Standard XIII—Grievance and Appeal System

Summary of Findings Resulting in Compliance or Strengths

MCNA staff members provided evidence of an effective system to respond to member grievances and process appeals. Review of grievance and appeal records demonstrated that, for all records reviewed, the grievance and appeal acknowledgements and resolutions were provided to members within the required time frames; resolution decisions were made by individuals who had not been involved in the previous level of review; and with only one exception, resolution letters included the required content, written at a readability level easy for members to understand. Records also demonstrated that the DBM worked with members to obtain written consent for providers or representatives to file the appeal and that members were notified of the right to obtain documents from the DBM and to submit records to support the appeal. MCNA's documentation system maintained all required elements pertinent to processing the grievance or appeal and to report grievance and appeal activity to DHHS.

Members and providers were given the information needed to be able to file a grievance and appeal and to participate in the grievance and appeal processes. Policies and procedures included concepts consistently presented across policies, and MCNA submitted staff training that demonstrated a thorough understanding of grievance and appeal processes.

Summary of Findings Resulting in Opportunities for Improvement

HSAG did not identify opportunities for improvement other than those that resulted in required corrective actions for this standard.

Summary of Findings Resulting in Required Actions

In one grievance case reviewed, MCNA deemed the case a quality of care concern and sent it to the quality department for further review. MCNA sent a letter to the member stating that this case needs more time to review (see case number 4 of the grievance record review). It was unclear whether this letter was intended to be a resolution letter. There was no further communication to resolve this case. HSAG recognizes that if this case was handled as a peer review, the information is protected; however, a resolution from the member's perspective must be sent. In another case reviewed, this type of situation was handled with the member more clearly (see case number 9 in the appeal record review). MCNA must ensure that communication sent to the member provides a resolution in clear terms that are easily understood.

The Grievance and Appeal overview policy and the UM Appeals policy stated that the member may file for a Medicaid fair hearing within no less than 90 calendar days and no greater that 120 days of receipt of MCNA's notice of appeal determination. This statement represents a misunderstanding of the federal regulation, which states that the member must have at least 90 calendar days and no more than 120 calendar days from the date on MCNA's appeal resolution notice. MCNA's member handbook and provider manual accurately depicted the 120-day filing time frame. MCNA must clarify its policies to ensure members are afforded the right to request a State fair hearing at any time after receiving the notice of appeal resolution, up to 120 days following the date of the appeal resolution letter.

While the policies related to continuing service during the appeal correctly stated the 10-day filing time frame as filing for the continuation of benefits only, which is correct, the UM Program Description and the provider manual incorrectly stated that the member must also file for the appeal within that time frame. According to the revisions released in 2016 via the Medicaid and CHIP managed care regulations, the member need only request that services continue during the appeal within that 10-day time frame (or before the services are scheduled to change or terminate), but has the full 60-day time frame to file the appeal. In addition, MCNA had revised the 10-day timeline for requesting continuation of services during the State fair hearing to also include only requesting continuation. When a member has received continued service during an appeal and wishes to continue service during the State fair hearing, the member must request the continuation and file for the State fair hearing both within 10 days following the appeal resolution. MCNA must revise its applicable documents to clearly state that members need only request continued services during an appeal within the 10-calendar-day time frame (or before the effective date of the termination or change in service) and has the full 60-day time frame to file the appeal; however, following the appeal, if the member requests continuation during the State fair hearing, he or she must request both the State fair hearing and continued service within 10 calendar days following the notice of appeal resolution.

MCNA's provider manual addressed the member grievance and appeal system; however, the manual included the following inaccuracies:

- The manual stated that all appeals filed by a member or by a provider on behalf of a member must be submitted in writing.

- The definition of "adverse benefit determination" in the provider manual was incomplete and was missing the denial of a member's request to dispute a member's financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other).
- The manual stated that the provider may file an expedited review request verbally that must be followed up in writing.
- The manual stated that members who wish to request continued services during an appeal must file the appeal within 10 days following the NABD.

MCNA must ensure that the provider manual includes accurate information about the member grievance an appeal system and clarify that:

- Members may file an appeal orally or in writing, and oral requests to appeal do not require written follow-up regardless of whether they are standard or expedited requests.
- The definition of "adverse benefit determination" includes the denial of a member's request to dispute a member's financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other).
- Members who wish to continue services during the appeal must request the continuation within 10 days following the NABD, or before the intended effective date of the termination or change (whichever is later); however, the member has the full 60-day filing time frame to file the appeal.

2. Overview and Methodology

Overview of CY 2021–2022 Compliance Monitoring Activities

For the CY 2021–2022 compliance review process, DHHS requested that HSAG review the performance of the MCEs for compliance with all regulations at 42 CFR Part 438. HSAG developed a review strategy and monitoring tools, which included the applicable regulations by standard as they appear in the regulations. The compliance monitoring tool, approved by DHHS, consisted of 13 standards for reviewing the performance areas. Table 2-1 presents the standards found in the compliance monitoring tool and the associated managed care regulation.

Table 2-1—Summary of Standards and Associated Regulations

Standard	Federal Requirements Included	Standard	Federal Requirements Included
Standard I—Enrollment and Disenrollment	42 CFR §438.3(d) 42 CFR §438.56	Standard VIII—Provider Selection and Program Integrity	42 CFR §438.12 42 CFR §438.102 42 CFR §438.106 42 CFR §438.214 42 CFR §438.602(b) 42 CFR §438.608 42 CFR §438.610
Standard II—Member Rights and Confidentiality	42 CFR §438.100 42 CFR §438.224 42 CFR §422.128	Standard IX—Subcontractual Relationships and Delegation	42 CFR §438.230
Standard III—Member Information	42 CFR §438.10	Standard X—Practice Guidelines	42 CFR §438.236
Standard IV—Emergency and Poststabilization Services	42 CFR §438.114	Standard XI—Health Information Systems	42 CFR §438.242
Standard V—Adequate Capacity and Availability of Services	42 CFR §438.206 42 CFR §438.207	Standard XII—Quality Assessment and Performance Improvement	42 CFR §438.330
Standard VI—Coordination and Continuity of Care	42 CFR §438.208	Standard XIII—Grievance and Appeal System	42 CFR §438.400– 42 CFR §438.424
Standard VII—Coverage and Authorization of Services	42 CFR §438.210 42 CFR §438.404		

Objective of the Compliance Review

The objective of the review was to provide meaningful information to DHHS and the MCE regarding:

- The MCE's compliance with Medicaid and CHIP managed care regulations and managed care contract requirements.
- Strengths, opportunities for improvement, and corrective actions required to bring the MCE into compliance with managed care regulations and contract requirements.
- Findings that may impact the quality and timeliness of, and access to, services furnished by the MCE.
- Although not required, recommendations of possible interventions to improve the quality of the MCE's services.

Compliance Monitoring Review Methodology

In developing the data collection tools and in reviewing documentation related to the standards, HSAG used the MCE's contract requirements and regulations specified by the Medicaid and CHIP managed care regulations published May 6, 2016, with revisions released November 13, 2020. HSAG assigned each requirement in the compliance monitoring tool a score of *M*, *NM*, or *NA*. DHHS determined that the review period was July 1, 2020, through June 30, 2021. HSAG conducted a desk review of materials submitted prior to the scheduled webinar review, which consisted of administrative records related to grievances, appeals, and denied requests for services; policies and procedures; and other applicable documents and materials requested. HSAG then conducted webinar interviews and conversations with key MCE personnel to clarify information found during the desk review and to make final determinations of compliance with the Medicaid and CHIP managed care regulations and contract requirements. Examples of documents submitted for the desk review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, and member and provider informational materials.

For the MCE's administrative records, reviewers used record review tools approved by DHHS to review the records and document findings. HSAG reviewed a sample of 10 records (to the extent that a sufficient number existed) for each record review. Using a random sampling technique, HSAG selected the samples from denials that occurred and from grievances and appeals filed during the review period. For each record review, the MCE received a score of *M*, *NM*, or *NA* for each required element. HSAG separately calculated a record review score for each record review and an average record review score (refer to Table 1-2). Findings within the record reviews were also considered during scoring of the associated requirements found in the compliance monitoring tool.

Table 2-2 describes the activities HSAG performed throughout the compliance monitoring process. The activities listed below are consistent with CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.

Table 2-2—Compliance Monitoring Review Activities Performed

For this protocol activity,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Conducted before the review to assess compliance with federal managed care regulations and DHHS contract requirements: • HSAG and DHHS participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with DHHS to develop monitoring tools, record review tools, report templates, agendas, and set review dates. • HSAG submitted all materials to DHHS for review and approval. • HSAG conducted training for all reviewers to ensure consistency in scoring across the MCEs.
Activity 2:	**Perform Preliminary Review**
	• HSAG conducted an MCE training webinar to describe HSAG's processes and allow the MCEs the opportunity to ask questions about the review process and MCE expectations. • HSAG confirmed a primary MCE contact person for the review and assigned HSAG reviewers to participate. • No less than 60 days prior to the scheduled date of the review, HSAG notified the MCE in writing of the request for desk review documents via email delivery of a desk review form, the compliance monitoring tool, and a webinar review agenda. The desk review request included instructions for organizing and preparing the documents to be submitted. Forty-five days prior to the review the MCE provided data files from which HSAG chose sample grievance, appeal, and denial cases to be reviewed. HSAG provided the final samples to the MCEs via HSAG's secure access file exchange (SAFE) site. No less than 30 days prior to the scheduled review, the MCE provided documentation for the desk review, as requested. • Examples of documents submitted for the desk review and compliance review consisted of the completed desk review form, the compliance monitoring tool with the MCE's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The HSAG review team reviewed all documentation submitted prior to the scheduled webinar and prepared a request for further documentation and an interview guide to use during the webinar.

For this protocol activity,	HSAG completed the following activities:
Activity 3:	**Conduct MCE Review**
	• During the review, HSAG met with groups of the MCE's key staff members to obtain a complete picture of the MCE's compliance with Medicaid and CHIP managed care regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCE's performance. • HSAG requested, collected, and reviewed additional documents, as needed. • At the close of the webinar review, HSAG provided MCE staff members and DHHS personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the CY 2021–2022 DHHS-approved Compliance Review Report Template to compile the findings and incorporate information from the compliance review activities. • HSAG analyzed the findings and calculated final scores based on DHHS-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and corrective actions required based on the review findings.
Activity 5:	**Report Results to DHHS**
	• HSAG populated the DHHS-approved report template. • HSAG submitted the draft report to DHHS for review and comment. • HSAG incorporated the DHHS comments, as applicable, and submitted the draft report to the MCE for review and comment. • HSAG incorporated the MCE's comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all requirements determined to be out of compliance with managed care regulations (i.e., received a score of *NM*). • HSAG distributed the final report to the MCE and DHHS.

Appendix A. Compliance Monitoring Tool

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the DBM**	**Score**
1. The MCE agrees to accept individuals enrolled into its plan in the order in which they apply without restriction (unless authorized by CMS). *42 CFR §438.3(d)(1)* MCO Contract: IV(B)(4)(a)(i-iii) DBM Contract: None	**Suggested Documents:** Enrollment policies and procedures Workflow documents Internal protocols **Documents Submitted for Desk Review:** Internal Protocols Document Process Flowcharts and System Diagrams-Enrollment and Eligibility 11.300 Enrollment File Processing **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
2. The MCE does not discriminate against individuals eligible to enroll or use any policy or practice that has the effect of discriminating against individuals, based on health history, health status, need for healthcare services, age, religious belief, race, color, national origin, sex, sexual orientation, gender identity, or disability. *42 CFR §438.3(d)(3-4)* MCO Contract: IV(B)(4)(a)(i) DBM Contract: IV(G)(4)	**Suggested Documents:** Enrollment policies and procedures Internal protocols **Documents Submitted for Desk Review:** 11.300 Enrollment File Processing **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the DBM**	**Score**
3. The MCE may not request disenrollment of a member because of an adverse change in the member's health status or because of the member's: • Utilization of medical services. • Diminished mental capacity. • Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the MCE's ability to furnish services to the member or to other members). • The member's attempts to exercise his or her rights under the MCE's grievance system. • Attempts to exercise his or her rights to change, for cause, the chosen or assigned PCP. *42 CFR §438.56(b)(2)* MCO Contract: IV(B)(8)(a) DBM Contract: None	**Suggested Documents:** Disenrollment policies and procedures Internal protocols **Documents Submitted for Desk Review:** 11.403MIC Disenrollment Process **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
4. The MCE may only initiate disenrollment of any member's participation in the MCE on one or more of the following grounds: • The MCE has sufficient documentation to establish fraud, forgery, or evidence of unauthorized use/abuse of service by the member, including circumstances in which the member misuses or loans the member's ID card to another person to obtain services. If this occurs, the MCE must report it to the Division of Medicaid and Long-Term Care (MLTC).	**Suggested Documents:** Member handbook Disenrollment policies and procedures Internal protocols Redacted example **Documents Submitted for Desk Review:** Member Handbook, page 9	☒ Met ☐ Not Met ☐ Not Applicable

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the DBM**	**Score**
• The member's behavior is disruptive, unruly, abusive, or uncooperative to the extent that enrollment in the MCE seriously impairs the MCE's ability to furnish services to the member or to other members. In this case, the MCE must take reasonable measures (e.g., education, counseling) to correct the member's behavior prior to requesting disenrollment. *42 CFR §438.56(b)(1)* MCO Contract: IV(B)(10)(b-d) DBM Contract: None	11.403MIC Disenrollment Process MCNA has not initiated disenrollment requests during the review period **Additional Documents Submitted:**	
5. When the MCE requests a member disenrollment, it must not include an effective date that is earlier than 45 days after the event that prompted the disenrollment request: • Notify the member in writing of the request, the reason for the request, and the date of anticipated disenrollment. • Submit disenrollment requests to the enrollment broker that include: – Member's name. – Member's ID number. – Detailed reasons for requesting disenrollment. – Description of the measures taken to correct the member's behavior. • Maintain disenrollment documents in an identifiable member record. *42 CFR §438.56(b)(3)* MCO Contract IV(B)(8)(e-h) DBM Contract: None	**Suggested Documents:** Disenrollment policies and procedures Internal protocols Redacted example **Documents Submitted for Desk Review:** 11.403MIC Disenrollment Process MCNA has not requested a member disenrollment during the review period. **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the DBM**	**Score**
6. The member may request disenrollment as follows: • For cause at any time, including: – The MCE does not (due to moral or religious objections) cover the service the member seeks. – The member needs related services to be performed at the same time, not all related services are available from the MCE's plan, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk. – The contract between the MCE and MLTC is terminated. – Poor quality of care. – Lack of access, or lack of access to providers experienced in dealing with the member's specific needs. • Without cause at the following times: – During the 90 days following the date of the member's initial enrollment – At least once every 12 months thereafter – Upon automatic re-enrollment if temporary loss of eligibility has caused the member to miss the annual disenrollment opportunity – When the MLTC has imposed sanctions on the MCE (consistent with 42 CFR §438.702[a][4]) *42 CFR §438.56(c)-(d)(2)* MCO Contract: IV(B)(7)(c) DBM Contract: None	**Suggested Documents:** Member handbook Disenrollment policies and procedures Redacted example **Documents Submitted for Desk Review:** 11.403MIC Disenrollment Process **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the DBM**	**Score**
7. The MCO must, at least annually, no less than 60 days prior to the end of each enrollment period, provide each member with an explanation of members' disenrollment rights. *42 CFR §438.3(d)(3-4)* MCO Contract: IV(F)(6)(a) DBM Contract: Not applicable	**Suggested Documents:** Enrollment policies and procedures Internal protocols Redacted sample letter or template **Documents Submitted for Desk Review:** N/A to Dental **Additional Documents Submitted:**	☐ Met ☐ Not Met ☒ Not Applicable
Findings: MCNA is not required to provide each member with an explanation of members' disenrollment rights; therefore, this requirement is not applicable to MCNA.		

Results for Standard I—Enrollment and Disenrollment						
Met	=	6	X	1.00	=	6
Not Met	=	0	X	.00	=	0
Not Applicable	=	1				NA
Total Applicable	=	6	Total Score		=	6
Total Score ÷ Total Applicable					=	100%

Standard II—Member Rights and Confidentiality		
Requirement	**Evidence as Submitted by the DBM**	**Score**
1. The MCE has written policies regarding the member rights specified in this standard. *42 CFR §438.100(a)(1)* MCO Contract: IV(F)(1)(a)(i) DBM Contract: IV(C)(1)(d-h)	**Suggested Documents:** Member rights policies and procedures **Documents Submitted for Desk Review:** 4.106MIC Ensuring Member Rights & Responsibilities **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
2. The MCE's policies and procedures ensure that each member is guaranteed the right to: • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information in accordance with information requirements (42 CFR §438.10). • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her healthcare, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of his or her medical records and request that they be amended or corrected. • Obtain available and accessible healthcare services covered under the contract.	**Suggested Documents:** Member rights policies and procedures Member and provider messaging about member rights **Documents Submitted for Desk Review:** Nebraska Member Handbook, page 25 Nebraska Provider Manual, page 62 4.106MIC Ensuring Member Rights & Responsibilities **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard II—Member Rights and Confidentiality		
Requirement	**Evidence as Submitted by the DBM**	**Score**
42 CFR §438.100(b)(2-3) MCO Contract: IV(F)(1)(a)(i) DBM Contract: IV(C)(1)(d-h)		
3. The MCE ensures that each member is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the MCE, its network providers, or MLTC treats the member. *42 CFR §438.100(c)* MCO Contract: IV(F)(1)(a)(ii) DBM Contract: IV(C)(1)(h)	**Suggested Documents:** Member rights policies and procedures Member handbook Other applicable member materials **Documents Submitted for Desk Review:** Nebraska Member Handbook, page 26 4.106MIC Ensuring Member Rights & Responsibilities **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
4. The MCE complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91, the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.	**Suggested Documents:** Privacy policies and procedures Confidentiality policies and procedures Nondiscrimination policies and procedures Provider messaging **Documents Submitted for Desk Review:** Nebraska Provider Manual, page 56 1.106 Non-Discriminatory Practices	☒ Met ☐ Not Met ☐ Not Applicable

Standard II—Member Rights and Confidentiality		
Requirement	**Evidence as Submitted by the DBM**	**Score**
The MCE ensures that its employees and contracted providers observe and protect members' rights. *42 CFR §438.100(a)(2); (d)* MCO Contract: IV(C)(2)(a-b) DBM Contract: IV(C)(1)(b-c)	**Additional Documents Submitted:**	
5. For medical records and any other health and enrollment information that identifies a particular member, the MCE uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that these requirements are applicable. The MCE provides employee training on privacy and security (including but not limited to HIPAA). *42 CFR §438.224* MCO Contract: IV(C)(2)(a); IV(O)(9)(c)(ii) DBM Contract: IV(C)(12); IV(O)(9)(c)(ii)	**Suggested Documents:** Privacy policies and procedures Employee training and orientation materials related to privacy and security **Documents Submitted for Desk Review:** Training Module – Health Insurance Portability and Accountability Act (HIPAA) Training Module – Calls and Verification 7.400 HIPAA Compliance Program Employee Compliance and FWA Training **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
6. The MCE maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to all adult individuals receiving care by or through the MCE. Advance directives policies and procedures and information for members include:	**Suggested Documents:** Advance directive policies and procedures Member handbook Other member materials related to advance directives	☐ Met ☐ Not Met ☒ Not Applicable

Standard II—Member Rights and Confidentiality		
Requirement	**Evidence as Submitted by the DBM**	**Score**
• Members' rights under the State (advance directives) law to make decisions concerning medical care, including the right to refuse or accept treatment. • A clear statement of limitation if the MCE cannot implement an advance directive as a matter of conscience. – The difference between institution-wide conscientious objections and those raised by individual physicians. – Identification of the State legal authority permitting such objection. – Description of the range of medical conditions or procedures affected by the conscientious objection. • Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and unable to receive information. • Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated. • Provisions for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. • Provisions that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and that members are not discriminated against based on whether they have executed an advance directive.	Staff training or orientation materials related to advance directives Evidence of community education about advance directives **Documents Submitted for Desk Review:** Training Module – Advanced Directives 1.119 Advance Directives **Additional Documents Submitted:**	

Standard II—Member Rights and Confidentiality		
Requirement	**Evidence as Submitted by the DBM**	**Score**
• Provisions for ensuring compliance with State laws regarding advance directives. • Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. • Provisions for the education of staff concerning its policies and procedures on advance directives. • Provisions for community education regarding advance directives that include: − What constitutes an advance directive. − Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. − Description of applicable State law concerning advance directives. • Complaints regarding advance directives may be filed with the State Survey Agency. • Information must be provided to the member at the time of the initial enrollment. *42 CFR §438.3(j)* *42 CFR §438.10(g)(xii)* *42 CFR §422.128* MCO Contract: IV(F)(12)(a-e) DBM Contract: Not Applicable		
Findings: MCNA does not contract with the provider type applicable to advance directives requirements; therefore, this requirement is not applicable to MCNA.		

Results for Standard II—Member Rights and Confidentiality						
Met	=	5	X	1.00	=	5
Not Met	=	0	X	.00	=	0
Not Applicable	=	1				NA
Total Applicable	=	5		Total Score	=	5
				Total Score ÷ Total Applicable	=	100%

Standard III—Member Information		
Requirement	**Evidence as Submitted by the DBM**	**Score**
1. The MCE provides all required member information to members in a manner and format that may be easily understood (at no higher than a 6.9 grade reading level) and is readily accessible by members. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR §438.10(c)(1)* MCO Contract: IV(F)(4)(b) DBM Contract: IV(G)(16)(b)	**Suggested Documents:** Policies and procedures for developing member materials (HSAG will evaluate the reading level of letters, handbooks, and other materials submitted for requirements throughout this standard.) **Documents Submitted for Desk Review:** 11.301 Member Materials **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
2. The MCE has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR §438.10(c)(7)* MCO Contract: IV(F)(3)(c) DBM Contract: IV(G)(13)(b)	**Suggested Documents:** Applicable policies and procedures Internal protocols Member-facing communications **Documents Submitted for Desk Review:** 11.301 Member Materials Fight Against Cavities Member Postcard Dental Checkups Member Postcard Member Welcome Letter Nebraska Member Handbook, page 2 **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard III—Member Information		
Requirement	**Evidence as Submitted by the DBM**	**Score**
3. For consistency in the information provided to members, the MCE uses the following as developed by the State: • 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 healthcare, hospice services, hospitalization, hospital outpatient care, medically necessary, network, nonparticipating provider, participating provider, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR §438.10(c)(4)* MCO Contract: Contract Glossary of Terms DBM Contract: Contract Glossary of Terms	**Suggested Documents:** Member handbook Training or other materials that include definitions (HSAG will assess policies and procedures submitted throughout.) **Documents Submitted for Desk Review:** Nebraska Member Handbook, throughout the document **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
4. The MCE makes written materials that are critical to obtaining services available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • All written materials for members must: – Use a font size no smaller than 12 point.	**Suggested Documents:** Interpretation/translation/alternate format/communication policies and procedures Member marketing materials Examples of materials available in the prevalent non-English language (Spanish). (HSAG will assess materials submitted throughout this standard.)	☐ Met ☒ Not Met ☐ Not Applicable

Standard III—Member Information		
Requirement	**Evidence as Submitted by the DBM**	**Score**
– Be available in alternative formats and through provision of auxiliary aids and service that takes into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines for written materials critical to obtaining services printed in large print (conspicuously visible font size) and the prevalent non-English language describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and Telecommunications Device for the Deaf/TeleTYpewriter (TTY/TDY) customer service number. – Inform of the availability of the materials in alternative formats. *42 CFR §438.10(d)(3);(6)* MCO Contract: IV(F)(4)(h); IV(F)(3)(c); IV(F)(4)(k); IV(F)(4)(e-f) DBM Contract: IV(G)(16)	**Documents Submitted for Desk Review:** 11.301 Member Materials Fight Against Cavities Member Postcard Dental Checkups Member Postcard Halloween Trick or Treat Member Infographic Tooth Tribune December 2020 Tooth Tribune May 2021 Healthy Smiles for Mom and Baby Member Flyer Diabetes and Oral Health Member Flyer **Additional Documents Submitted:**	
Findings: Within its member handbook, MCNA did not include conspicuously visible taglines in its non-English prevalent language (Spanish).		
Required Actions: MCNA must update the member handbook to include conspicuously visible taglines in Spanish. HSAG recommends that MCNA use the same content used in its English tagline.		
5. If the MCE makes information available electronically—Information provided electronically must meet the following requirements:	**Suggested Documents:** If the requirement for providing the handbook or provider directory is met through availability of the materials in an electronic format, submit an example	☐ Met ☒ Not Met ☐ Not Applicable

Standard III—Member Information		
Requirement	**Evidence as Submitted by the DBM**	**Score**
• The format is readily accessible (see definition of readily accessible above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five business days. *42 CFR §438.10(c)(6)* MCO Contract: IV(F)(10); IV(F)(4); IV(F)(5); IV(F)(6) DBM Contract: IV(G)(15-16)	of how members are notified how to access the materials electronically (welcome letter, etc.) Example of how members are informed that materials accessed electronically are available in paper form within five business days. **Documents Submitted for Desk Review:** 11.301 Member Materials **Additional Documents Submitted:**	
Findings: MCNA's website did not include a notice that the information found on the website is available in paper form without charge upon request and will be provided within five business days.		
Required Actions: MCNA must update its website to include a notice to the member that this information is available in paper form without charge upon request and will be provided within five business days.		
6. The MCE must make available on its website information about its formulary in a machine-readable file and format as specified by the Secretary of Health and Human Services, including: • Which medications are covered (generic and name brand). • On which tier each medication is listed. *42 CFR §438.10(i)*	**Suggested Documents:** Link to Formulary List MCE website address **Documents Submitted for Desk Review:** N/A for Dental	☐ Met ☐ Not Met ☒ Not Applicable

Standard III—Member Information		
Requirement	**Evidence as Submitted by the DBM**	**Score**
MCO Contract: IV(J)(4)(b)(viii) DBM Contract: Not applicable	**Additional Documents Submitted:**	
Findings: MCNA is not responsible for providing prescription drug benefits; therefore, this requirement is not applicable to MCNA.		
7. The MCE makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and how to access these services. • This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language. • The MCE notifies members that auxiliary aids and services are available upon request and at no cost for members with disabilities, and how to access them. *42 CFR §438.10(d)(2); (d)(4-5)* MCO Contract: IV(F)(3) DBM Contract: IV(G)(1)(e)(iii); IV(G)(13)(a)	**Suggested Documents:** Member handbook Interpretation/translation/alternate format/communication policies and procedures **Documents Submitted for Desk Review:** Nebraska Member Handbook, page 25 11.301 Member Materials **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
8. The MCE must give members written notice of any significant change (as defined by the State) in the information required at 42 CFR §438.10(g) at least 30 days before the intended effective date of the change. The written notice must inform the member that a hard copy of the information is available and how to request it. *42 CFR §438.10(g)(4)*	**Suggested Documents:** Example notification (if applicable within the last year) Template letter (if available) **Documents Submitted for Desk Review:** 11.301 Member Materials	☒ Met ☐ Not Met ☐ Not Applicable

Standard III—Member Information		
Requirement	**Evidence as Submitted by the DBM**	**Score**
MCO Contract: IV(F)(5)(e) DBM Contract: IV(G)(14)(e)	No notices of significant changes was sent to members within the review period. **Additional Documents Submitted:**	
9. The MCE must make a good faith effort to give written notice of termination of a contracted provider within 15 calendar days after the receipt or issuance of the termination notice or 30 calendar days prior to the effective date of the termination, whichever is later, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR §438.10(f)(1)* MCO Contract: IV(F)(1)(c)(i) DBM Contract: IV(G)(12)(a)	**Suggested Documents:** Redacted example letter Template letter **Documents Submitted for Desk Review:** 11.104 Member Notification of Provider Termination **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
10. The MCE makes available to members in paper form upon request, and electronic form, a provider directory that includes the following information about contracted network physicians (including specialists), hospitals, pharmacies, and behavioral health providers (as applicable): • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), and whether the providers will accept new members. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) spoken by the	**Suggested Documents:** Provider directory **Documents Submitted for Desk Review:** 11.301 Member Materials Provider Directory **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard III—Member Information		
Requirement	**Evidence as Submitted by the DBM**	**Score**
provider or skilled medical interpreters offered by the provider's office. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *42 CFR §438.10(h)(1)* MCO Contract: IV(I)(15)(a-b) DBM Contract: IV(G)(8)(d)		
11. For the MCO, the provider directory in: • Paper format must be updated at least monthly. • Web-based format must be updated in real time and no less often than three business days after the MCO is notified of the change. For the DBM, the provider directory in: • A paper format must be updated at least: – Monthly, if the MCE does not have a mobile-enabled, electronic directory; or – Quarterly, if the DBM has a mobile-enabled, electronic provider directory. • An electronic format must be updated no later than 30 calendar days after the DBM receives updated provider information. *42 CFR §438.10(h)(3)* MCO Contract: IV(F)(8)(c) DBM Contract: IV(G)(8)	**Suggested Documents:** PDF of hard copy provider directory Link to online provider directory **Documents Submitted for Desk Review:** Provider Directory https://www.mcnane.net/#locator **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard III—Member Information		
Requirement	**Evidence as Submitted by the DBM**	**Score**
12. Provider directories must be made available on the MCE's website in a machine-readable file and format as specified by the Secretary of Health and Human Services. *42 CFR §438.10(h)(4)* MCO Contract: IV(F)(8)(e) DBM Contract: IV(G)(4)(b)(iii)(b)	**Suggested Documents:** Link to the MCE's provider directory on the website **Documents Submitted for Desk Review:** https://www.mcnane.net/#locator **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
13. The MCE must provide each member with: • A member handbook within a reasonable time after receiving notification of the member's enrollment. To meet this requirement, the MCE may notify each member in electronic or paper form that the member handbook is available on the MCE's website and include the website address where the handbook can be found. • A Welcome Packet within 10 business days from the date of receipt of the member enrollment file from MLTC. The Welcome Packet must include (all MCEs): – A welcome letter highlighting major program features and contact information for the MCE. – A provider directory (in hard copy if requested) or the address where the directory can be found online. – The member ID card (or notification that the ID card will also be sent). • MCO only Welcome Packet requirements: – Information on how to request a member handbook.	**Suggested Documents:** Member handbook New member enrollment policies and procedures Member material distribution policies and procedures Sample Welcome Letter Sample Welcome Packet materials **Documents Submitted for Desk Review:** 11.301 Member Materials Nebraska Member Handbook Member Welcome Letter Member ID Card **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard III—Member Information		
Requirement	**Evidence as Submitted by the DBM**	**Score**
– Notice that the provider directory and member handbook are available on the member portal and that the member may request a hardcopy if he or she wants one. – Directions for obtaining hard copies. – Other information the MCO wishes to include (e.g., Early and Periodic Screening, Diagnostic, and Treatment [EPSDT] periodicity schedule, prenatal care materials, guidance regarding emergency services, availability of community resources). *Note: The MCE has met this requirement if materials are provided through any of the following methods:* • *Mailing a printed copy of the information to the member's mailing address.* • *Providing the information by email after obtaining the member's agreement to receive the information by email.* • *Posting the information on the website of the MCE and advising 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.* • *Providing the information by any other method that can reasonably be expected to result in the member receiving that information.* *42 CFR §438.10(g)(1;3)* MCO Contract: IV(F)(5); IV(F)(13)(b) DBM Contract: IV(G)(14); IV(G)(4)(b); IV(G)(7)		

Standard III—Member Information		
Requirement	**Evidence as Submitted by the DBM**	**Score**
14. The member handbook provided to members following enrollment includes: • A table of contents. • A general description of basic features of how MCOs/DBMs (as applicable) operate and information about the MCE in particular. • A description of the Member Services department including: – What services it can provide. – How member services representatives (MSRs) may be reached for assistance. – The toll-free number, fax number, email address, and mailing address of the Member Services department. – Hours of operation of the Member Services department. • A section that stresses the importance of notifying Medicaid Eligibility of any change to family size, mailing address, living arrangement, income, other health insurance, assets, or other situations that might affect ongoing eligibility. • A description of the purpose of the Medicaid MCO and DBM ID cards, why both are necessary, and how to use them. • Appropriate and inappropriate behavior when seeing a provider including that: – The member is responsible for protecting his or her ID cards. – Misuse of the card including loaning, selling, or giving it to another person could result in loss of Medicaid eligibility and/or legal action. MCO Contract: IV(F)(5)(f) DBM Contract: IV(G)(14)(f)	**Suggested Documents:** Member handbook New member enrollment policies and procedures Member material distribution policies and procedures Sample Welcome Letter Sample Welcome Packet materials **Documents Submitted for Desk Review:** 11.301 Member Materials Nebraska Member Handbook Member Welcome Letter Member ID Card **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard III—Member Information		
Requirement	**Evidence as Submitted by the DBM**	**Score**
15. The member handbook provided to members following enrollment includes: • Information about health education and promotion programs including chronic care management. • Appropriate utilization of services, including not using the emergency department for nonemergent conditions. • Information about the EPSDT program and the importance of children obtaining these services. • Information about notifying the MCO if a female member becomes pregnant or gives birth and the importance of: – Early and regular prenatal care. – Obtaining prenatal and postpartum care. • The importance of notifying the MCO/DBM immediately if the member files a workers' compensation claim, has a pending personal injury or medical malpractice lawsuit, or has been involved in an accident of any kind. • That the member has the right to refuse to undergo any medical or diagnostic service or treatment if the member objects (or in the case of a child, the member's parent or guardian objects) to the service on religious grounds. MCO Contract: IV(F)(5)(f) DBM Contract: IV(G)(14)(f)	**Suggested Documents:** Member handbook New member enrollment policies and procedures Member material distribution policies and procedures Sample Welcome Letter Sample Welcome Packet materials **Documents Submitted for Desk Review:** Nebraska Member Handbook Member Welcome Letter Member ID Card **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
16. The member handbook provided to members following enrollment includes: • The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members	**Suggested Documents:** Member handbook **Documents Submitted for Desk Review:** Nebraska Member Handbook	☒ Met ☐ Not Met ☐ Not Applicable

Standard III—Member Information		
Requirement	**Evidence as Submitted by the DBM**	**Score**
understand the benefits to which they are entitled, and to effectively use the managed care program. • Procedures for obtaining benefits (i.e., how to make, change, or cancel appointments). • The importance of canceling or rescheduling an appointment, rather than being a "no-show." • Procedures for authorization requirements and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider/dental home. • The extent to which and how members may obtain benefits, including family planning services, from out-of-network providers. • An explanation that the MCE cannot require the member to obtain a referral before choosing a family planning provider in or out of network. • A description of the PCP/dental home selection process and the PCP's/dental home's role as coordinator of services. • *MCOs only:* The member's right to select a different MCO or change providers within the MCO. • *DBM only:* The member's right to select a different dental home within the DBM network. • Any restrictions on the member's freedom of choice among network providers. • In the case of a counseling or referral service that the MCE does not cover due to moral or religious objections, the Contractor informs the member that the service is not covered by the MCE and how the member can obtain information from the State about how to access such services.	**Additional Documents Submitted:**	

Standard III—Member Information		
Requirement	**Evidence as Submitted by the DBM**	**Score**
Note: Family planning services are not applicable to the DBM. *42 CFR §438.10(g)(2)* MCO Contract: IV(F)(5)(f) DBM Contract: IV(G)(14)(f)		
17. The member handbook provided to members following enrollment includes member rights and responsibilities. As specified in 42 CFR §438.100, a member has the right to: • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information in accordance with information requirements (42 CFR §438.10). • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her healthcare, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of his or her medical records, and request that they be amended or corrected. • Obtain available and accessible healthcare services covered under the contract with MLTC. *42 CFR §438.10(g)(2)(ix)* MCO Contract: IV(F)(5)(f) DBM Contract: IV(G)(14)(f)	**Suggested Documents:** Member handbook **Documents Submitted for Desk Review:** Nebraska Member Handbook **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard III—Member Information		
Requirement	**Evidence as Submitted by the DBM**	**Score**
18. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and fair hearing procedures and time frames. For grievances and appeals: • Definitions of "grievance" and "appeal." • The right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The availability of assistance in the filing processes. • The toll-free number(s) members can use to file a grievance or an appeal by telephone. • The fact that, when requested by the member: – Benefits that the MCE seeks to reduce or terminate will continue if the member files an appeal within the time frames specified for filing. – If benefits continue during the appeal process, the member may be required to pay the cost of those services if the final decision is adverse to the member. For State fair hearings: • The definition of "State fair hearing." • The right to a request a State fair hearing after the MCE has made a determination on a member's appeal which is adverse to the member. • The requirements and time frames for requesting a State fair hearing. • The availability of assistance to request a State fair hearing. • The fact that, when requested by the member:	**Suggested Documents:** Member handbook **Documents Submitted for Desk Review:** Nebraska Member Handbook **Additional Documents Submitted:**	☐ Met ☒ Not Met ☐ Not Applicable

Standard III—Member Information		
Requirement	**Evidence as Submitted by the DBM**	**Score**
– Benefits that the MCE seeks to reduce or terminate will continue if the member files a request for a State fair hearing within the time frames specified for filing. – If benefits continue during the appeal process, the member may be required to pay the cost of those services if the final decision is adverse to the member. *42 CFR §438.10(g)(2)(xi)* MCO Contract: IV(F)(5)(f) DBM Contract: IV(G)(14)(f)		
Findings: Within its member handbook, MCNA did not include all required information about State fair hearings.		
Required Actions: MCNA must update its member handbook to include the following information: • The availability of assistance to request a State fair hearing. • The fact that, when requested by the member: – Benefits that the MCE seeks to reduce or terminate will continue if the member files a request for a State fair hearing within the time frames specified for filing. – If benefits continue during the appeal process, the member may be required to pay the cost of those services if the final decision is adverse to the member.		
19. The member handbook provided to members following enrollment includes the extent to which and how after-hours and emergency coverage are provided, including: • What constitutes an emergency medical condition, emergency services, and poststabilization services. • The fact that prior authorization is not required for emergency services.	**Suggested Documents:** Member handbook **Documents Submitted for Desk Review:** Nebraska Member Handbook	☒ Met ☐ Not Met ☐ Not Applicable

Standard III—Member Information		
Requirement	**Evidence as Submitted by the DBM**	**Score**
• The process and procedures for obtaining emergency services including the use of the 911 telephone system. • The fact that the member has the right to use any hospital or other setting for emergency care. *42 CFR §438.10(g)(2)(v)* MCO Contract: IV(F)(5)(f) DBM Contract: IV(G)(14)(f)	**Additional Documents Submitted:**	
20. The member handbook provided to members following enrollment must include: • Information about member copayments. • How and where to access any benefits that are available under the Medicaid State plan but not covered under the MCE's contract with MLTC (either because the service is carved out or because the MCE will not provide the service because of a moral or religious objection). • How to obtain emergency and nonemergency transportation. • The toll-free telephone number for member services, medical management, and any other unit providing services directly to members. • Information on how to report suspected fraud or abuse, which must include: – The MCE's toll-free number. – MLTC's toll-free number. – Website links created for reporting fraud. • How to access auxiliary aids and services, including information in alternative formats or languages.	**Suggested Documents:** Member handbook **Documents Submitted for Desk Review:** Nebraska Member Handbook **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard III—Member Information		
Requirement	**Evidence as Submitted by the DBM**	**Score**
42 CFR §438.10(g)(2)(ii, viii, xiii, xiv, xv) MCO Contract: IV(F)(5)(f) DBM Contract: IV(G)(14)(f)		
21. The member handbook provided to members following enrollment must include how to exercise an advance directive as required in §438.3(j), which includes: • The State's policies regarding advance directives. • The MCO's policies regarding advance directives. • Information about where a member can seek assistance in executing an advance directive, and to whom copies should be given. • How members can file a complaint with MLTC or the Division of Public Health about a provider's failure to comply with advance directive requirements. *42 CFR §438.10(g)(2)(xii)* MCO Contract: IV(F)(5)(f) DBM Contract: Not Applicable	**Suggested Documents:** Member handbook **Documents Submitted for Desk Review:** Nebraska Member Handbook **Additional Documents Submitted:**	☐ Met ☐ Not Met ☒ Not Applicable
Findings: MCNA does not contract with the provider type applicable to advance directives requirements; therefore, this requirement is not applicable to MCNA.		
22. The member handbook informs members of the information available to members, upon request, which includes: • The structure and operation of the MCE. • The MCE's physician incentive plans. • The MCE's service utilization policies.	**Suggested Documents:** Member handbook **Documents Submitted for Desk Review:** Nebraska Member Handbook	☒ Met ☐ Not Met ☐ Not Applicable

Standard III—Member Information		
Requirement	**Evidence as Submitted by the DBM**	**Score**
• How to report alleged marketing violations. • Reports of transactions between the MCE and parties in interest (as defined in 1318(h) of the Public Health Service Act) provided to the State. *42 CFR §438.10(f)(3)* MCO Contract: IV(F)(5)(f)(xxxii)(b); IV(Q)(7)(e) DBM Contract: IV(Q)(5)(e); IV(G)(14)(f)(xxix)(e)	**Additional Documents Submitted:**	

Results for Standard III—Member Information						
Met	=	17	X	1.00	=	17
Not Met	=	3	X	.00	=	0
Not Applicable	=	2				NA
Total Applicable	=	20	Total Score		=	17
Total Score ÷ Total Applicable					=	85%

Standard IV—Emergency and Poststabilization Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
1. The MCE defines "emergency medical condition" as a 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: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. *42 CFR §438.114(a)(i-iii)* MCO Contract: Contract Glossary of Terms DBM Contract: Contract Glossary of Terms	**Suggested Documents:** Policies and procedures Member handbook or other member messaging **Documents Submitted for Desk Review:** 3.203NE_Service Authorization Including Retrospective Reviews Member Handbook **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
2. The MCE defines "emergency services" as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and are needed to evaluate or stabilize an emergency medical condition. *42 CFR §438.114(a)* MCO Contract: Contract Glossary of Terms DBM Contract: Contract Glossary of Terms	**Suggested Documents:** Policies and procedures Member messaging **Documents Submitted for Desk Review:** 3.203NE_Service Authorization Including Retrospective Reviews **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard IV—Emergency and Poststabilization Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
3. The MCE defines "poststabilization care services" as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or provided to improve or resolve the member's condition. *42 CFR §438.114(a)* MCO Contract: Glossary of Terms DBM Contract: IV(G)(14)(f)(xix)(a)	**Suggested Documents:** Policies and procedures Member messaging **Documents Submitted for Desk Review:** Member Handbook, page 28 **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
4. The MCE may not require prior authorization for emergency services. *42 CFR §438.10(g)(2)(v)(B)* MCO Contract: IV(E)(14)(a)(i) DBM Contract: IV(G)(14)(f)(xix)(b)	**Suggested Documents:** Applicable policies and procedures Member messaging **Documents Submitted for Desk Review:** 3.203NE_Service Authorization Including Retrospective Reviews **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
5. The MCE covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the MCE. *42 CFR §438.114(c)(1)(i)* MCO Contract: IV(E)(14) DBM Contract: IV(Q)(6)(d); IV(Q)(10)(d)	**Suggested Documents:** Policies and procedures Claims management workflows Internal protocols **Documents Submitted for Desk Review:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard IV—Emergency and Poststabilization Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
	9.110 Provider Reimbursement for Emergency Claims **Additional Documents Submitted:**	
6. The MCE may not deny payment for treatment obtained under either of the following circumstances: • A representative of the MCE's organization (including the member's primary care provider) instructed the member to seek emergency services. • A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have resulted in the following outcomes specified in the definition of an emergency medical condition. – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; – Serious impairment to bodily functions; or – Serious dysfunction of any bodily organ or part. *Note: The MCE bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR §438.114--Preamble* *42 CFR §438.114(c)(1)(ii)* MCO Contract: IV(E)(14)(a) DBM Contract: IV(Q)(3)(d-e)	**Suggested Documents:** Policies and procedures Claims management workflows Internal protocols **Documents Submitted for Desk Review:** 9.110 Provider Reimbursement for Emergency Claims **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard IV—Emergency and Poststabilization Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
7. The MCE does not: • Limit what constitutes an emergency medical/dental condition based on a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the MCE, or State agency of the member's screening and treatment within 10 calendar days of presentation for emergency services. *42 CFR §438.114(d)(1)* MCO Contract: IV(E)(14)(a)(iv-v) DBM Contract: IV(Q)(3)(c)	**Suggested Documents:** Policies and procedures Claims management workflows Internal protocols **Documents Submitted for Desk Review:** 9.110 Provider Reimbursement for Emergency Claims **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
8. The MCE does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR §438.114(d)(2)* MCO Contract: IV(E)(14)(a)(vi) DBM Contract: IV(Q)(3)(e)	**Suggested Documents:** Policies and procedures Claims management workflows Internal protocols Provider messaging **Documents Submitted for Desk Review:** 9.110 Provider Reimbursement for Emergency Claims **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
9. The MCE allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for	**Suggested Documents:** Policies and procedures Claims management workflows	☐ Met ☐ Not Met ☒ Not Applicable

Standard IV—Emergency and Poststabilization Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
transfer or discharge, and that determination is binding on the MCE who is responsible for coverage and payment. *42 CFR §438.114(d)(3)* MCO Contract: IV(E)(14)(a)(vii) DBM Contract: IV(E)(7)(f)	Internal protocols Provider messaging **Documents Submitted for Desk Review:** 9.110 Provider Reimbursement for Emergency Claims **Additional Documents Submitted:**	
Findings: MCNA is not responsible for facility charges when emergency services are provided at hospital or facility-based emergency facilities; therefore, this requirement is not applicable for MCNA.		
10. The MCE is financially responsible for poststabilization services that are: • ***Prior authorized*** by an in-network provider or MCE representative, regardless of whether they are provided within or outside the MCE's network of providers. • Obtained within or outside the network that are ***not pre-approved*** by a plan provider or other organization representative but are administered to maintain the member's stabilized condition within one hour of a request to the organization for pre-approval of further poststabilization care services. • Obtained within or outside the network that are ***not pre-approved*** by a plan provider or other organization	**Suggested Documents:** Policies and procedures Claims management workflows Internal protocols Provider messaging **Documents Submitted for Desk Review:** 9.110 Provider Reimbursement for Emergency Claims **Additional Documents Submitted:**	☐ Met ☐ Not Met ☒ Not Applicable

Standard IV—Emergency and Poststabilization Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: – The organization does not respond to a request for pre-approval within one hour; – The organization cannot be contacted; or – Services are provided and when the organization 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 organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in §422.113(c)(3) is met. *42 CFR §438.114(e); 422.113(c)(2)* MCO Contract: IV(E)(14)(b)(i) DBM Contract: Not Applicable		
Findings: MCNA is not responsible for inpatient services. 42 CFR §422.113 states that for the purpose of payment, poststabilization care services begin at the time of admission. Therefore, this requirement is not applicable for MCNA.		
11. The MCE's financial responsibility for poststabilization care services it has not pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care; • A plan physician assumes responsibility for the member's care through transfer;	**Suggested Documents:** Emergency/Poststabilization policies and procedures Workflows or protocols used for claims payment Care coordination policies and procedures (if applicable) **Documents Submitted for Desk Review:**	☐ Met ☐ Not Met ☒ Not Applicable

Standard IV—Emergency and Poststabilization Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
• A plan representative and the treating physician reach an agreement concerning the member's care; or • The member is discharged. *42 CFR §438.114(e); 422.113(c)(3)* MCO Contract: IV(E)(14)(b)(ii) DBM Contract: Not applicable	N/A to Dental **Additional Documents Submitted:**	
Findings: MCNA is not responsible for inpatient services. 42 CFR §422.113 states that for the purpose of payment, poststabilization care services begin at the time of admission. Therefore, this requirement is not applicable for MCNA.		
12. In the event the member receives emergency or poststabilization services from a provider outside the MCE's network, the MCE must limit charges to the member to an amount no greater than what the MCE would charge if he or she had obtained the services through an in-network provider. *42 CFR §438.114(e); 422.113(c)(2)* MCO Contract: IV(Q)(8)(b) DBM Contract: IV(Q)(10)(b)	**Suggested Documents:** Policies and procedures Example of communication to out-of-network emergency provider Emergency Operations Plan (EOP) template **Documents Submitted for Desk Review:** 9.110 Provider Reimbursement for Emergency Claims **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Results for Standard IV—Emergency and Poststabilization Services						
Met	=	9	X	1.00	=	9
Not Met	=	0	X	.00	=	0
Not Applicable	=	3				NA
Total Applicable	=	9		Total Score	=	0
				Total Score ÷ Total Applicable	=	100%

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
1. The MCE must comply with the following State geographic standards for primary care providers, OB/GYN providers, specialists, hospitals, and pharmacies: **MCO Standards:** • Urban: Two PCPs within 30 miles of residences for all members • Rural: One PCP within 45 miles of residences for all members • Frontier: One PCP within 60 miles of residences for all members • One high-volume specialist within 90 miles of residences for all members for each of the following specialties: – Cardiology – Neurology – Hematology/Oncology – Obstetrics/Gynecology – Orthopedics • Pharmacy Urban: One within five miles of residences for 90% of members • Pharmacy Rural: One within 15 miles of residences for 70% of members • Pharmacy Frontier: One within 60 miles of residences for 70% of members • Hospital access: 30 minutes travel time (one way) for all members (allowing for rural and frontier exceptions) • Behavioral Health Inpatient and Residential: Single-day travel time (round trip)	**Suggested Documents:** Policies and procedures Network adequacy reports **Documents Submitted for Desk Review:** 10.104NE Network Adequacy Provider Network Access and Adequacy Report **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
• Behavioral Health Outpatient: – Urban: "Adequate choice" of providers within 30 miles of residences for all members – Rural: Two providers within 45 miles of residences for all members – Frontier: Two providers within 60 miles of residences for all members – Telehealth must be used for behavioral health outpatient care if standards cannot be met due to lack of providers in rural or frontier areas **DBM Standards:** • Urban: Two dentists within 45 miles of residences for all members • Rural: One dentist within 60 miles of residences for all members • Frontier: One dentist within 100 miles of residences for all members in frontier counties • Dental Specialists: – Urban: One oral surgeon, one orthodontist, one periodontist, and one pediadontist within 45 miles for all members – Rural: One oral surgeon, one orthodontist, one periodontist, and one pediadontist within 60 miles of residences for all members		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
– Frontier: One oral surgeon, one orthodontist, one periodontist, and one pediadontist within 100 miles of for all members *42 CFR §438.206(a)* MCO Contract: Attachment 39 DBM Contract: Attachment 4		
2. The MCE maintains and monitors a network of providers sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. *42 CFR §438.206(b)(1)* MCO Contract: IV(I) DBM Contract: IV(B)(1)(a)(iii); IV(I)(1)(a)	**Suggested Documents:** Network adequacy reports Network adequacy committee minutes (or equivalent) **Documents Submitted for Desk Review:** 10.300NE Provider Network Development and Management Program **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
3. The MCE provides female members with direct access to a women's healthcare specialist within the network for covered care necessary to provide women's routine and preventive healthcare 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)* MCO Contract: IV(I)(4)(f) DBM Contract: Not Applicable	**Suggested Documents:** Policies and procedures Member messaging Claims staff protocols **Documents Submitted for Desk Review:** N/A to Dental	☐ Met ☐ Not Met ☒ Not Applicable

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
	Additional Documents Submitted:	
Findings: MCNA is not responsible for providing female members with direct access to a women's healthcare specialist; therefore, this requirement is not applicable for MCNA.		
4. The MCE 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)* MCO Contract: IV(E)(5) DBM Contract: IV(E)(4); IV(G)(14)(f)(xviii)	**Suggested Documents:** Policies and procedures Member messaging **Documents Submitted for Desk Review:** 10.33 NE Provider Network Development and Management Program **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
5. If the provider network is unable to provide necessary services, covered under the contract, to a particular member in network, the MCE must adequately and in a timely manner cover the services out of network for the member, for as long as the MCE provider network is unable to provide them. *42 CFR §438.206(b)(4)* MCO Contract: IV(Q)(8)(a) DBM Contract: IV(Q)(10)(a)	**Suggested Documents:** Policies and procedures Example, if applicable **Documents Submitted for Desk Review:** 10.104NE Network Adequacy **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
6. The MCE requires out-of-network providers to coordinate with the MCE for payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42 CFR §438.206(b)(5)* MCO Contract: IV(Q)(8)(b) DBM Contract: IV(Q)(10)(b)	**Suggested Documents:** Out-of-network policies and procedures Single case agreement Communications to out-of-network providers via EOP or other means **Documents Submitted for Desk Review:** 10.300NE Provider Network Development and Management Program MCNA did not process any single case agreements during the period **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
7. The MCE demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. *42 CFR §438.206(b)(7)* MCO Contract: Attachment 39 DBM Contract: Not applicable	**Suggested Documents:** Network adequacy reporting **Documents Submitted for Desk Review:** N/A to Dental **Additional Documents Submitted:**	☐ Met ☐ Not Met ☒ Not Applicable
Findings: MCNA is not responsible for providing family planning services; therefore, this requirement is not applicable for MCNA.		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
8. The MCE must meet, and require its providers to meet, the State standards for timely access to care and services taking into account the urgency of the need for services. MCOs must meet the following standards: **Emergency services**: • Available immediately at the service site, 24 hours a day, seven days a week • Emergent behavioral health needs must be referred to services one hour generally and within two hours in designated rural areas **Urgent care:** • Available same day and be provided by the PCP or as arranged by the MCE **Non-urgent sick care:** • Available within 72 hours, or sooner if the member's medical condition(s) deteriorate into an urgent or emergent situation **Family planning:** • Available within seven calendar days **Non-urgent, preventive care:** • Available within four weeks **High-volume specialty care** (cardiologist, neurologist, hematologist/oncologist, OB/GYNs, and orthopedic): • Routine appointments within 30 calendar days of referral **Other specialty care:** • Consultation within one month of referral or as clinically indicated	**Suggested Documents:** **Documents Submitted for Desk Review:** 5.105NE Availability and Accessibility of Services **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
Laboratory and x-rays: • Available within three weeks for routine appointments and 48 hours (or as clinically indicated) for urgent care **Maternity:** • Available within 14 calendar days of request during the first trimester • Available within seven calendar days of request during the second trimester • Available within three calendar days of request during the third trimester **High-risk pregnancies:** • Must be seen within three calendar days of identification of high-risk by the MCE or maternity provider, or immediately if an emergency exists **DBM must meet the following standards:** **Urgent care:** • Must be provided within 24 hours by either the primary dentist or through other arrangements **Routine or preventive dental services:** • Within six weeks *42 CFR §438.206(c)(1)(i)* MCO Contract: Attachment 39 DBM Contract: Attachment 4		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
9. The MCE and its 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 (if the provider serves only Medicaid members). *42 CFR §438.206(c)(1)(ii)* Contract: IV(I)(1)(b) DBM Contract: None	**Suggested Documents:** **Documents Submitted for Desk Review:** N/A to Dental **Additional Documents Submitted:** 5.105NE: "MCNA will also ensure its network providers offer office hours at least equal to those offered to MCNA's Medicaid FFS participants, if the provider accepts only Medicaid patients."	☒ Met ☐ Not Met ☐ Not Applicable
10. The MCE makes services included in the contract available 24 hours a day, seven days a week, when medically necessary. *42 CFR §438.206(c)(1)(iii)* MCO Contract: Attachment 39 DBM Contract: Attachment 4	**Suggested Documents:** **Documents Submitted for Desk Review:** 5.105NE Availability and Accessibility of Services **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
11. The MCE has mechanisms to ensure compliance by network providers regarding timely access to services, monitors network providers regularly to determine compliance, and takes corrective action if there is failure to comply. *42 CFR §438.206(c)(1)(iv)-(vi)* MCO Contract: IV(I)(1)(g) DBM Contract: IV(I)(1)(h)(v); IV(I)(1)(2)	**Suggested Documents:** Network adequacy reports Timely access survey **Documents Submitted for Desk Review:** Provider Network Access and Adequacy Report NE Appointment Availability Survey	☒ Met ☐ Not Met ☐ Not Applicable

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
	Additional Documents Submitted:	
12. The MCE participates in the State'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 gender, sexual orientation, or gender identity. *42 CFR §438.206(c)(2)* MCO Contract: IV(G)(1)(k) DBM Contract: IV(G)(1)(i)	**Suggested Documents:** Access and cultural consideration policies and procedures Cultural competency plan Quality initiatives or studies **Documents Submitted for Desk Review:** 5.105NE Availability and Accessibility of Services Cultural Competency Plan **Additional Documents Submitted:** Provider Manual, pg. 57-58	☒ Met ☐ Not Met ☐ Not Applicable
13. The MCE must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR §438.206(c)(3)* MCO Contract: IV(I)(1)(m) DBM Contract: IV(I)(1)(c)	**Suggested Documents:** **Documents Submitted for Desk Review:** 10.300NE Provider Network Development and Management Program **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
14. The MCE submits to the State (in a format specified by the State) documentation to demonstrate that the MCE: • Offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of members for the service area. • 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. The documentation is submitted to the State no less frequently than: • At the time the MCE enters into a contract with the State. • Annually. • At any time, there has been a significant change (as defined by the State) in the MCE's operations that would affect adequacy of capacity and services, including: – Changes in the MCE's services, benefits, geographic service area, composition of or payments to its network providers. – Enrollment of a new population in the health plan. *42 CFR §438.207(b)-(c)* MCO Contract: IV(I)(16) DBM Contract: IV(I)(11-12)	**Suggested Documents:** Network adequacy reports **Documents Submitted for Desk Review:** 10.300NE Provider Network Development and Management Program 10.107NE Material Changes to the Provider Network **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Results for Standard V—Adequate Capacity and Availability of Services						
Met	=	12	X	1.00	=	12
Not Met	=	0	X	.00	=	0
Not Applicable	=	2				NA
Total Applicable	=	12		Total Score	=	12
				Total Score ÷ Total Applicable	=	100%

Standard VI—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the DBM**	**Score**
1. The MCO implements procedures to deliver care to and coordinate services for all members. These procedures meet all requirements of this standard. The DBM must designate a staff member to serve as the lead for coordination of services with each MCO. The staff member's contact information must be shared with the MCOs. *42 CFR §438.208(b)* MCO Contract: IV(L)(4)(a) DBM Contract: IV(L)(2)(a)	**Suggested Documents:** Care coordination policies and procedures Care management program description (Throughout this standard, HSAG will use results from denials record reviews to score the related requirements.) **Documents Submitted for Desk Review:** 3.303 Coordination of Care 3.507NE Coordination of Non-Capitated Services **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
2. The MCE ensures 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 healthcare services accessed by the member. • The member must be provided information on how to contact his or her designated person or entity. *42 CFR §438.208(b)(1)* MCO Contract: IV(F)(9); IV(L)(1)(e) DBM Contract: IV(G)(7); IV(I)(7)(a)	**Suggested Documents:** Member handbook **Documents Submitted for Desk Review:** NE Member Handbook, page 14 3.303 Coordination of Care **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard VI—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the DBM**	**Score**
3. The MCE implements procedures to coordinate services the MCE furnishes the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in FFS Medicaid. • With the services the member receives from community and social support providers. *42 CFR §438.208(b)(2)* MCO Contract: IV(4)(b) DBM Contract: Not Applicable	**Suggested Documents:** Care coordination policies and procedures Policies and procedures that address continuity of care **Documents Submitted for Desk Review:** 3.303 Coordination of Care **Additional Documents Submitted:**	☐ Met ☐ Not Met ☒ Not Applicable
Findings: MCNA is not responsible for coordinating the services listed within this requirement; therefore, this requirement is not applicable for MCNA.		
4. The MCE provides best efforts to conduct an initial screening of each new member's needs within 90 days of enrollment, including subsequent attempts if the initial attempt to contact the member is unsuccessful. *42 CFR §438.208(b)(3)* MCO Contract: IV(L)(2) DBM Contract: Not Applicable	**Suggested Documents:** Initial screening policies and procedures Sample of the initial screening form/template **Documents Submitted for Desk Review:** N/A to Dental **Additional Documents Submitted:**	☐ Met ☐ Not Met ☒ Not Applicable

Standard VI—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the DBM**	**Score**
Findings: MCNA is not responsible for conducting an initial screening to determine members' care coordination needs; therefore, this requirement is not applicable for MCNA.		
5. The MCE shares with other entities serving the member the results of its identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR §438.208(b)(4)* MCO Contract: IV(L)(5)(b) DBM Contract: Not Applicable	**Suggested Documents:** Care coordination policies and procedures **Documents Submitted for Desk Review:** 3.303 Coordination of Care **Additional Documents Submitted:**	☐ Met ☐ Not Met ☒ Not Applicable
Findings: MCNA is not responsible for conducting an initial screening to determine members' care coordination needs; therefore, this requirement is not applicable for MCNA.		
6. The MCE ensures 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)* MCO Contract: IV(F)(11) DBM Contract: IV(H)(21)(c)	**Suggested Documents:** Care coordination policies and procedures Health/dental record documentation requirements or policies Provider messaging regarding documentation requirements Policies guiding health record disclosure for care coordination **Documents Submitted for Desk Review:** 3.303 Coordination of Care	☒ Met ☐ Not Met ☐ Not Applicable

Standard VI—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the DBM**	**Score**
	Additional Documents Submitted:	
7. The MCE ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that they are applicable. *42 CFR §438.208(b)(6)* MCO Contract: IV(E)(1)(c) DBM Contract: IV(C)(12)	**Suggested Documents:** Care coordination policies and procedures Privacy/HIPAA policies and procedures **Documents Submitted for Desk Review:** 3.303 Coordination of Care **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
8. The MCE implements mechanisms to assess members with special healthcare needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. *42 CFR §438.208(c)(2)* MCO Contract: IV(E)(22) DBM Contract: IV(B)(1)(a)(iii)	**Suggested Documents:** Member onboarding procedures Care Coordination policies and procedures **Documents Submitted for Desk Review:** 3.804 Members with Special Healthcare Needs and Catastrophic Dental Conditions **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
9. For members with special healthcare needs determined through an assessment by appropriate healthcare professionals to need a course of treatment or regular care monitoring, the MCE must have a mechanism in place to allow members to directly access a	**Suggested Documents:** Case management policies and procedures **Documents Submitted for Desk Review:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard VI—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the DBM**	**Score**
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)* MCO Contract: IV(I)(4)(g) DBM Contract: IV(I)(5)(e)	3.804 Members with Special Healthcare Needs and Catastrophic Dental Conditions **Additional Documents Submitted:**	

Results for Standard VI—Coordination and Continuity of Care						
Met	=	6	X	1.00	=	6
Not Met	=	0	X	.00	=	0
Not Applicable	=	3				NA
Total Applicable	=	6		**Total Score**	=	6
				Total Score ÷ Total Applicable	=	100%

Standard VII—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
1. The MCE ensures that the services defined in the contract are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. *42 CFR §438.210(a)(2); (3)(i)* MCO Contract: IV(E)(2) DBM Contract: IV(E)(2)(a)	**Suggested Documents:** Coverage and authorization policies and procedures **Documents Submitted for Desk Review:** 3.101NE 2021 UM Program Description, page 10, IX **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
2. The MCE 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 member. *42 CFR §438.210(a)(3)(ii)* MCO Contract: IV(N)(4)(d)(iv); IV(E)(2)(c) DBM Contract: IV(E)(2)(b)	**Suggested Documents:** Coverage and authorization policies and procedures **Documents Submitted for Desk Review:** 3.101NE 2021 UM Program Description, page 11, first paragraph **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
3. The Contractor may place appropriate limits on services: • On the basis of criteria applied under the State plan (such as medical necessity). • For the purpose of utilization control, provided that: – The services furnished can reasonably achieve their purpose.	**Suggested Documents:** Coverage and authorization policies and procedures **Documents Submitted for Desk Review:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard VII—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
– Family planning services are provided in a manner that enables the member to choose the method of family planning. *Note: Family planning services are not applicable to the DBM.* *42 CFR §438.210(a)(4)* MCO Contract: IV(E)(2)(c); IV(E)(16) DBM Contract: IV(E)(2)(c)	3.101NE 2021 UM Program Description, page 10-11, IX **Additional Documents Submitted:**	
4. The MCE specifies what constitutes medically necessary covered services in a manner that: • Is no more restrictive than that used in the State Medicaid program. • Takes into account and addresses the following: – The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. – The ability for a member to achieve age-appropriate growth and development. – The ability for a member to attain, maintain, or regain functional capacity. *42 CFR §438.210(a)(5)* MCO Contract: IV(E)(4)(a) DBM Contract: IV(E)(3)	**Suggested Documents:** Coverage and authorization policies and procedures **Documents Submitted for Desk Review:** 3.101NE 2021 UM Program Description, page 10, IX **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard VII—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
5. The MCE and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR §438.210(b)(1)* MCO Contract: IV(N)(4)(a) DBM Contract: IV(N)(23)(b)(i)	**Suggested Documents:** Utilization review/utilization management (UR/UM) policies and procedures **Documents Submitted for Desk Review:** 3.203aNE Adverse Determinations **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
6. The MCE has and follows written policies and procedures that include mechanisms to ensure consistent application of review criteria for authorization decisions. *42 CFR §438.210(b)(2)(i)* MCO Contract: IV(N)(4)(a) DBM Contract: IV(N)(3)(e)	**Suggested Documents:** UR/UM policies and procedures **Documents Submitted for Desk Review:** 3.101NE 2021 UM Program Description, page 19, XXV **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
7. The MCE has and follows written policies and procedures to consult with the requesting provider for medical services when appropriate. *42 CFR §438.210(b)(2)(ii)* MCO Contract: IV(N)(4)(d)(ix) DBM Contract: IV(N)(23)(b)(ii)	**Suggested Documents:** Care coordination policies and procedures **Documents Submitted for Desk Review:** 3.101NE 2021 UM Program Description, page 5, first paragraph	☒ Met ☐ Not Met ☐ Not Applicable

Standard VII—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
	Additional Documents Submitted:	
8. The MCE ensures 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 treating the member's condition or disease. *42 CFR §438.210(b)(3)* MCO Contract: IV(N)(4)(b) DBM Contract: IV(H)(3)(a)(ii)	**Suggested Documents:** Denial policies and procedures **Documents Submitted for Desk Review:** 3.203aNE Adverse Determinations **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
9. The MCE has and follows written policies and procedures that include the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires, but no later than 14 calendar days from the receipt of the request for service authorization. • If the provider indicates, or the MCE determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the MCE makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR §438.210(d)(1-2)* MCO Contract: IV(N)(4)(d)(xi); IV(H)(3)(c)(vi-vii)	**Suggested Documents:** Authorization policies and procedures **Documents Submitted for Desk Review:** 3.203NE Service Authorizations Including Retrospective Review, page 3, middle of the page **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard VII—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
DBM Contract: IV(H)(3)(c)(v-vi); IV(N)(24)(a)		
10. The MCE's policies and procedures include provisions for extending the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension; or • The MCE justifies (to the State upon request) a need for additional information and how the extension is in the member's interest. If the MCE extends the time frame for standard or expedited authorization decisions, it must: • Give the member written notice of the reason for the extension (no later than the date the authorization time frame expires). • Inform the member of the right to file a grievance if he or she disagrees with that decision. • 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 §438.210(d)(1); (d)(2)(ii)* *42 CFR §438.404(c)(4)* MCO Contract: IV(H)(3)(c)(v-vii) DBM Contract: IV(H)(24)(a)(ii); IV(H)(3)(c)(v)	**Suggested Documents:** Authorization policies and procedures **Documents Submitted for Desk Review:** 3.203NE Service Authorizations Including Retrospective Review, page 3, bottom of the page **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
11. The MCE has and follows written policies and procedures that include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (notice to the provider need not be in writing).	**Suggested Documents:** Authorization policies and procedures Denial policies and procedures **Documents Submitted for Desk Review:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard VII—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
42 CFR §438.210(c) MCO Contract: IV(N)(4)(a-b)(d)(x) DBM Contract: IV(H)(23)(b)	3.203aNE Adverse Determinations **Additional Documents Submitted:**	
12. The MCE operates a drug utilization review program that includes: • Policies and procedures to govern prospective and retrospective prescription drug service authorizations. • Prospective and retrospective drug review. • An educational program. *42 CFR §438.3(s)* MCO Contract: IV(N)(9) DBM Contract: Not Applicable	**Suggested Documents:** UR policies and procedures **Documents Submitted for Desk Review:** N/A to Dental **Additional Documents Submitted:**	☐ Met ☐ Not Met ☒ Not Applicable
Findings: MCNA is not responsible for providing prescription drug benefits; therefore, this requirement is not applicable to MCNA.		
13. The MCE provides response within 24 hours of a request for authorization for all covered outpatient drug authorization decisions as described in Section 1927(d)(5)(A) of the Social Security Act: Provide response by telephone or other telecommunication device within 24 hours of request for prior authorization. *42 CFR §438.210(d)(3)* *42 U.S. Code §1396r-8(d)(5)* MCO Contract: IV(E)(11)(b)(ix)(a) DBM Contract: Not applicable	**Suggested Documents:** Authorization policies and procedures **Documents Submitted for Desk Review:** N/A to Dental **Additional Documents Submitted:**	☐ Met ☐ Not Met ☒ Not Applicable
Findings: MCNA is not responsible for providing prescription drug benefits; therefore, this requirement is not applicable to MCNA.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
14. If the MCE denies a request for a service authorization or authorizes a service in an amount, duration, or scope less than requested, the MCE mails the notice of adverse benefit determination within the following time frames: • For standard service authorization decisions that deny or limit services, within 14 calendar days of the request for authorization. • For expedited service authorization decisions, within 72 hours of the request for authorization. • For service authorization decisions not reached within the 14-calendar-day or 72-hour time frames, on the date these time frames expire. *42 CFR §438.404(c)* *42 CFR §438.210(d)* MCO Contract: IV(H)(3)(v-vii) DBM Contract: IV(H)(3)(v-vi)	**Suggested Documents:** Authorization policies and procedures **Documents Submitted for Desk Review:** 3.203NE Service Authorizations Including Retrospective Reviews **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
15. If the MCE denies payment for a service, in whole or in part, the MCE mails the notice of adverse benefit determination at the time of any denial affecting the claim. *42 CFR §438.404(c)* MCO Contract: IV(H)(3)(c)(iv) DBM Contract: IV(H)(3)(c)(iv)	**Suggested Documents:** Denial policies and procedures Notice of ABD letter template **Documents Submitted for Desk Review:** 9.301Adverse Determinations **Additional Documents Submitted:**	☐ Met ☒ Not Met ☐ Not Applicable

Standard VII—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
Findings: Although MCNA's Adverse Benefit Determination policy included the provision to send members notification of claims denials, during the interview, MCNA staff members stated that NABDs are not sent for claims denials. During the grievance record review, HSAG found several cases that were processed as grievances which should have been treated as appeals as they were related to claims denials. In absence of the NABD, staff processed the members' calls as grievances. Grievance resolution letters do not contain State fair hearing rights; therefore, it is important that members receive the appropriate notifications so that their subsequent communications can proceed correctly and afford members the appropriate due process.		
Required Actions: MCNA must develop a mechanism to send members an NABD at the time of any decision to deny payment for a service, in whole or in part.		
16. If the MCE proposes to reduce, suspend, or terminate a previously authorized Medicaid-covered service, the MCE gives advance notice (notice of adverse benefit determination) at least 10 days before the proposed effective date except when: • The MCE gives notice on or before the date of action if: – The agency has factual information confirming the death of a member. – The agency receives a clear written statement signed by the member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information. – The member has been admitted to an institution where he or she is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns agency mail directed to him or her indicating no forwarding address.	**Suggested Documents:** Policies and procedures **Documents Submitted for Desk Review:** **Additional Documents Submitted:**	☐ Met ☒ Not Met ☐ Not Applicable

Standard VII—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
– The agency establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the MCE gives notice five calendar days before the date of action. *42 CFR §438.404(c); 431.211; 431.213; 431.214* MCO Contract: IV(H)(3)(c)(i-iii) DBM Contract: IV(H)(3)(c)(i-iii)		
Findings: MCNA did not submit a policy that included the requirement for a 10-day advance notice if MCNA proposes to terminate, reduce, or suspend services currently being received by the member. During the interview, MCNA staff members stated that once a service is authorized, MCNA would not seek to terminate the services prior to the end of the authorization period.		
Required Actions: HSAG recognizes that these situations may be rare for a DBM; however, MCNA must have processes in place if a situation such as this does occur. MCNA must revise policies and procedures and develop a mechanism to ensure that if MCNA proposes to terminate, suspend, or reduce previously authorized services prior to the end of the authorization period, it provides a 10-day advance notice of such termination or change to the service.		
17. The notice of adverse benefit determination must be in writing and meet the language and format requirements of 42 CFR §438.10(c). *42 CFR §438.404(a)* MCO Contract: IV(H)(3)(b)(iii) DBM Contract: IV(H)(3)(b)(iii)	**Suggested Documents:** Notice of ABD letter template **Documents Submitted for Desk Review:** Notice of ABD Letter Template	☐ Met ☒ Not Met ☐ Not Applicable

Standard VII—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
	Additional Documents Submitted:	
Findings: While MCNA consistently sent the NABD in writing in 10 of the 10 denial records reviewed, HSAG found that only one of the 10 NABDs reviewed was written at a 6.9 grade reading level as required by MCNA's contract with DHHS.		
Required Actions: MCNA must develop a mechanism to ensure that NABDs are written at a 6.9 grade reading level (to the extent possible) as required by MCNA's contract with DHHS.		
18. The notice of adverse benefit determination explains the following: • The adverse benefit determination the MCE has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to all documents, records, and other information relevant to the adverse benefit determination (medical necessity criteria and information or processes used in setting coverage limits). • The member's right (or provider's right, on behalf of the member) to request one level of appeal with the MCE and the procedures for doing so. • The member's right to request a State fair hearing after receiving an appeal resolution notice from the MCE that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State fair hearing.	**Suggested Documents:** Sample denial letter **Documents Submitted for Desk Review:** Sample Denial Letter **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard VII—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the DBM**	**Score**
• The circumstances under which an appeal process can be expedited and how to request it. • The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances (consistent with State policy) under which the member may be required to pay the cost of these services. *42 CFR §438.404(b)* MCO Contract: IV(H)(3)(b)(ii) DBM Contract: IV(H)(3)(b)(ii)		
19. The MCE provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR §438.210(e)* MCO Contract: IV(N)(1)(d) DBM Contract: IV(N)(18)	**Suggested Documents:** Policies and procedures Staff messaging **Documents Submitted for Desk Review:** 3.101NE 2021 UM Program Description, page 3, #1 **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Results for Standard VII—Coverage and Authorization of Services						
Met	=	14	X	1.00	=	14
Not Met	=	3	X	.00	=	0
Not Applicable	=	2				NA
Total Applicable	=	17		Total Score	=	14
				Total Score ÷ Total Applicable	=	82%

Standard VIII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the DBM**	**Score**
1. The MCE must implement written policies and procedures for selection and retention of network providers. *42 CFR §438.214(a)* MCO Contract: IV(I)(14)(a) DBM Contract: IV(I)(9)(a) •	**Suggested Documents:** Credentialing/Recredentialing policies and procedures Provider Network Development Management Plan **Documents Submitted for Desk Review:** 10.300NE Provider Network Development and Management Program **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
2. The MCE follows a documented process for credentialing and recredentialing that complies with the requirements of the contract. *42 CFR §438.206(b)(1)* *42 CFR §438.214(b); (e)* MCO Contract: IV(I)(14) DBM Contract: IV(I)(9)(a)	**Suggested Documents:** Credentialing/Recredentialing policies and procedures Credentialing Committee meeting minutes **Documents Submitted for Desk Review:** 3.601 Initial Credentialing Application 6.401 Re-Credentialing **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
3. The MCE's provider network selection policies and procedures include provisions that the MCE does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification	**Suggested Documents:** Credentialing/Recredentialing policies and procedures Provider retention policies/procedures **Documents Submitted for Desk Review:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard VIII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the DBM**	**Score**
under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR §438.12(a)(1)-(2); 438.214(c)* MCO Contract: IV(I)(2)(a-b) DBM Contract: IV(I)(1)(d)	10.203NE Non-Discrimination Against Dental Providers 6.104 Non-Discrimination and Credentialing **Additional Documents Submitted:**	
4. If the MCE declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the MCE to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the MCE from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the MCE from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. *42 CFR §438.12(a-b)* MCO Contract: IV(I)(2)(c)(i-ii) DBM Contract: IV(I)(9)(h)(ii)	**Suggested Documents:** Policies and procedures Sample letter Letter template **Documents Submitted for Desk Review:** 6.301 Initial Credentialing Application MCNA has not declined any providers during the period **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard VIII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the DBM**	**Score**
5. The MCE does not employ or contract with providers or other individuals or entities excluded for participation in federal healthcare programs under either Section 1128 or 1128 A of the Social Security Act (this requirement also requires a policy). *42 CFR §438.214(d); 438.610* MCO Contract: IV(D)(1)(b); IV(K)(3) DBM Contract: IV(D)(1)(b); IV(I)(1)(h)(iii)	**Suggested Documents:** Provider participation policies and procedures Program integrity policies and procedures **Documents Submitted for Desk Review:** 6.309 Medicare-Medicaid Sanctions **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
6. The MCE may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the MCE's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or nonprocurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR §438.610* MCO Contract: IV(O)(3)(a) DBM Contract: IV(O)(3)(a)	**Suggested Documents:** Policies and procedures Evidence of exclusion searches **Documents Submitted for Desk Review:** 16.202 Review of OIG and SAM **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
7. The MCE does not prohibit, or otherwise restrict, healthcare professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care, or treatment options, including any alternative treatments that may be self-administered.	**Suggested Documents:** Provider manual or other applicable provider messaging **Documents Submitted for Desk Review:** Provider Manual, page 21	☒ Met ☐ Not Met ☐ Not Applicable

Standard VIII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the DBM**	**Score**
• Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or nontreatment. • The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions. *42 CFR §438.102(a)(1)* MCO Contract: IV(J)(7)(a) DBM Contract: IV(I)(1)(h)(iv)	**Additional Documents Submitted:**	
8. If the MCE objects to providing a service on moral or religious grounds, the MCE must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members within 90 calendar days after adopting the policy with respect to any particular service, and at least 30 days before the effective date of the policy. The notification informs members how to obtain information from the State about where to receive the services. *42 CFR §438.10(g)(2)(A); (4)* *42 CFR §438.102(b)* MCO Contract: IV(C)(18) DBM Contract: IV(C)(15)(b)	**Suggested Documents:** Policies and procedures Any applicable notifications Provider messaging **Documents Submitted for Desk Review:** 1.100MIC Covered Services **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard VIII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the DBM**	**Score**
9. The MCE has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes: • Written policies and procedures and standards of conduct that articulate the MCE's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices to ensure compliance with requirements of the contract and who reports directly to the CEO and Board of Directors. • The establishment of a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the MCE's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits,	**Suggested Documents:** Fraud, waste, and abuse policies and procedures Evidence of staff training Training materials/content Compliance committee meeting minutes Evidence of fraud and abuse auditing, monitoring, and enforcement Compliance committee minutes Ongoing staff messaging **Documents Submitted for Desk Review:** 2021 Compliance Program **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard VIII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the DBM**	**Score**
correction of such problems quickly and thoroughly to reduce the potential for reoccurrence, and ongoing compliance with the requirements under the contract. *42 CFR §438.608(a)(1)* MCO Contract: IV(O)(8)(a-b) DBM Contract: IV(O)(8)(a-b)		
10. The MCE's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • In the case of MCEs that make or receive payments of at least $5,000,000, written policies for all employees, MCEs, or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the State Medicaid Program Integrity Unit and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud. • The method the MCE will use to prevent payments to international accounts. *42 CFR §438.608(a)(6-8)* MCO Contract: IV(O)(8)-(9)(a); IV(O)(16)(a) DBM Contract: IV(O)(8)-(9)(a); IV(O)(16)(a)	**Suggested Documents:** Compliance plan and related policies and procedures **Documents Submitted for Desk Review:** 2021 FWA and Erroneous Payments Annual Plan **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard VIII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the DBM**	**Score**
11. The MCE's Compliance Program includes— • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potential fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the MCE. • Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR §438.608(a)(2-5)* MCO Contract: IV(B)(4)(c); IV(O)(1)(g); IV(O)(10)(a); IV(R)(8)(d) DBM Contract: IV(B)(1)(b)(2); IV(O)(1)g); IV(O)(10)(a); IV(S)(8)(d)	**Suggested Documents:** Compliance program description and/or overview Evidence of service verification **Documents Submitted for Desk Review:** 2021 FWA and Erroneous Payments Annual Plan **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
12. The MCE ensures that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure screening, and enrollment requirements of the State. *42 CFR §438.608(b)* MCO Contract: IV(I)(13)(a) DBM Contract: IV(I)(10)(a)	**Suggested Documents:** Policies and procedures **Documents Submitted for Desk Review:** 6.301 Initial Credentialing Application **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard VIII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the DBM**	**Score**
13. The MCE may execute network provider agreements pending the outcome of the State's screening and enrollment process of up to 120 days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one 120-day period without enrollment of the provider, and notify affected members. *42 CFR §438.602(b)* MCO Contract: IV(I)(13)(b) DBM Contract: IV(I)(10)(a)	**Suggested Documents:** Policies and procedures Tracking template **Documents Submitted for Desk Review:** 6.301 Initial Credentialing Application **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
14. The MCE has procedures to provide to the State: • Written disclosure of any prohibited affiliation (as defined in §438.610). • Written disclosure of ownership and control (as defined in §455.104) *42 CFR §438.608(c)* MCO Contract: IV(O)(1)(h); IV(O)(3) DBM Contract: IV(O)(1)(h); IV(O)(3)	**Suggested Documents:** Procedures Templates/forms Example, if applicable **Documents Submitted for Desk Review:** 1.105MIC Ownership and Management Disclosure NE 2021 FWA and Erroneous Payments Annual Plan **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
15. The MCE has a mechanism for a network provider to report to the MCE when it has received an overpayment, to return the overpayment to the MCE within 60 calendar days of identifying the overpayment, and to notify the MCE in writing of the reason for the overpayment.	**Suggested Documents:** Policies and procedures Example, if applicable Recent report	☒ Met ☐ Not Met ☐ Not Applicable

Standard VIII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the DBM**	**Score**
• The MCE reports monthly to the State on recoveries of overpayments. *42 CFR §438.608(d)(2)-(3)* MCO Contract: IV(O)(1)(g); IV(O)(13)(a)(v) DBM Contract: IV(O)(1)(g); IV(O)(13)(a); IV(O)(18)	**Documents Submitted for Desk Review:** 15.312NE Identifying and Recovering Overpayments **Additional Documents Submitted:**	
16. The MCE provides that Medicaid members are not held liable for: • The MCE's debts in the event of the MCE's insolvency. • Covered services provided to the member for which the State does not pay the MCE. • Covered services provided to the member for which the State or the MCE does not pay the healthcare provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the MCE provided the services directly. *42 CFR §438.106* MCO Contract: IV(C)(10)(a) DBM Contract: IV(C)(7)(a)	**Suggested Documents:** Member handbook Provider agreement template Provider messaging Policies and procedures **Documents Submitted for Desk Review:** 1.100MIC Covered Services **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Results for Standard VIII—Provider Selection and Program Integrity						
Met	=	16	X	1.00	=	16
Not Met	=	0	X	.00	=	0
Not Applicable	=	0				NA
Total Applicable	=	16		Total Score	=	16
				Total Score ÷ Total Applicable	=	100%

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the DBM**	**Score**
1. Notwithstanding any relationship(s) with any subcontractor, the MCE maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR §438.230(b)(1)* MCO Contract: IV(C)(14); IV(K)(1) DBM Contract: IV(C)(11); IV(K)(1)	**Suggested Documents:** Provider messaging Monitoring/oversight reports/other evidence of monitoring Joint operation committee minutes (if applicable /used as a monitoring mechanism) **Documents Submitted for Desk Review:** 1.200MIC Contracting and Oversight of Subcontractors **Additional Documents Submitted:** Dental Administrative Services Agreement, Pg. 1	☒ Met ☐ Not Met ☐ Not Applicable
2. All contracts or written arrangements between the MCE and any subcontractor specify— • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligation or specify other remedies in instances where the State or MCE determines that the subcontractor has not performed satisfactorily.	**Suggested Documents:** Delegation Policies and Procedures **MCOs:** • Executed contract with the pharmacy benefits manager (PBM) • One additional executed subcontract (nonprovider) **DBM:** Any two executed nonprovider subcontracts (if applicable) **Documents Submitted for Desk Review:** 1.200MIC Contracting and Oversight of Subcontractors	☒ Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the DBM**	**Score**
42 CFR §438.230(b)(2); (c)(1) MCO Contract: IV(K)(1)(c) DBM Contract: IV(K)(1)(c)	**Additional Documents Submitted:** Dental Administrative Services Agreement, Pg. 2	
3. The MCE's written agreement with any subcontractor must include: • The subcontractor's agreement to comply with all applicable Medicaid laws and regulations, including applicable subregulatory guidance and contract provisions. *42 CFR §438.230(c)(2)* MCO Contract: IV(K)(1) DBM Contract: IV(K)	**Suggested Documents:** **Documents Submitted for Desk Review:** 1.200MIC Contracting and Oversight of Subcontractors **Additional Documents Submitted:** Dental Administrative Services Agreement, Pg. 11	☐ Met ☒ Not Met ☐ Not Applicable
Findings: HSAG reviewed a written delegation agreement in place with Fiserv. The agreement did not include required details regarding compliance with Medicaid laws and regulations, applicable subregulatory guidance, or contract provisions.		
Required Actions: MCNA must update all written delegation agreements to include the required language from 42 CFR §438.230(c)(2).		
4. The written agreement with the subcontractor must include provisions that: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's MCE, that pertain to any aspect of services	**Suggested Documents:** Delegated Entity Audit Results **Documents Submitted for Desk Review:** 1.200MIC Contracting and Oversight of Subcontractors	☐ Met ☒ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the DBM**	**Score**
and activities performed, or determination of amounts payable under the MCE's contract with the State. • The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to Medicaid members. • The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. • If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR §438.230(c)(3)* MCO Contract: IV(K)(1) DBM Contract: IV(K)	**Additional Documents Submitted:** Dental Administrative Services Agreement, Pg. 2, 5	
Findings: HSAG reviewed a written delegation agreement in place with Fiserv. The agreement did not include the language required by 42 CFR §438.230(c)(3).		
Required Actions: MCNA must update all written delegation agreements to include the following language: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's MCE, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCE's contract with the State. • The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to Medicaid members.		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the DBM**	**Score**
• The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. • If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.		

Results for Standard IX—Subcontractual Relationships and Delegation						
Met	=	2	X	1.00	=	2
Not Met	=	2	X	.00	=	0
Not Applicable	=	0				NA
Total Applicable	=	4	Total Score		=	2
Total Score ÷ Total Applicable					=	50%

Standard X—Practice Guidelines		
Requirement	**Evidence as Submitted by the DBM**	**Score**
1. The MCE adopts practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field. • Consider the needs of the MCE's members. • Are adopted in consultation with network providers. • Are reviewed and updated periodically as appropriate. *42 CFR §438.236(b)* MCO Contract: IV(N)(3)(a)(i-iii)(vi) DBM Contract: IV(N)(2)(a-d)	**Suggested Documents:** Practice Guideline policies and procedures **Documents Submitted for Desk Review:** 2.100 Clinical Practice Guidelines, page 1-2 **Additional Documents Submitted:** NE Q2 2020 QIC Minutes_07/17/2020	☒ Met ☐ Not Met ☐ Not Applicable
2. The MCE disseminates the guidelines to all affected providers, and upon request, to members and potential members. *42 CFR §438.236(c)* MCO Contract: IV(N)(3)(a)(vii) DBM Contract: IV(N)(4)	**Suggested Documents:** Practice Guideline policies and procedures **Documents Submitted for Desk Review:** 2.100 Clinical Practice Guidelines, page 2 **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
3. The MCE ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR §438.236(d)* MCO Contract: IV(N)(3)(a)(ix) DBM Contract: IV(N)(6)	**Suggested Documents:** Interrater reliability results **Documents Submitted for Desk Review:** NE 2020 IRR Minutes	☒ Met ☐ Not Met ☐ Not Applicable

Standard X—Practice Guidelines		
Requirement	**Evidence as Submitted by the DBM**	**Score**
	Additional Documents Submitted: 2.018NE Dental Record Review	

Results for Standard X—Practice Guidelines						
Met	=	3	X	1.00	=	3
Not Met	=	0	X	.00	=	0
Not Applicable	=	0				NA
Total Applicable	=	3	Total Score		=	3
Total Score ÷ Total Applicable					=	100%

Standard XI—Health Information Systems		
Requirement	**Evidence as Submitted by the DBM**	**Score**
1. The MCE maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR §438.242(a)* MCO Contract: IV(R)(1)(a) DBM Contract: IV(S)(1)(a)	**Suggested Documents:** Health information-related policies and procedures Workflow diagrams **Documents Submitted for Desk Review:** 12.300 Management Information System Overview **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
2. The MCE's health information system provides information on areas including, but not limited to, utilization, claims, grievances, and appeals, and disenrollments for reasons other than loss of Medicaid eligibility. *42 CFR §438.242(a)* MCO Contract: IV(R)(1)(a) DBM Contract: IV(S)(1)(a)	**Suggested Documents:** Health information-related policies and procedures Example data reports used for quality improvement and tracking **Documents Submitted for Desk Review:** 12.300 Management Information System Overview **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
3. The MCE's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. *42 CFR §438.242(b)(1)* MCO Contract: IV(R)(1)(a)	**Suggested Documents:** Claims encounter policies and procedures **Documents Submitted for Desk Review:** 12.300 Management Information System Overview	☒ Met ☐ Not Met ☐ Not Applicable

Standard XI—Health Information Systems		
Requirement	**Evidence as Submitted by the DBM**	**Score**
DBM Contract: IV(R)(1-2)	**Additional Documents Submitted:**	
4. The MCE collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR §438.242(b)(2)* MCO Contract: IV(R)(1)(b); IV(M)(5)(b) DBM Contract: IV(R)(9)(k)	**Suggested Documents:** Encounter data policies and procedures **Documents Submitted for Desk Review:** 12.101NE Encounter Data **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
5. The MCE ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. • Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for Medicaid quality improvement and care coordination efforts. • Making all collected data available to the State and upon request to CMS. *42 CFR §438.242(b)(3);(4)* MCO Contract: IV(R)(1)(b-c) DBM Contract: IV(S)(b-c)	**Suggested Documents:** Encounter data policies and procedures **Documents Submitted for Desk Review:** 12.300 Management Information System Overview 12.101NE Encounter Data **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard XI—Health Information Systems		
Requirement	**Evidence as Submitted by the DBM**	**Score**
6. The MCE: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. • Submits member encounter data to the State in standardized Accredited Standards Committee (ASC) X12N 837 and National Council for Prescription Drug Programs (NCPDP) formats, and the ASC X12N 835 format as appropriate. • Submits member encounter data, including allowed amount and paid amount, to the State at the level of detail and frequency specified by the State, including data required for the State to report to CMS. *42 CFR §438.242(c)* MCO Contract: IV(R)(2)(a-k); IV(T)(4)(a) DBM Contract: IV(R)(9); IV(S)(2); IV(T)(4)	**Suggested Documents:** Encounter data policies and procedures **Documents Submitted for Desk Review:** 12.300 Management Information System Overview 12.101NE Encounter Data **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Results for Standard XI—Health Information Systems						
Met	=	6	X	1.00	=	6
Not Met	=	0	X	.00	=	0
Not Applicable	=	0				NA
Total Applicable	=	6		**Total Score**	=	6
Total Score ÷ Total Applicable					=	100%

Standard XII—Quality Assessment and Performance Improvement Program		
Requirement	**Evidence as Submitted by the DBM**	**Score**
1. The MCE implements an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR §438.330(a)* MCO Contract: IV(M)(1)(a); IV(M)(3)(b) DBM Contract: IV(M)(1)(a)	**Suggested Documents:** QAPI Program policies and procedures Quality Assessment and Performance Improvement Program Description **Documents Submitted for Desk Review:** 2.103NE Quality Improvement Program Description, page 19-24 **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
2. The MCE's QAPI Program includes conducting and submitting (to the State) annually performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators. • Planning and initiation of activities for increasing or sustaining improvement.	**Suggested Documents:** QAPI Program/Plan **Documents Submitted for Desk Review:** 2.103NE Quality Improvement Program Description, page 3-5, 7-8, 12-14, 21 2.102NE Performance Improvement Projects, page 1-4 **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard XII—Quality Assessment and Performance Improvement Program		
Requirement	**Evidence as Submitted by the DBM**	**Score**
42 CFR §438.330(b)(1); (d)(2); (3) MCO Contract: IV(M)(1)(d)(ii); IV(M)(7) DBM Contract: IV(M)(1)(a-c)		
3. The MCE's QAPI Program includes collecting and submitting (to the State) annually: • Performance measure data using standard measures identified by the State. • Data, specified by the State, which enable the State to calculate the MCE's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR §438.330(b)(2); (c)(2)* MCO Contract: IV(M)(1)(d)(iii); IV(M)(5)(d); IV(M)(6)(a-f) DBM Contract: IV(M)(3)(a-b)	**Suggested Documents:** Sample reports from 2020 **Documents Submitted for Desk Review:** MCNA NE PMV Jan Prelim RY 2021 (performance Measure Report submitted in 01/2021 for reporting year 202) 2.701NE Monitoring of Performance Measures, page 1-3 **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
4. The MCE's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR §438.330(b)(3)* MCO Contract: IV(N)(2)(c) DBM Contract: IV(M)(1)(a)(iii)	**Suggested Documents:** Underutilization and overutilization policies and procedures Sample reports or other mechanism used to identify underutilization and overutilization of services. **Documents Submitted for Desk Review:** 2.103NE Quality Improvement Program Description 3.602 Monitoring for Over and Under Utilization, page 1-3	☒ Met ☐ Not Met ☐ Not Applicable

Standard XII—Quality Assessment and Performance Improvement Program		
Requirement	**Evidence as Submitted by the DBM**	**Score**
	Over Utilization Report Samples **Additional Documents Submitted:** NE UM Committee Minutes Q3 2020 Nebraska KPI Dashboard	
5. The MCE's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special healthcare needs. *42 CFR §438.330(b)(4)* MCO Contract: IV(M)(2)(i) DBM Contract: IV(M)(1)(a)(iv)	**Suggested Documents:** QAPI Program policies and procedures **Documents Submitted for Desk Review:** 2.103NE Quality Improvement Program Description, page 10, 13 **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
6. The MCE has a process for evaluating the impact and effectiveness of the QAPI Program. *42 CFR §438.330(e)(2)* MCO Contract: IV(M)(2)(h) DBM Contract: IV(M)(1)(e)	**Suggested Documents:** QAPI Program Evaluation from 2020 **Documents Submitted for Desk Review:** 2.103NE Quality Improvement Program Description, page 4-8, 13 2020 NE QAPI Annual Evaluation **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Results for Standard XII—Quality Assessment and Performance Improvement Program						
Met	=	6	X	1.00	=	6
Not Met	=	0	X	.00	=	0
Not Applicable	=	0				NA
Total Applicable	=	6		Total Score	=	6
				Total Score ÷ Total Applicable	=	100%

Standard XIII—Grievance and Appeal System		
Requirement	**Evidence as Submitted by the DBM**	**Score**
1. The MCE has established internal grievance and appeal procedures under which members, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance. The MCE must have a grievance and appeal system in place to handle appeals of an adverse benefit determination and grievances, as well as processes to collect and track information about them. *42 CFR §438.400(a)(3)* MCO Contract: IV(H)(1)(a) DBM Contract: IV(H)(1)	**Suggested Documents:** Grievance and appeal policies and procedures Reports (Throughout this standard, HSAG will use results from grievance and appeal record reviews to score the related requirements.) **Documents Submitted for Desk Review:** 13.100 Grievances and Appeals Department Overview **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
2. The MCE defines "adverse benefit determination" as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole or in part, of payment for a service. • The failure to provide services in a timely manner, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals.	**Suggested Documents:** Policies and procedures that address denials/adverse benefit determination **Documents Submitted for Desk Review:** 13.100 Grievances and Appeals Department Overview, page 7	☒ Met ☐ Not Met ☐ Not Applicable

Standard XIII—Grievance and Appeal System		
Requirement	**Evidence as Submitted by the DBM**	**Score**
• The denial of a member's request to dispute a member's financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other). *Note: A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at 42 CFR §447.45(b) is not an adverse benefit determination.* *42 CFR §438.400(b); 438.52(b)(2)(ii)* MCO Contract: Contract Glossary of Terms DBM Contract: Contract Glossary of Terms	**Additional Documents Submitted:**	
3. The MCE defines "appeal" as a review by the MCE of an adverse benefit determination. *42 CFR §438.400(b)* MCO Contract: Contract Glossary of Terms DBM Contract: Contract Glossary of Terms	**Suggested Documents:** Policies and procedures Staff training materials **Documents Submitted for Desk Review:** 13.100 Grievances and Appeals Department Overview, page 7 13.200 Member Appeals, page 5 G&A NE Medicaid Training 2020, slide 17 **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
4. The MCE defines "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination.	**Suggested Documents:** Grievance policies and procedures Staff training materials	☒ Met ☐ Not Met ☐ Not Applicable

Standard XIII—Grievance and Appeal System		
Requirement	**Evidence as Submitted by the DBM**	**Score**
• Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the MCE to make an authorization decision. *42 CFR §438.400(b)* MCO Contract: IV(H)(1)(a)(i) DBM Contract: IV(H)(1)(a)(i)	**Documents Submitted for Desk Review:** 13.100 Grievances and Appeals Department Overview, page 8 G&A Letter Writing Training G&A NE Medicaid Training 2020, slide 17 **Additional Documents Submitted:**	
5. The MCE has provisions for who may file: • A member may file a grievance, an MCE-level appeal, and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance, an MCE-level appeal, and may request a State fair hearing on behalf of a member. *Note: When the term "member" is used, it may include the provider or authorized representative, acting on behalf of the member.* *42 CFR §438.402(c)* MCO Contract: IV(H)(2)(a); IV(H)(4)(a); IV(H)(7)(a) DBM Contract: IV(H)(2)(a); IV(H)(4)(a); IV(H)(7)(a)	**Suggested Documents:** Grievance policies and procedures **Documents Submitted for Desk Review:** 13.100 Grievances and Appeals Department Overview, page 1-3 **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
6. The MCE accepts grievances orally or in writing. *42 CFR §438.402(c)(3)(i)* MCO Contract: IV(H)(2)(a)	**Suggested Documents:** Grievance policies and procedures **Documents Submitted for Desk Review:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard XIII—Grievance and Appeal System		
Requirement	**Evidence as Submitted by the DBM**	**Score**
DBM Contract: IV(H)(2)(a)	13.105 Formal Grievance Policy, page 4 **Additional Documents Submitted:**	
7. Members may file a grievance at any time. *42 CFR §438.402(c)(2)(i)* MCO Contract: IV(H)(2)(b) DBM Contract: IV(H)(2)(b)	**Suggested Documents:** Member handbook Grievance policies and procedures **Documents Submitted for Desk Review:** 13.105 Formal Grievance Policy, page 1 **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
8. The MCE acknowledges receipt of each grievance in writing within 10 calendar days of receipt of the grievance. *42 CFR §438.406(b)(1)* MCO Contract: IV(H)(1)(b)(ii) DBM Contract: IV(H)(1)(b)(ii)	**Suggested Documents:** Grievance policies and procedures **Documents Submitted for Desk Review:** 13.105 Formal Grievance Policy, page 4 **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
9. The MCE must resolve each grievance and provide notice as expeditiously as the member's health condition requires, within 90 calendar days from the day on which the MCE receives the grievance.	**Suggested Documents:** Grievance policies and procedures **Documents Submitted for Desk Review:** 13.105 Formal Grievance Policy, page 1, 5	☐ Met ☒ Not Met ☐ Not Applicable

Standard XIII—Grievance and Appeal System		
Requirement	**Evidence as Submitted by the DBM**	**Score**
• Notice to the member must be in writing and in a format and language that may be easily understood by the member. *42 CFR §438.408(a); (d)(1)* MCO Contract: IV(H)(2)(c); IV(H)(2)(d) DBM Contract: IV(H)(2)(c); IV(H)(3)(i)	**Additional Documents Submitted:**	
Findings: In one grievance case reviewed, MCNA deemed the case a quality of care concern and sent it to the quality department for further review. MCNA sent a letter to the member stating that this case needs more time to review (see case number 4 of the grievance record review). It was unclear whether this letter was intended to be a resolution letter. There was no further communication to resolve this case. HSAG recognizes that if this case was handled as a peer review, the information is protected; however, a resolution from the member's perspective must be sent. In another case reviewed, this type of situation was handled with the member more clearly (see case number 9 in the appeal record review).		
Required Actions: MCNA must ensure that communication sent to the member provides a resolution in clear terms that are easily understood.		
10. In handling grievances and appeals, the MCE must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR §438.406(a)* MCO Contract: IV(H)(1)(b)(i) DBM Contract: IV(H)(1)(b)(i)	**Suggested Documents:** Grievance and appeals policies and procedures **Documents Submitted for Desk Review:** 13.105 Formal Grievance Policy, page 3 **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard XIII—Grievance and Appeal System		
Requirement	**Evidence as Submitted by the DBM**	**Score**
11. The MCE ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. • Take into account all comments, documents, records, and other information submitted by the member or his or her representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR §438.406(b)(2)* MCO Contract: IV(H)(1)(b)(iii-iv) DBM Contract: IV(H)(1)(b)(iii-iv)	**Suggested Documents:** UR policies and procedures Grievance and appeals policies and procedures **Documents Submitted for Desk Review:** 13.100 Grievances and Appeals Department Overview, page 2-3 **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
12. A member may file an appeal with the MCE within 60 calendar days from the date on the notice of adverse benefit determination. *42 CFR §438.402(c)(2)(ii)* MCO Contract: IV(H)(4)(b) DBM Contract: IV(H)(4)(b)	**Suggested Documents:** Grievance and appeal policies and procedures **Documents Submitted for Desk Review:** 13.200 Member Appeals, page 1	☒ Met ☐ Not Met ☐ Not Applicable

Standard XIII—Grievance and Appeal System		
Requirement	**Evidence as Submitted by the DBM**	**Score**
	Additional Documents Submitted:	
13. The member may file an appeal either orally or in writing, and the MCE must treat oral appeals in the same manner as appeals received in writing. The MCE may not require that oral requests for an appeal be followed with a written appeal. *42 CFR §438.402(c)(3)(ii); 438.406(b)(3)* MCO Contract: IV(H)(4)(c) DBM Contract: IV(H)(4)(c)	**Suggested Documents:** Member handbook Grievance and appeal policies and procedures **Documents Submitted for Desk Review:** 13.200 Member Appeals, page 4 **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
14. The MCE acknowledges receipt of each appeal in writing within 10 calendar days of receipt of the appeal. *42 CFR §438.406(b)(1)* MCO Contract: IV(H)(1)(b)(ii) DBM Contract: IV(H)(1)(b)(ii)	**Suggested Documents:** Appeal policies and procedures **Documents Submitted for Desk Review:** 13.200 Member Appeals, page 5 **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
15. The MCE's appeal process must provide: • That the MCE may have only one level of appeal for members (or providers acting on their behalf). • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal	**Suggested Documents:** Appeal policies and procedures **Documents Submitted for Desk Review:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard XIII—Grievance and Appeal System		
Requirement	**Evidence as Submitted by the DBM**	**Score**
and factual arguments. (The MCE must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) • The member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the MCE in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. • That included, as parties to the appeal, are: – The member and his or her representative; or – The legal representative of a deceased member's estate. *42 CFR §438.406(b)(4-6)* MCO Contract: IV(H)(4)(d)(i-v) DBM Contract: IV(H)(4)(d)(i-v)	13.100 Grievances and Appeals Department Overview, page 2, 6, 8 **Additional Documents Submitted:**	
16. The MCE must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 30 calendar days from the day the MCE receives the appeal. • For expedited resolution of an appeal and notice to affected parties, within 72 hours after the MCE receives the appeal. • For notice of an expedited resolution, the MCE must also make reasonable efforts to provide oral notice of resolution. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member.	**Suggested Documents:** Appeal policies and procedures Sample letter/Template **Documents Submitted for Desk Review:** 13.200 Member Appeals, page 1-2 Exp-AckLtr_apprvd non-urgent process Member-Appeal-Acknowledgement-Letter Member Expedited Appeal Decision (Upheld) Member Appeal Resolution Letter (Upheld)	☒ Met ☐ Not Met ☐ Not Applicable

Standard XIII—Grievance and Appeal System		
Requirement	**Evidence as Submitted by the DBM**	**Score**
42 CFR §438.408(b)(2); (3); (d)(2); 438.10 MCO Contract: IV(H)(4)(e)(i-iii); IV(H)(5)(d;f) DBM Contract: IV(H)(4)(e)(i-iii); IV(H)(5)(d;f)	Appeal-Determination-Overturn-Letter Nebraska Member Expedited Appeal-Decision (Overturned) **Additional Documents Submitted:**	
17. The MCE may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The MCE shows (to the satisfaction of MLTC, upon request) that there is need for additional information and how the delay is in the member's interest. • If the MCE extends the time frames for resolution of grievances or appeals, it must—for any extension not requested by the member: – Make reasonable efforts to give the member prompt oral notice of the delay. – Within two calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision. – Resolve the appeal as expeditiously as the member's health condition requires and no later than the date on which the extension expires (14 days following the expiration of the original appeal resolution time frame).	**Suggested Documents:** Grievance and appeal policies and procedures **Documents Submitted for Desk Review:** 13.200 Member Appeals, page 2 13.105 Formal Grievance Procedure, page 2 **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard XIII—Grievance and Appeal System		
Requirement	**Evidence as Submitted by the DBM**	**Score**
• If the MCE fails to adhere to the notice and timing requirements for extension of the appeal resolution time frame, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR §438.408(c)* MCO Contract: IV(H)(5)(d-e) DBM Contract: IV(H)(5)(d-e)		
18. Appeal resolution notices must be in writing, meet the language and format requirements of §438.10, and must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request to continue to receive the services while the State fair hearing is pending. – How to request the continued services. – A statement that the member may be held liable for the cost of these continued services if the hearing decision upholds the MCE's adverse benefit determination. *Note: Continuation of benefits/services applies only to previously authorized services for which the MCE provides 10-day advance notice to terminate, suspend, or reduce the services.* *42 CFR §438.408(e)* MCO Contract: IV(H)(4)(f) DBM Contract: IV(H)(4)(f)	**Suggested Documents:** Sample notice/Letter template Appeal policies and procedures **Documents Submitted for Desk Review:** Member Expedited Appeal Decision (Upheld) Member Appeal Resolution Letter (Upheld) Claims NABD Letter Template Claims NPAR Letter Template 13.200 Member Appeals, page 7, 8 **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard XIII—Grievance and Appeal System		
Requirement	**Evidence as Submitted by the DBM**	**Score**
19. The member may request a State fair hearing after receiving notice that the MCE is upholding the adverse benefit determination, within 120 calendar days from the date of the notice of appeal resolution. • The parties to the State fair hearing include the MCE, as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR §438.408(f)(1)–(3)* MCO Contract: IV(H)(7)(a-d) DBM Contract: IV(H)(7)(a-d)	**Suggested Documents:** State fair hearing policies and procedures Sample letter/Template **Documents Submitted for Desk Review:** 13.207 Medicaid Fair Hearing, page 1 **Additional Documents Submitted:**	☐ Met ☒ Not Met ☐ Not Applicable
Findings: The Grievance and Appeal overview policy and the UM Appeals policy stated that the member may file for a Medicaid fair hearing within no less than 90 calendar days and no greater that 120 days of receipt of MCNA's notice of appeal determination. This statement represents a misunderstanding of the federal regulation, which states that the member must have at least 90 calendar days and no more than 120 calendar days from the date on MCNA's appeal resolution notice. MCNA's member handbook and provider manual accurately depicted the 120-day filing time frame.		
Required Actions: MCNA must clarify its policies to ensure members are afforded the right to request a State fair hearing at any time after receiving the notice of appeal resolution, up to 120 days following the date of the appeal resolution letter.		
20. The MCE maintains an expedited review process for appeals when the MCE determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. The MCE's expedited review process includes:	**Suggested Documents:** Appeal policies and procedures **Documents Submitted for Desk Review:** 13.203 Expedited Appeals, page 1-3 MCNA Member Handbook v1.3, page 25, 34	☒ Met ☐ Not Met ☐ Not Applicable

Standard XIII—Grievance and Appeal System		
Requirement	**Evidence as Submitted by the DBM**	**Score**
• The MCE ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. • If the MCE denies a request for expedited resolution of an appeal, it must: – Transfer the appeal to the time frame for standard resolution. – Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution. – Follow up within two calendar days with a written notice of the denial of expedition and inform the member of the right to file a grievance if he or she disagrees with the decision to deny an expedited resolution. *42 CFR §438.410* MCO Contract: IV(H)(5)(a)(f)(g)(h) DBM Contract: IV(H)(5)(a)(f)(g)(h)	**Additional Documents Submitted:**	
21. The MCE provides for continuation of benefits/services while the MCE-level appeal and the State fair hearing are pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the MCE mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.	**Suggested Documents:** Appeal policies and procedures State fair hearing policies and procedures **Documents Submitted for Desk Review:** 13.200 Member Appeals, page 1, 3 13.209 Continuation of Authorized Services, page 1 13.207 Medicaid Fair Hearing, page, 1-3	☐ Met ☒ Not Met ☐ Not Applicable

Standard XIII—Grievance and Appeal System		
Requirement	**Evidence as Submitted by the DBM**	**Score**
• The services were ordered by an authorized provider. • The period covered by the original authorization has not expired. • The member requests an appeal within 60 days following the adverse benefit determination. *Note: This definition of "timely filing" only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced.* *Note: The provider may not request continuation of benefits on behalf of the member.* *42 CFR §438.420(a);(b)* MCO Contract: IV(H)(6)(a) DBM Contract: IV(H)(6)(a)	**Additional Documents Submitted:**	

Findings:
While the policies submitted for this requirement correctly stated the 10-day filing time frame as filing for the continuation of benefits only, which is correct, the UM Program Description and the provider manual incorrectly stated that the member must also file for the appeal within that time frame. According to the revisions released in 2016 via the Medicaid and CHIP managed care regulations, the member need only request that services continue during the appeal within that 10-day time frame (or before the services are scheduled to change or terminate), but has the full 60-day time frame to file the appeal. In addition, MCNA had revised the 10-day timeline for requesting continuation of services during the State fair hearing to also include only requesting continuation. When a member has received continued service during an appeal and wishes to continue service during the State fair hearing, the member must request the continuation and file for the State fair hearing both within 10 days following the appeal resolution.

Required Actions:
MCNA must revise its applicable documents to clearly state that members need only request continued services during an appeal within the 10-calendar-day time frame (or before the effective date of the termination or change in service) and has the full 60-day time frame to file the appeal; however, following the appeal, if the member requests continuation during the State fair hearing, he or she must request both the State fair hearing and continued service within 10 calendar days following the notice of appeal resolution.

Standard XIII—Grievance and Appeal System		
Requirement	**Evidence as Submitted by the DBM**	**Score**
22. If, at the member's request, the MCE continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • Ten days pass after the MCE sends the appeal resolution that is adverse to the member and, within those 10 days, the member has not requested a State fair hearing and continuation of benefits. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR §438.420(c)* MCO Contract: IV(H)(6)(b) DBM Contract: IV(H)(6)(b)	**Suggested Documents:** Appeal policies and procedures State fair hearing policies and procedures **Documents Submitted for Desk Review:** 13.207 Medicaid Fair Hearing, page 1, 2 13.209 Continuation of Authorized Services, page 1 **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
23. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the MCE's adverse benefit determination, the MCE may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR §438.420(d)* MCO Contract: IV(H)(6)(c) DBM Contract: IV(H)(6)(c)	**Suggested Documents:** Member handbook **Documents Submitted for Desk Review:** MCNA Member Handbook v1.3, page 33, 35 13.200 Member Appeals 13.209 Continuation of Authorized Services, page 3. **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable

Standard XIII—Grievance and Appeal System		
Requirement	**Evidence as Submitted by the DBM**	**Score**
24. Effectuation of reversed appeal resolutions: • If the MCE or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE or officer must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. • If the MCE or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE must pay for those services, in accordance with State policy and regulations. *42 CFR §438.424* MCO Contract: IV(H)(8)(a-b) DBM Contract: IV(H)(8)(a-b)	**Suggested Documents:** Appeal policies and procedures State fair hearing policies and procedures **Documents Submitted for Desk Review:** 13.207 Medicaid Fair Hearing, page 2 13.209 Continuation of Authorized Services, page 2 **Additional Documents Submitted:**	☒ Met ☐ Not Met ☐ Not Applicable
25. The MCE maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS. The record of each grievance and appeal must contain, at a minimum, all of the following information: • A general description of the reason for the grievance or appeal. • The date the grievance or appeal was received. • The date of each review or, if applicable, review meeting.	**Suggested Documents:** Grievance and appeal policies and procedures Grievance and appeal tracking reports **Documents Submitted for Desk Review:** 13.100 Grievances and Appeals Department Overview, page 1, 2, 3 13.103 Grievance and Appeal File Maintenance, page 1, 2 13.105 Formal Grievance Policy, page 1, 6	☒ Met ☐ Not Met ☐ Not Applicable

Standard XIII—Grievance and Appeal System		
Requirement	**Evidence as Submitted by the DBM**	**Score**
• Resolution at each level of the appeal or grievance process, as applicable. • Date of resolution at each level of the appeal or grievance process, as applicable. • Name of the covered member for whom the appeal or grievance was filed. *42 CFR §438.416* MCO Contract: IV(H)(9)(a-f) DBM Contract: IV(H)(9)(a-f)	NE EQR Performance Tracking Report **Additional Documents Submitted:**	
26. The MCE provides the information about the grievance, appeal, and fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the MCE has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • Toll-free numbers to use to file verbal grievances and appeals. • The member's right to request in a timely manner the continuation of services during an appeal or State fair hearing, and the fact that, when requested by the member: – Services that the MCE seeks to reduce or terminate will continue if the appeal or request for a State fair hearing is filed within the time frames specified for filing.	**Suggested Documents:** Grievance and Appeal policies and procedures Provider Agreement Subcontractor Contract **Documents Submitted for Desk Review:** Provider Manual v1.5, page 62, 65, 67 **Additional Documents Submitted:**	☐ Met ☒ Not Met ☐ Not Applicable

Standard XIII—Grievance and Appeal System		
Requirement	**Evidence as Submitted by the DBM**	**Score**
– The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending if the final decision is adverse to the member. • Any state-determined provider appeal rights to challenge the MCE's failure to cover a service. *42 CFR §438.414* MCO Contract: IV(H)(10) DBM Contract: IV(H)(10)		
Findings: MCNA's provider manual addressed the member grievance and appeal system; however, the manual included the following inaccuracies: • The manual stated that all appeals filed by a member or by a provider on behalf of a member must be submitted in writing. • The definition of "adverse benefit determination" in the provider manual was incomplete and was missing the denial of a member's request to dispute a member's financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other). • The manual stated that the provider may file an expedited review request verbally that must be followed up in writing. • The manual stated that members who wish to request continued services during an appeal must file the appeal within 10 days following the NABD.		
Required Actions: MCNA must ensure that the provider manual includes accurate information about the member grievance an appeal system and clarify that: • Members may file an appeal orally or in writing, and oral requests to appeal do not require written follow-up regardless of whether they are standard or expedited requests. • The definition of "adverse benefit determination" includes the denial of a member's request to dispute a member's financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other). • Members who wish to continue services during the appeal must request the continuation within 10 days following the NABD, or before the intended effective date of the termination or change (whichever is later); however, the member has the full 60-day filing time frame to file the appeal.		

Results for Standard XIII—Grievance and Appeal System						
Met	=	22	X	1.00	=	22
Not Met	=	4	X	.00	=	0
Not Applicable	=	0				NA
Total Applicable	=	26	Total Score		=	22
Total Score ÷ Total Applicable					=	85%

Appeals Record Review Tool

Review Period:	July 1, 2020–June 30, 2021
Date of Review:	September 16–17, 2021
Reviewer:	Barbara McConnell

1	2	3	4	5	6	7	8	9	10	11	12	13
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 10 Calendar Days (XIII.14)	Decision Maker Not Previous Level (XIII.11)	Decision Maker Has Clinical Expertise (XIII.11)	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame (XIII.16)	If Expedited, Reasonable Effort-Verbal Notice (XIII.16)	Resolution Letter Includes Required Content (XIII.18)	Resolution Letter Easy to Understand (XIII.18)
1	***	07/09/20	M ☐ N ☐ NA ☐	M ☐ N ☐ NA ☐	M ☐ N ☐ NA ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐ NA ☐	M ☐ N ☐	M ☐ N ☐
	Comments: This appeal was not processed. The member asked for an appeal more than 60 days past the NABD. On 07/13/20 MCNA sent a letter stating that the member's appeal rights were exhausted, and that MCNA could not process the appeal. During the interview, MCNA staff confirmed that the provider may request the service again, in this situation. This case was removed from the sample.											
2	***	07/18/20	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	Yes ☐ No ☒	Yes ☐ No ☒	07/27/21	M ☒ N ☐	M ☐ N ☐ NA ☒	M ☒ N ☐	M ☒ N ☐
	Comments: This was a denied request for a crown that was upheld. Acknowledgement sent 07/20/20.											
3	***	08/24/20	M ☐ N ☐ NA ☐	M ☐ N ☐ NA ☐	M ☐ N ☐ NA ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐ NA ☐	M ☐ N ☐	M ☐ N ☐
	Comments: This appeal was not processed. The member asked for an appeal more than 60 days past the NABD. On 08/27/20 MCNA sent a letter stating that the member's appeal rights were exhausted and that MCNA could not process the appeal. This case was removed from the sample.											
4	***	09/09/20	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	Yes ☐ No ☒	Yes ☐ No ☒	09/22/20	M ☒ N ☐	M ☐ N ☐ NA ☒	M ☒ N ☐	M ☒ N ☐
	Comments: This was a denied request for dental work secondary to a car accident that was overturned on appeal. Acknowledgement was sent 09/11/20.											
5	***	12/21/20	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	Yes ☐ No ☒	Yes ☐ No ☒	12/30/20	M ☒ N ☐	M ☐ N ☐ NA ☒	M ☒ N ☐	M ☒ N ☐
	Comments: This was a denied request for orthodontic services. The original request was for an expedited review. The acknowledgement letter sent 12/22/20 denied the expedited review and included the right to file a grievance if the member disagreed with the denial of expedition. System notes documented efforts to inform the member of the denial of an expedited review.											

1	2	3	4	5	6	7	8	9	10	11	12	13
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 10 Calendar Days (XIII.14)	Decision Maker Not Previous Level (XIII.11)	Decision Maker Has Clinical Expertise (XIII.11)	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame (XIII.16)	If Expedited, Reasonable Effort-Verbal Notice (XIII.16)	Resolution Letter Includes Required Content (XIII.18)	Resolution Letter Easy to Understand (XIII.18)
6	***	03/02/21	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	Yes ☐ No ☒	Yes ☐ No ☒	12/10/21	M ☒ N ☐	M ☐ N ☐ NA ☒	M ☒ N ☐	M ☒ N ☐
	Comments: This was a request for orthodontic services that was upheld. This case was reviewed for criteria for an expedited review. Acknowledgement was sent on 03/03/21 that denied an expedited review and included all requirements for such. System notes included documentation of verbal notice that denied an expedited review.											
7	***	03/23/21	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	Yes ☐ No ☒	Yes ☐ No ☒	04/08/21	M ☒ N ☐	M ☐ N ☐ NA ☒	M ☒ N ☐	M ☒ N ☐
	Comments: This was a denied request for orthodontic services that was upheld. Acknowledgement was sent 03/29/21.											
8	***	05/06/21	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	Yes ☐ No ☒	Yes ☐ No ☒	05/14/21	M ☒ N ☐	M ☐ N ☐ NA ☒	M ☒ N ☐	M ☒ N ☐
	Comments: This was a request for a partial that was upheld. Acknowledgement was sent 05/07/21.											
9	***	06/10/21	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	Yes ☐ No ☒	Yes ☐ No ☒	06/25/21	M ☒ N ☐	M ☐ N ☐ NA ☒	M ☒ N ☐	M ☒ N ☐
	Comments: This was a denied request for orthodontic treatment that was upheld. Acknowledgement was sent 06/14/21.											
10	***	06/24/21	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	Yes ☐ No ☒	Yes ☐ No ☒	07/07/21	M ☒ N ☐	M ☐ N ☐ NA ☒	M ☒ N ☐	M ☒ N ☐
	Comments: This was a denied request for a tooth removal that was overturned on appeal. Acknowledgement was sent on 06/25/21.											
OS1	***		M ☐ N ☐ NA ☐	M ☐ N ☐ NA ☐	M ☐ N ☐ NA ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐ NA ☐	M ☐ N ☐	M ☐ N ☐
	Comments: This appeal was not processed. The member asked for an appeal more than 60 days past the NABD. On 08/19/20 MCNA sent a letter stating that the member's appeal rights were exhausted, and that MCNA could not process the appeal. This case was removed from the sample.											
OS2	***	11/09/20	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	Yes ☐ No ☒	Yes ☐ No ☒	11/20/20	M ☒ N ☐	M ☐ N ☐ NA ☒	M ☒ N ☐	M ☒ N ☐
	Comments: This was a denied request for orthodontic services that was upheld. Acknowledgement was sent 11/09/20.											
OS3	***	01/22/21	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	Yes ☐ No ☒	Yes ☐ No ☒	02/04/21	M ☒ N ☐	M ☐ N ☐ NA ☒	M ☒ N ☐	M ☒ N ☐
	Comments: This was a denied request for a crown that was upheld. Acknowledgement was sent 01/22/21.											

1	2	3	4	5	6	7	8	9	10	11	12	13
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 10 Calendar Days (XIII.14)	Decision Maker Not Previous Level (XIII.11)	Decision Maker Has Clinical Expertise (XIII.11)	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame (XIII.16)	If Expedited, Reasonable Effort-Verbal Notice (XIII.16)	Resolution Letter Includes Required Content (XIII.18)	Resolution Letter Easy to Understand (XIII.18)
Do not score shaded columns below.												
Column Subtotal of Applicable Elements			10	10	10				10	0	10	10
Column Subtotal of Compliant (Met) Elements			10	10	10				10	0	10	10
Percent Compliant (Divide Met by Applicable)			100%	100%	100%				100%	NA	100%	100%

Key: M = Met; N = Not Met (scored elements)
NA = Not Applicable
Yes; No = Not scored—information only
*** = Redacted Member ID

Total Applicable Elements	60
Total Compliant (Met) Elements	60
Total Percent Compliant	100%

Denials Record Review Tool

Review Period:	July 1, 2020–June 30, 2021
Date of Review:	September 16–17, 2021
Reviewer:	Amy Lewis

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date of Initial Request	Type of Request (Standard or Expedited)	Date NABD Sent	Time Frame Extended	If Extended, Notice of Extension Meets Requirement	Notice Given to Requesting Provider (written not needed) (VII.11)	Decision Maker Has Clinical Expertise (VII.8)	Notice Sent Within Time Frame (VII.14)	NABD Includes Required Content (VII.18)	NABD Easy to Understand (VII.17)
1	***	09/10/20	S ☒ E ☐	09/14/20	Y ☐ No ☒	M ☐ N ☐ NA ☒	M ☒ N ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☐ N ☒ NA ☐
Comments: Sealant—Adult. Denied due to medical necessity. 9.8 grade reading level for denial reason.											
2	***	10/09/20	S ☒ E ☐	10/13/20	Y ☐ No ☒	M ☐ N ☐ NA ☒	M ☒ N ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☐ N ☒ NA ☐
Comments: Crown, scaling, root planing. Administrative denial and lack of information. 10th grade reading level for denial reason.											
3	***	10/14/20	S ☒ E ☐	10/16/20	Y ☐ No ☒	M ☐ N ☐ NA ☒	M ☒ N ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☐ N ☒ NA ☐
Comments: Braces. Denied due to medical necessity. 10th grade reading level for denial reason.											
4	***	01/14/21	S ☒ E ☐	01/19/21	Y ☐ No ☒	M ☐ N ☐ NA ☒	M ☒ N ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☐ N ☒ NA ☐
Comments: Space maintainer. Denied due to medical necessity. 9.7 grade reading level for denial reason.											
5	***	02/10/21	S ☒ E ☐	02/12/21	Y ☐ No ☒	M ☐ N ☐ NA ☒	M ☒ N ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☐ N ☒ NA ☐
Comments: Partial denture. Denied due to benefit limitation. 10.4 grade reading level for denial reason.											
6	***	03/16/21	S ☒ E ☐	03/19/21	Y ☐ No ☒	M ☐ N ☐ NA ☒	M ☒ N ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☐ N ☒ NA ☐
Comments: Braces. Denied due to medical necessity. 8.4 grade reading level for denial reason.											
7	***	04/19/21	S ☒ E ☐	04/22/21	Y ☐ No ☒	M ☐ N ☐ NA ☒	M ☒ N ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐
Comments: Post and crown. Administrative denial. 5.8 grade reading level for denial reason.											
8	***	05/11/21	S ☒ E ☐	05/13/21	Y ☐ No ☒	M ☐ N ☐ NA ☒	M ☒ N ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☐ N ☒ NA ☐
Comments: Hospital call. Denied due to lack of information. 10.1 grade reading level for denial reason.											

Appendix B. Record Review Tools
Nebraska Department of Health and Human Services
Contract Year 2021–2022 MCE Compliance Review
for Managed Care of North America, Inc.

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date of Initial Request	Type of Request (Standard or Expedited)	Date NABD Sent	Time Frame Extended	If Extended, Notice of Extension Meets Requirement	Notice Given to Requesting Provider (written not needed) (VII.11)	Decision Maker Has Clinical Expertise (VII.8)	Notice Sent Within Time Frame (VII.14)	NABD Includes Required Content (VII.18)	NABD Easy to Understand (VII.17)
9	***	05/12/21	S ☒ E ☐	05/13/21	Y ☐ No ☒	M ☐ N ☐ NA ☒	M ☒ N ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☐ N ☒ NA ☐
Comments: Buccal/Labial Frenectomy. Denied due to medical necessity. 8.1 grade reading level for denial reason.											
10	***	06/02/21	S ☐ E ☐	06/02/21	Y ☐ No ☐	M ☐ N ☐ NA ☐	M ☐ N ☐	M ☐ N ☐ NA ☐	M ☐ N ☐ NA ☐	M ☐ N ☐ NA ☐	M ☐ N ☐ NA ☐
Comments: Extractions. Administrative denial—not a MCNA member. This case was removed from the sample and replaced with an oversample case.											
OS1	***	12/28/20	S ☒ E ☐	12/29/20	Y ☐ No ☒	M ☐ N ☐ NA ☒	M ☒ N ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐	M ☐ N ☒ NA ☐
Comments: Periodontal maintenance. Denied due to lack of information. 11.8 grade reading level for denial reason.											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements						**10**	**10**	**10**	**10**	**10**	**10**
Column Subtotal of Compliant (Met) Elements						**0**	**10**	**10**	**10**	**10**	**1**
Percent Compliant (Divide Met by Applicable)						**NA**	**100%**	**100%**	**100%**	**100%**	**10%**

Key: M = Met; N = Not Met (scored elements)
NA = Not Applicable
Y = Yes; No (These are not scored elements—for information only)
NABD = Notice of Adverse Benefit Determination
*** = Redacted Member ID

Total Applicable Elements	**50**
Total Compliant (Met) Elements	**41**
Total Percent Compliant	**82%**

Grievances Record Review Tool

Review Period:	July 1, 2020–June 30, 2021
Date of Review:	September 16–17, 2021
Reviewer:	Barbara McConnell

1	2	3	4	5	6	7	8	9	10
File #	**Member ID #**	**Date Grievance Received**	**Acknowledgement Sent Within 10 Calendar Days**	**Date of Written Disposition**	**# of Days to Notice**	**Resolved and Notice Sent in Time Frame***	**Decision Maker Not Previous Level**	**Appropriate Level of Expertise (if Clinical)**	**Resolution Letter Easy to Understand**
1	***		M ☐ N ☐ NA ☐			M ☐ N ☐	M ☐ N ☐ NA ☐	M ☐ N ☐ NA ☐	M ☐ N ☐ NA ☐
Comments: This was a denied request for a crown that was upheld. An adverse benefit determination was sent to the member; however, this was processed as a grievance and therefore the resolution letter did not contain State fair hearing rights as required. Since this should have been processed as an appeal, this case was removed from the sample.									
2	***	10/05/20	M ☒ N ☐ NA ☐	10/14/20	9	M ☒ N ☐	M ☐ N ☐ NA ☒	M ☐ N ☐ NA ☒	M ☒ N ☐ NA ☐
Comments: This is a grievance regarding a member filing an oral appeal indicating that she did not receive the appeal form she thought the customer service representative had agreed to send. The member stated that she had been having difficulties reaching the appeals department to follow up. Acknowledgement was sent 10/06/20. As a result, the appeal was received after the 60-day filing time frame. The resolution stated that the appeal could not be processed; however, the member was informed that the provider may not bill her and stated that the appeal form would be included with all denial letters in the future. The letter stated that "denied services that have been completed cannot be appealed." During the interview, MCNA staff members clarified that only preservice denials can be appealed since MCNA does not send NABDs for claims denials. HSAG informed MCNA that this practice is out of compliance. NABDs must be sent for any decision to deny payment for a service. (See Standard XIII, Requirement 15 of the Compliance Monitoring Tool.)									
3	***		M ☐ N ☐ NA ☐			M ☐ N ☐	M ☐ N ☐ NA ☐	M ☐ N ☐ NA ☐	M ☐ N ☐ NA ☐
Comments: This case was an appeal related to a claims denial for services when the member was in Medicaid fee-for-service (FFS) but not yet enrolled in MCNA. Given that, in essence this was an appeal, and on the service date, the member was not enrolled in MCNA. This case was removed from the sample. (MCNA staff did assist the member in verifying how to handle the appeal with DHHS.)									
4	***	01/22/21	M ☒ N ☐ NA ☐	None	Not resolved	M ☐ N ☒	M ☐ N ☐ NA ☒	M ☐ N ☐ NA ☒	M ☐ N ☒ NA ☐
Comments: This was a complaint regarding a dentist who submitted a claim for services not rendered. Acknowledgement sent 01/26/21. On 02/16/21 MCNA sent a letter to the member stating that the case needs further review and will be sent to the appropriate department. The member did not receive any further resolution.									
5	***	02/26/21	M ☒ N ☐ NA ☐	04/02/21	35	M ☒ N ☐	M ☐ N ☐ NA ☒	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐
Comments: The member complained that the dentist was refusing to re-line her bottom denture until July. Acknowledgement was sent 03/01/21. The MCNA representative worked with the provider and explained that the service would be covered and directed him to send a service request.									

1	2	3	4	5	6	7	8	9	10
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 10 Calendar Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame*	Decision Maker Not Previous Level	Appropriate Level of Expertise (if Clinical)	Resolution Letter Easy to Understand
6	***	03/16/21	M ☒ N ☐ NA ☐	04/14/21	29	M ☒ N ☐	M ☐ N ☐ NA ☒	M ☐ N ☐ NA ☒	M ☒ N ☐ NA ☐
Comments: Member was unhappy with treatment received. The MCNA representative provided a list of alternative providers. Acknowledgement sent 03/16/21.									
7	***		M ☐ N ☐ NA ☐			M ☐ N ☐	M ☐ N ☐ NA ☐	M ☐ N ☐ NA ☐	M ☐ N ☐ NA ☐
Comments: Member requested an appeal, stating that a service was being denied due to frequency rules. The member stated that the previous provider had not completed the service. MCNA verified that the previous provider had returned the payment, then contacted the new provider to assist in resubmitting an authorization. Although the member complained about the previous provider not having completed the work, the essence of the call was to appeal the denial of the lower denture. This case should have been processed as an appeal and was removed from the sample.									
8	***	05/06/21	M ☒ N ☐ NA ☐	05/24/21	18	M ☒ N ☐	M ☐ N ☐ NA ☒	M ☐ N ☐ NA ☒	M ☒ N ☐ NA ☐
Comments: This complaint was about the quality of service provided by a dentist's office and that the office did not address the issue immediately. Acknowledgement was sent 05/07/21.									
9	***	05/18/21	M ☒ N ☐ NA ☐	07/01/21	44	M ☒ N ☐	M ☐ N ☐ NA ☒	M ☒ N ☐ NA ☐	M ☒ N ☐ NA ☐
Comments: This complaint was regarding a dentist who did not explain the process of performing fillings, and the member left still in pain. She subsequently saw another dentist who told her the fillings were done incorrectly and that she needed a crown due to damage to the tooth. Acknowledgement was sent 05/19/21. Notes indicate a quality of care issue was found and MCNA plans to follow up with the previous provider. The resolution letter to the member appropriately explained the confidentiality of the peer review process and assured her that MCNA will follow up with the previous provider.									
10	***	06/15/21	M ☒ N ☐ NA ☐	07/08/21	23	M ☒ N ☐	M ☐ N ☐ NA ☒	M ☐ N ☐ NA ☒	M ☒ N ☐ NA ☐
Comments: The member complained that the facility submitted a claim for dentures that she did not receive. She is requesting to receive dentures. Acknowledgement sent 06/18/21. Dentist notes were attached to the claim. The provider has since retired. MCNA informed the member of the benefit to obtain replacement for lost dentures.									
OS 1	***	10/05/20	M ☒ N ☐ NA ☐	10/13/20	8	M ☒ N ☐	M ☐ N ☐ NA ☒	M ☐ N ☐ NA ☒	M ☒ N ☐ NA ☐
Comments: The member complained that the dentist's office informed him he would be billed for a partial. Acknowledgement was sent 10/06/20.									
OS 2	***	11/04/20	M ☒ N ☐ NA ☐	11/23/20	19	M ☒ N ☐	M ☐ N ☐ NA ☒	M ☐ N ☐ NA ☒	M ☒ N ☐ NA ☐
Comments: The member complained that the provider initially told him that a crown had been denied by MCNA. Acknowledgement was sent 11/05/20. After the member verified from MCNA that the crown had been approved, he called the provider back. The member stated that at this point the provider told him he did not like what MCNA would pay and that the member does not need the crown anyway. MCNA contacted the provider who confirmed that a filling was provided and that the crown was not medically necessary. The provider admitted that he may have mentioned that he was not happy with the Medicaid fee schedule. The member obtained a second opinion from another provider who agreed that the crown was not medically necessary. As a result, the member called MCNA to withdraw the grievance. A letter was sent to confirm that the member had withdrawn the grievance.									

1	2	3	4	5	6	7	8	9	10
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 10 Calendar Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame*	Decision Maker Not Previous Level	Appropriate Level of Expertise (if Clinical)	Resolution Letter Easy to Understand
OS 3	***	01/29/21	M ☒ N ☐ NA ☐	02/19/21	21	M ☒ N ☐	M ☐ N ☐ NA ☒	M ☐ N ☐ NA ☒	M ☒ N ☐ NA ☐
Comments: The member complained that she never received the partial because it did not fit, and the provider took it back to his office. MCNA worked with the provider to recoup payment so the member's benefit could be reset. Acknowledgement was sent 02/01/21.									
Do not score shaded columns below.									
Column Subtotal of Applicable Elements			**10**			**10**	**0**	**2**	**10**
Column Subtotal of Compliant (Met) Elements			**10**			**9**	**0**	**2**	**9**
Percent Compliant (Divide Met by Applicable)			**100%**			**90%**	**NA**	**100%**	**90%**

Key: M = Met; N = Not Met
NA = Not Applicable
* Grievance timeline for resolution and notice sent is 90 calendar days (unless extended).
*** = Redacted Member ID

Total Applicable Elements	**32**
Total Compliant (Met) Elements	**30**
Total Percent Compliant	**94%**

Appendix C. Compliance Review Participants

Table C-1 lists the participants in the CY 2020–2021 compliance review of MCNA.

Table C-1—HSAG Reviewers, MCNA, and DHHS Participants

HSAG Review Team	Title
Barbara McConnell	Executive Director
Amy Lewis	Director
Gina Stepuncik	Associate Director
MCNA Participants	**Title**
Brittany Martin	Operations Analyst/Contract Compliance Coordinator —NE
Richard Hearon	Operations Manager/Contract Compliance Coordinator—NE
Colleen Grace	Associate Vice President (VP) of Operations
Shannon Turner	Executive VP
Meghan Gardner	Director of Utilization Management and Case Management
DeDe Davis	VP, Dental Management and Quality Improvement
Kendra Aracena	Director of Quality Improvement
Vonnie Schaeffer	Senior Manager, Claims
Mayre Herring	Chief Compliance Officer
Leeona Ramdat	Regulatory Compliance Manager
Daniel Acqloue	Special Projects Manager
Cheryl Stephens	Credentialing Manager
Jaclyn Brown	Program Integrity Officer
Kelly Giger	Grievances and Appeals Manager—NE
Jolie Greaux	Corporate Compliance Coordinator
Mary Laughlin	Director of Grievance & Appeals
Rebecca Hoover	Communications Design Manager
Rene Canales	VP, Network Development & Provider Engagement
Ricky Ann Fletcher	Provider Relations Manager Tribal Liaison, Federally Qualified Health Center (FQHC) Provider Relations
Shawn Zielinske	Director of Training and Quality Assurance
Theresa Sanchirico	Credentialing Supervisor

MCNA Participants	Title
Tiffany Cooper	Compliance and Privacy Director
Dr. Linda Altenhoff	VP, Program Integrity
Jeanette Logan	Client Services Manager
DHHS Observer	**Title**
Abigail Anderson	Plan Management Administrator

Appendix D. Corrective Action Plan Template for CY 2021–2022

If applicable, the MCE is required to submit a CAP to HSAG for all elements within each standard scored as *Not Met*. The CAP must be submitted within 60 days of receipt of the final report. For each required action, the MCE should identify the planned interventions and complete the attached CAP template. Following HSAG and DHHS approval, the MCE must submit documents as evidence of planned intervention implementation, according to the approved timeline as indicated in the completed CAP.

Table D-1—Corrective Action Plan Process

Step	Action
Step 1	**Corrective action plans are submitted**
	If applicable, the MCE will submit a CAP to HSAG and DHHS within 60 calendar days of receipt of the final compliance review report via email or through the file transfer SAFE site, with an email notification to HSAG and DHHS. The MCE must submit the CAP using the template provided (see page 3 of this appendix). For each element receiving a score of *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with those activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 60 days**
	If the MCE is unable to submit the plan for corrective actions within 60 calendar days following receipt of the final report, it must obtain prior approval from DHHS in writing.
Step 3	**Department approval**
	Following review of the CAP, DHHS and HSAG will: • Approve the planned interventions and instruct the MCE to proceed with implementation, or • Instruct the MCE to revise specific planned interventions and/or other components of the plan and also to proceed with implementation.
Step 4	**Documentation substantiating implementation**
	Once the MCE has received DHHS approval of the CAP, the MCE must complete the planned interventions within the time frames it indicated in the plan and were approved. Once all planned interventions are complete the MCE will submit documents that provide evidence of implementation of those interventions.
Step 5	**Technical Assistance**
	At the MCE's request, HSAG will schedule an interactive, verbal consultation and technical assistance session at any time following the receipt of the final report. The session may be scheduled at the MCE's discretion at any time the MCE determines would be most beneficial.

Step	Action
Step 6	**Review and completion**
	Following a review of the CAP and all supporting documentation, HSAG will inform the MCE as to whether or not the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements. Any documentation that is considered unsatisfactory to bring the MCE into full compliance with the requirement may be revised and resubmitted. HSAG will continue to work with the MCE until all required actions are satisfactorily completed.

The CAP template follows.

Table D-2—CY 2020–2021 Corrective Action Plan for MCNA

Standard III—Member Information		
Requirement	**Findings**	**Required Action**
4. The MCE makes written materials that are critical to obtaining services available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • All written materials for members must: – Use a font size no smaller than 12 point. – Be available in alternative formats and through provision of auxiliary aids and service that takes into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines for written materials critical to obtaining services printed in large print (conspicuously visible font size) and the prevalent non-English language describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and Telecommunications Device for the	Within its member handbook, MCNA did not include conspicuously visible taglines in its non-English prevalent language (Spanish).	MCNA must update the member handbook to include conspicuously visible taglines in Spanish. HSAG recommends that MCNA use the same content used in its English tagline.

Standard III—Member Information		
Requirement	**Findings**	**Required Action**
Deaf/TeleTYpewriter (TTY/TDY) customer service number. – Inform of the availability of the materials in alternative formats. *42 CFR §438.10(d)(3);(6)* MCO Contract: IV(F)(4)(h); IV(F)(3)(c); IV(F)(4)(k); IV(F)(4)(e-f) DBM Contract: IV(G)(16)		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard III—Member Information		
Requirement	**Findings**	**Required Action**
5. If the MCE makes information available electronically—Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of readily accessible above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five business days. *42 CFR §438.10(c)(6)* MCO Contract: IV(F)(10); IV(F)(4); IV(F)(5); IV(F)(6) DBM Contract: IV(G)(15-16)	MCNA's website did not include a notice that the information found on the website is available in paper form without charge upon request and will be provided within five business days.	MCNA must update its website to include a notice to the member that this information is available in paper form without charge upon request and will be provided within five business days.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard III—Member Information		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard III—Member Information		
Requirement	**Findings**	**Required Action**
18. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and fair hearing procedures and time frames. For grievances and appeals: • Definitions of "grievance" and "appeal." • The right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The availability of assistance in the filing processes. • The toll-free number(s) members can use to file a grievance or an appeal by telephone. • The fact that, when requested by the member: – Benefits that the MCE seeks to reduce or terminate will continue if the member files an appeal within the time frames specified for filing. – If benefits continue during the appeal process, the member may be required to pay the cost of those services if the final decision is adverse to the member. For State fair hearings: • The definition of "State fair hearing."	Within its member handbook, MCNA did not include all required information about State fair hearings.	MCNA must update its member handbook to include the following information: • The availability of assistance to request a State fair hearing. • The fact that, when requested by the member: – Benefits that the MCE seeks to reduce or terminate will continue if the member files a request for a State fair hearing within the time frames specified for filing. If benefits continue during the appeal process, the member may be required to pay the cost of those services if the final decision is adverse to the member.

Standard III—Member Information		
Requirement	**Findings**	**Required Action**
• The right to a request a State fair hearing after the MCE has made a determination on a member's appeal which is adverse to the member. • The requirements and time frames for requesting a State fair hearing. • The availability of assistance to request a State fair hearing. • The fact that, when requested by the member: – Benefits that the MCE seeks to reduce or terminate will continue if the member files a request for a State fair hearing within the time frames specified for filing. – If benefits continue during the appeal process, the member may be required to pay the cost of those services if the final decision is adverse to the member. *42 CFR §438.10(g)(2)(xi)* MCO Contract: IV(F)(5)(f) DBM Contract: IV(G)(14)(f)		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard III—Member Information		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VII—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
15. If the MCE denies payment for a service, in whole or in part, the MCE mails the notice of adverse benefit determination at the time of any denial affecting the claim. *42 CFR §438.404(c)* MCO Contract: IV(H)(3)(c)(iv) DBM Contract: IV(H)(3)(c)(iv)	Although MCNA's Adverse Benefit Determination policy included the provision to send members notification of claims denials, during the interview, MCNA staff members stated that NABDs are not sent for claims denials. During the grievance record review, HSAG found several cases that were processed as grievances which should have been treated as appeals as they were related to claims denials. In absence of the NABD, staff processed the members' calls as grievances. Grievance resolution letters do not contain State fair hearing rights; therefore, it is important that members receive the appropriate notifications so that their subsequent communications can proceed correctly and afford members the appropriate due process.	MCNA must develop a mechanism to send members an NABD at the time of any decision to deny payment for a service, in whole or in part.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VII—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
16. If the MCE proposes to reduce, suspend, or terminate a previously authorized Medicaid-covered service, the MCE gives advance notice (notice of adverse benefit determination) at least 10 days before the proposed effective date except when: • The MCE gives notice on or before the date of action if: – The agency has factual information confirming the death of a member. – The agency receives a clear written statement signed by the member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information. – The member has been admitted to an institution where he or she is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns agency mail directed to him or her indicating no forwarding address. – The agency establishes the fact that the member has been accepted for	MCNA did not submit a policy that included the requirement for a 10-day advance notice if MCNA proposes to terminate, reduce, or suspend services currently being received by the member. During the interview, MCNA staff members stated that once a service is authorized, MCNA would not seek to terminate the services prior to the end of the authorization period.	HSAG recognizes that these situations may be rare for a DBM; however, MCNA must have processes in place if a situation such as this does occur. MCNA must revise policies and procedures and develop a mechanism to ensure that if MCNA proposes to terminate, suspend, or reduce previously authorized services prior to the end of the authorization period, it provides a 10-day advance notice of such termination or change to the service.

Standard VII—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
Medicaid services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the MCE gives notice five calendar days before the date of action. *42 CFR §438.404(c); 431.211; 431.213; 431.214* MCO Contract: IV(H)(3)(c)(i-iii) DBM Contract: IV(H)(3)(c)(i-iii)		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VII—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
17. The notice of adverse benefit determination must be in writing and meet the language and format requirements of 42 CFR §438.10(c). *42 CFR §438.404(a)* MCO Contract: IV(H)(3)(b)(iii) DBM Contract: IV(H)(3)(b)(iii)	While MCNA consistently sent the NABD in writing in 10 of the 10 denial records reviewed, HSAG found that only one of the 10 NABDs reviewed was written at a 6.9 grade reading level as required by MCNA's contract with DHHS.	MCNA must develop a mechanism to ensure that NABDs are written at a 6.9 grade reading level (to the extent possible) as required by MCNA's contract with DHHS.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Findings**	**Required Action**
3. The MCE's written agreement with any subcontractor must include: • The subcontractor's agreement to comply with all applicable Medicaid laws and regulations, including applicable subregulatory guidance and contract provisions. *42 CFR §438.230(c)(2)* MCO Contract: IV(K)(1) DBM Contract: IV(K)	HSAG reviewed a written delegation agreement in place with Fiserv. The agreement did not include required details regarding compliance with Medicaid laws and regulations, applicable subregulatory guidance, or contract provisions.	MCNA must update all written delegation agreements to include the required language from 42 CFR §438.230(c)(2).
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Findings**	**Required Action**
4. The written agreement with the subcontractor must include provisions that: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's MCE, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCE's contract with the State. • The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to Medicaid members. • The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. • If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.	HSAG reviewed a written delegation agreement in place with Fiserv. The agreement did not include the language required by 42 CFR §438.230(c)(3).	MCNA must update all written delegation agreements to include the following language: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's MCE, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCE's contract with the State. • The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to Medicaid members. • The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. • If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Findings**	**Required Action**
42 CFR §438.230(c)(3) MCO Contract: IV(K)(1) DBM Contract: IV(K)		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard XIII—Grievance and Appeal System		
Requirement	**Findings**	**Required Action**
9. The MCE must resolve each grievance and provide notice as expeditiously as the member's health condition requires, within 90 calendar days from the day on which the MCE receives the grievance. • Notice to the member must be in writing and in a format and language that may be easily understood by the member. *42 CFR §438.408(a); (d)(1)* MCO Contract: IV(H)(2)(c); IV(H)(2)(d) DBM Contract: IV(H)(2)(c); IV(H)(3)(i)	In one grievance case reviewed, MCNA deemed the case a quality of care concern and sent it to the quality department for further review. MCNA sent a letter to the member stating that this case needs more time to review (see case number 4 of the grievance record review). It was unclear whether this letter was intended to be a resolution letter. There was no further communication to resolve this case. HSAG recognizes that if this case was handled as a peer review, the information is protected; however, a resolution from the member's perspective must be sent. In another case reviewed, this type of situation was handled with the member more clearly (see case number 9 in the appeal record review).	MCNA must ensure that communication sent to the member provides a resolution in clear terms that are easily understood.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard XIII—Grievance and Appeal System		
Requirement	**Findings**	**Required Action**
19. The member may request a State fair hearing after receiving notice that the MCE is upholding the adverse benefit determination, within 120 calendar days from the date of the notice of appeal resolution. • The parties to the State fair hearing include the MCE, as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR §438.408(f)(1)–(3)* MCO Contract: IV(H)(7)(a-d) DBM Contract: IV(H)(7)(a-d)	The Grievance and Appeal overview policy and the UM Appeals policy stated that the member may file for a Medicaid fair hearing within no less than 90 calendar days and no greater that 120 days of receipt of MCNA's notice of appeal determination. This statement represents a misunderstanding of the federal regulation, which states that the member must have at least 90 calendar days and no more than 120 calendar days from the date on MCNA's appeal resolution notice. MCNA's member handbook and provider manual accurately depicted the 120-day filing time frame.	MCNA must clarify its policies to ensure members are afforded the right to request a State fair hearing at any time after receiving the notice of appeal resolution, up to 120 days following the date of the appeal resolution letter.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard XIII—Grievance and Appeal System		
Requirement	**Findings**	**Required Action**
21. The MCE provides for continuation of benefits/services while the MCE-level appeal and the State fair hearing are pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the MCE mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The period covered by the original authorization has not expired. • The member requests an appeal within 60 days following the adverse benefit determination. *Note: This definition of "timely filing" only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced.* *Note: The provider may not request continuation of benefits on behalf of the member.*	While the policies submitted for this requirement correctly stated the 10-day filing time frame as filing for the continuation of benefits only, which is correct, the UM Program Description and the provider manual incorrectly stated that the member must also file for the appeal within that time frame. According to the revisions released in 2016 via the Medicaid and CHIP managed care regulations, the member need only request that services continue during the appeal within that 10-day time frame (or before the services are scheduled to change or terminate), but has the full 60-day time frame to file the appeal. In addition, MCNA had revised the 10-day timeline for requesting continuation of services during the State fair hearing to also include only requesting continuation. When a member has received continued service during an appeal and wishes to continue service during the State fair hearing, the member must request the continuation and file for the State fair hearing both within 10 days following the appeal resolution.	MCNA must revise its applicable documents to clearly state that members need only request continued services during an appeal within the 10-calendar-day time frame (or before the effective date of the termination or change in service) and has the full 60-day time frame to file the appeal; however, following the appeal, if the member requests continuation during the State fair hearing, he or she must request both the State fair hearing and continued service within 10 calendar days following the notice of appeal resolution.

Standard XIII—Grievance and Appeal System		
Requirement	**Findings**	**Required Action**
42 CFR §438.420(a);(b) MCO Contract: IV(H)(6)(a) DBM Contract: IV(H)(6)(a)		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard XIII—Grievance and Appeal System		
Requirement	**Findings**	**Required Action**
26. The MCE provides the information about the grievance, appeal, and fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the MCE has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • Toll-free numbers to use to file verbal grievances and appeals. • The member's right to request in a timely manner the continuation of services during an appeal or State fair hearing, and the fact that, when requested by the member: – Services that the MCE seeks to reduce or terminate will continue if the appeal or request for a State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair	MCNA's provider manual addressed the member grievance and appeal system; however, the manual included the following inaccuracies: • The manual stated that all appeals filed by a member or by a provider on behalf of a member must be submitted in writing. • The definition of "adverse benefit determination" in the provider manual was incomplete and was missing the denial of a member's request to dispute a member's financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other). • The manual stated that the provider may file an expedited review request verbally that must be followed up in writing. The manual stated that members who wish to request continued services during an appeal must file the appeal within 10 days following the NABD.	MCNA must ensure that the provider manual includes accurate information about the member grievance an appeal system and clarify that: • Members may file an appeal orally or in writing, and oral requests to appeal do not require written follow-up regardless of whether they are standard or expedited requests. • The definition of "adverse benefit determination" includes the denial of a member's request to dispute a member's financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other). Members who wish to continue services during the appeal must request the continuation within 10 days following the NABD, or before the intended effective date of the termination or change (whichever is later); however, the member has the full 60-day filing time frame to file the appeal.

Standard XIII—Grievance and Appeal System		
Requirement	**Findings**	**Required Action**
hearing is pending if the final decision is adverse to the member. • Any state-determined provider appeal rights to challenge the MCE's failure to cover a service. *42 CFR §438.414* MCO Contract: IV(H)(10) DBM Contract: IV(H)(10)		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		