

State of Nevada
Department of Administration

Purchasing Division

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Purchasing Division

Request for Proposal: 1988

For

MEDICAID MANAGED CARE ORGANIZATION SERVICES

Release Date: September 7, 2012

Deadline for Submission and Opening Date and Time: November 15, 2012 @ 2:00 p.m.

Refer to Section 9, RFP Timeline for the complete RFP schedule

For additional information, please contact:

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Refer to Section 10 for instructions on submitting proposals

VENDOR INFORMATION SHEET FOR RFP 1988

Vendor Must:

- A) Provide all requested information in the space provided next to each numbered question. The information provided in Sections V1 through V6 will be used for development of the contract;
- B) Type or print responses; and
- C) Include this Vendor Information Sheet in Tab III, State Documents of the Technical Proposal.

V1	Firm Name	
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V2	Street Address	
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V3	City, State, ZIP	
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V4	Telephone Number	
	Area Code:	Number:

V5	Facsimile Number	
	Area Code:	Number:

V6	Toll Free Number	
	Area Code:	Number:

V7	<i>Contact Person for Questions / Contract Negotiations, including address if different than above</i>	
	Name:	
	Title:	
	Address:	
Email Address:		

V8	Telephone Number for Contact Person	
	Area Code:	Number:

V9	Facsimile Number for Contact Person	
	Area Code:	Number:

V10	<i>Name of Individual Authorized to Bind the Organization</i>	
	Name:	Title:

V11	<i>Signature (Individual must be legally authorized to bind the vendor per NRS 333.337)</i>	
	Signature:	Date:

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A Request for Proposal process is different from an Invitation to Bid. The State expects vendors to propose creative, competitive solutions to the agency's stated problem or need, as specified below. Vendors' technical exceptions and/or assumptions should be clearly stated in *Attachment B, Technical Proposal Certification of Compliance with Terms and Conditions of RFP*. Vendors' cost exceptions and/or assumptions should be clearly stated in *Attachment P, Cost Proposal Certification of Compliance with Terms and Conditions of RFP*. Exceptions and/or assumptions will be considered during the evaluation process; however, vendors must be specific. Nonspecific exceptions or assumptions may not be considered. The State reserves the right to limit the Scope of Work prior to award, if deemed in the best interest of the State per NRS 333.350(1).

Prospective vendors are advised to review Nevada's ethical standards requirements, including but not limited to, NRS 281A and the Governor's Proclamation, which can be found on the Purchasing Division's website (<http://purchasing.state.nv.us>).

1. OVERVIEW OF PROJECT

1.1 DIVISION STRATEGIC PLAN AND OBJECTIVES

The State of Nevada, Purchasing Division, on behalf of the Division of Health Care Financing and Policy (hereinafter referred to as "DHCFP") a Division of the State of Nevada, Department of Health and Human Services (DHHS), is soliciting responses from qualified Vendors to provide risk-based capitated Managed Care Organization (Vendor) services designed in support of the Title XIX (Medicaid) and Title XXI State Child Health Insurance Program (CHIP is also known as Nevada Check Up) medical assistance programs.

Please be on notice that on the advice of the Division of Insurance pursuant to NRS 695G.090 and NRS 679A.130, et. al., Managed Care Organizations must have a Certificate of Authority for all mandatory managed care counties issued in accordance with NRS 695G in order to solicit and submit bids for this RFP. Contact the Nevada Division of Insurance for information on obtaining a Certificate of Authority.

DHCFP will contract with two (2) Vendors to provide services, in the statewide, designated areas, to Medicaid recipients determined categorically eligible under the Family Medical Categories (FMC) of Temporary Assistance to Needy Families (TANF) and Child Health Assurance Program (CHAP), as well as Nevada Check Up/CHIP recipients that will include the administration or delivery of the following services:

- 1.1.1 Maintenance of a provider network designed to encourage health care providers to deliver cost-effective quality services;
- 1.1.2 Provision of utilization review and management of health care services, and provision of treatment in accordance with established protocols and standards of care;
- 1.1.3 The implementation of peer review and other quality assurance techniques to ensure appropriate services are rendered; and

- 1.1.4 Implementation of a Benchmark Plan to address the needs of newly eligible recipients under the Patient Protection and Affordable Care Act (ACA) of 2010. The Benchmark Plan is applicable to the newly eligible childless adult recipients and will be part of the broader Medicaid plan (pending the approval of the Nevada Governor and Legislature).

A qualified Vendor is one that can deliver medically necessary covered services in an efficient and effective manner while ensuring the highest standards of performance, integrity, customer service, and fiscal accountability. DHCFP will contract with Vendors that can demonstrate their understanding of the importance of the tasks and the impact they have on the lives of Nevada Medicaid and Nevada Check Up recipients.

Currently, DHCFP contracts with two (2) Vendors in the urban areas of Washoe and Clark Counties. Other areas may become mandatory managed care during the course of this contract and are to be considered as covered for this Request for Proposal. The DHCFP managed care program, through the use of Vendors, has been in effect since April of 1997. The current Vendor contracts have been in place since November 1, 2006.

In order to facilitate the vendor's response to this RFP, various supporting Medicaid and Nevada Check Up data has been provided in *Attachment N, Data Book*.

The contract resulting from this RFP shall be effective from July 1, 2013, to June 30, 2017. An open enrollment process will be conducted prior to full implementation of all contracts that result from this RFP.

1.2 GOALS – MISSION STATEMENT

The mission of the Nevada Division of Health Care Financing and Policy (Nevada Medicaid and Nevada Check Up) is to: purchase and provide quality health care services to low-income Nevadans in the most efficient manner; promote equal access to health care at an affordable cost to the taxpayers of Nevada; restrain the growth of health care costs; and review Medicaid and other State health care programs to maximize potential federal revenue.

The mission of DHCFP in this procurement is to improve the health of Nevadans by:

- 1.2.1 Emphasizing preventive care and appropriate utilization;
- 1.2.2 Enhancing continuity of care through integrated medical and social case management;
- 1.2.3 Ensuring a medical home for Medicaid and Nevada Check Up recipients; and
- 1.2.4 Ensuring that each recipient can access high quality, comprehensive healthcare services within the recipient's service area.

DHCFP will accomplish this mission by contracting for measurable results that improve recipient access, recipient satisfaction; maximize program efficiency, effectiveness, integrity, and responsiveness; and reduce operational costs.

1.3 DIVISION STRATEGIC PLAN AND OBJECTIVES

- 1.3.1 Primary factors that are creating significant areas of change within DHCFP and the medical assistance programs are:
 - 1.3.1.1 Procurement for risk based capitated rate Vendor contracts;
 - 1.3.1.2 The implementation of the provisions of the ACA and the establishment of a Benchmark Plan for new Medicaid eligible (pending the approval of the Nevada Governor and Legislature);
 - 1.3.1.3 Coordination with the State and/or Federal Health Insurance Exchange, as directed by the Nevada Governor and the Legislature, to ensure smooth transitions between Medicaid and the HIX; and
 - 1.3.1.4 Cost-containment/avoidance initiatives.
- 1.3.2 Enrollment in managed care is mandatory in urban Washoe and Clark Counties for TANF/CHAP Medicaid recipients. The objectives of this procurement are to:
 - 1.3.2.1 Improve recipient access to medically necessary covered services;
 - 1.3.2.2 Provide recipients choices for managed health care;
 - 1.3.2.3 Manage utilization of services through case management and effective outreach programs;
 - 1.3.2.4 Reduce operational costs;
 - 1.3.2.5 Incorporate managed care encounter data (shadow claims) into the existing MMIS;
 - 1.3.2.6 Streamline and simplify the Medicaid and Nevada Check Up health care program administration;
 - 1.3.2.7 Provide and implement a process for continuous quality improvement; and
 - 1.3.2.8 Minimize the occurrence of fraud, abuse, and waste in the Medicaid and Nevada Check Up programs.

The successful Vendor will demonstrate the ability to consistently meet these objectives and will be evaluated, in part, by the degree to which the Vendor demonstrates how it will achieve these objectives through measurable outcome data.

1.4 HOW MEDICAID AND NEVADA CHECK UP OPERATE IN NEVADA

- 1.4.1 DHCFP administers the Medicaid and Nevada Check-Up Programs in accordance with the applicable Title XIX and Title XXI State Plans, all applicable Nevada Revised Statutes (NRS), the Social Security Act, Code of Federal Regulations

(CFR's), the United States Code (USC) and the Nevada Administrative Code (NAC). DHCFP may adopt such regulations and policies as deemed necessary and may also amend the Title XIX or Title XXI State Plans at its sole discretion, in accordance with federal law.

1.4.2 In addition to the State Plan services, the Medicaid program includes a number of Waiver categories, which are as follows:

1.4.2.1 The Waiver for Persons with Mental Retardation and Related Conditions – Administered by DHCFP and operated by the State of Nevada, Division of Mental Health and Developmental Services Division (MHDS);

1.4.2.2 The Waiver for the Frail Elderly - Administered by DHCFP and operated by the State of Nevada, Aging and Disability Services Division (ADSD);

1.4.2.3 The Waiver for People with Disabilities – Administered and operated by DHCFP;

1.4.2.4 The Assisted Living Waiver – Administered and operated by the ADSD; and

1.4.2.5 The Nevada Comprehensive Care Management Waiver (pending CMS approval) - Administered by DHCFP.

1.4.3 An Administrator, appointed by the Director of Health and Human Services (DHHS), manages DHCFP, under whose authority the following sections operate:

1.4.3.1 Compliance Unit;

A. Hearings

B. Recipient Civil Rights (including HIPAA) Surveillance Utilization Review Subsystem (SURS)

C. Medicaid Estate Recovery (MER)

D. Policy

1.4.3.2 Information Services Unit;

1.4.3.3 Program Administration Section;

1.4.3.4 Continuum of Care Unit;

1.4.3.5 Business Lines Unit;

- 1.4.3.6 Program Services Unit;
- 1.4.3.7 Grants Management Unit; and
- 1.4.3.8 District Offices Unit.
- 1.4.3.9 Fiscal Services Section
 - A. Accounting & Budget Unit;
 - B. Rates & Cost Containment Unit; and
 - C. Personnel Unit.
- 1.4.4 Nevada operates both a fee-for-service system and managed care delivery system. The State of Nevada's Medicaid and Nevada Check Up managed care program and services for Non-Emergency Transportation (NET) broker program are monitored by DHCFP's Business Lines Unit.
- 1.4.5 The DHCFP's managed care program currently offers a risk-based capitated rate program operated through contracts with Managed Care Organizations (Vendors). DHCFP contracts with Vendors to provide covered medically necessary services for eligible recipients at an established risk-based capitation rate.
- 1.4.6 Enrollment in a managed care organization is mandatory for TANF/CHAP recipients when there is more than one managed care option from which to choose in a particular geographic service area. Managed care enrollment is mandatory for all CHIP recipients when an option is available in their service area.
- 1.4.7 The eligibility and enrollment functions for the Medicaid and Nevada Check Up programs are the responsibility of DHCFP and the Division of Welfare and Supportive Services (DWSS). The DWSS determines Medicaid recipient eligibility for the TANF/CHAP programs, while DHCFP makes eligibility determinations for the Nevada Check Up program.
- 1.4.8 DHCFP currently contracts with a fiscal agent for fee-for-service (FFS) claims processing and related functions and a Quality Improvement Organization-like Vendor (QIO) for FFS payment authorization, concurrent and retrospective review and related functions. Other independent contractors provide services, which include but are not limited to external quality review, actuarial services, non-emergency transportation (NET) services, and other clinical and administrative services.
- 1.4.9 The DHCFP Medical Care Advisory Committee (MCAC) was established, in accordance with 42 CFR 431.12, to ensure adequate community and provider input is obtained regarding decisions affecting the levels and types of services covered under the program.

The MCAC is comprised of nine (9) members who include, but are not limited to, health care professionals, other providers, and consumers, all of whom offer specialized advice on various components of the program.

1.5 CONTRACTING FOR RESULTS

DHCFP's fundamental commitment is to contract for results. A successful result is defined as the generation of discrete, defined, measurable, and beneficial outcomes that support its mission and objectives and satisfy the requirements of the resulting contract. DHCFP expects potential Vendors to prescribe specific solutions that will achieve DHCFP's objectives and the service levels described elsewhere in this RFP. Simply put, this RFP describes what is required and places the responsibility for how it is accomplished on the Vendor. Vendors should consider and identify cost saving and cost-avoidance methods and measures when developing their proposals.

1.6 REPRESENTATIONS

1.6.1 DHCFP will consider all representations contained in a proposal as the Vendor's response to this RFP. DHCFP will also consider any oral or written presentations, correspondence, discussions, and negotiations as representations of the Vendor's expertise in performing similar activities for entities such as DHCFP. DHCFP accepts these representations as inducements to enter into a mutually beneficial relationship with the Vendor under the terms and conditions of this RFP.

1.6.2 Any contract resulting from this RFP shall consist of this Request for Proposal, any addenda thereto, the Vendor's technical proposal and the cost proposal (*Attachment O*) submitted in response to the RFP. In the event of a conflict in language between the documents referenced above, the provisions and requirements set forth and/or referenced in the Request for Proposal and addenda shall govern.

1.6.3 If a proposal is silent regarding an RFP requirement, then DHCFP assumes that the Vendor will meet that requirement at no additional cost. However, DHCFP reserves the right under its sole discretion to waive the conflict in writing. Such written clarification shall govern in case of conflict with the applicable requirements stated in the RFP, any addenda thereto, or the Vendor's proposal. In all other matters not affected by the written clarification, the RFP and addenda shall govern.

1.6.4 This RFP is intended to solicit proposals for a contract.

1.7 MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

The DHHS implemented a Medicaid Management Information System (MMIS) in October 2003.

1.7.1 The MMIS ensures that all elements of the process flows, requirements, interfaces and reports, support claims and encounter data processing, capitated

payments, information needs, and include the ability to support multiple claims systems.

1.7.2 The MMIS Claims Processor incorporates all FFS and managed care capitated payments and the various stand-alone applications including the following databases:

- 1.7.2.1 Nevada Check Up;
- 1.7.2.2 Hospital Health Care;
- 1.7.2.3 Surveillance/Utilization Review Subsystem (SURS);
- 1.7.2.4 Notices of Decision (NODs);
- 1.7.2.5 Hospice;
- 1.7.2.6 High Risk Pregnancy Data and Care Coordination;
- 1.7.2.7 Health Care Cost Containment, Pharmacy; and
- 1.7.2.8 The Home and Community Based Waiver Services.

1.7.3 The MMIS Vendor provides the following administrative functions:

- 1.7.3.1 Provider Relations / Training;
- 1.7.3.2 Third Party Liability Recovery (TPL) for the FFS program only;
- 1.7.3.3 FFS Payment Authorization Requests;
- 1.7.3.4 Pre-Admission Screening and Resident Review (PASRR);
- 1.7.3.5 Provider Audits, including: Nursing Facility (NF); Intermediate Care Facility for the Mentally Retarded (ICF/MR); Hospital; Federally Qualified Health Center (FQHC); and, Rural Health Clinic (RHC);
- 1.7.3.6 FFS Medical Claims Review;
- 1.7.3.7 Operation of the Drug Rebate Program;
- 1.7.3.8 Eligibility engine, which will provide eligibility determination functions for Medicaid, Nevada Check Up, and the Silver State Health Insurance Exchange; and
- 1.7.3.9 Data warehousing and counter data collection (under development).

1.8 COORDINATION WITH THE STATE-DESIGNATED HEALTH INSURANCE EXCHANGE (HIX)

In addition to providing Medicaid Managed Care services, the Vendor must also provide, at a minimum; one (1) Silver and one (1) Gold Qualified Health Plan (QHP) on the Individual Exchange of the State designated Health Insurance Exchange (HIX), which could be either a State HIX or the federal HIX. Lack of a Gold and Silver QHP in the State-designated HIX will disqualify any submitted bid. The QHPs offered pursuant to this

requirement must meet the qualifications of an *MCO Transition QHP* (to distinguish these plans from other QHPs that may not meet the following standards), as described below.

The purpose of this requirement is to minimize adverse impacts and improve continuity of care of individuals and families who have a change in Medicaid or CHIP eligibility status; to minimize the negative impacts related to recipients who move, sometimes frequently, between the programs, due to changes in eligibility status. An *MCO Transition QHP* must:

- 1.8.1 Meet the requirements of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (together referred to as the Affordable Care Act or ACA) and the associated Federal regulations;
- 1.8.2 Meet the licensing requirements of the Department of Business and Industry, Division of Insurance;
- 1.8.3 Be certified as a QHP in accordance with the criteria determined by the State-designated HIX;
- 1.8.4 Be able to accept enrollees during the initial open enrollment of the State-designated HIX beginning October 1, 2013 for an initial effective date of coverage of January 1, 2014;
- 1.8.5 Use the same provider network as is available to those eligible for Medicaid in addition to any network adequacy standards set by the State-designated HIX;
- 1.8.6 Be available to consumers in the same geographic area as the geographic area served by the Vendor's MCO;
- 1.8.7 Coordinate prior authorizations and edit patterns for members who transition between the Vendor's MCO and the Vendor's QHP;
- 1.8.8 Use a formulary that is similar to that of the Vendor's MCO. If a drug or its generic equivalent is covered by the Vendor's MCO but is not covered by the *MCO Transition QHP*, the *MCO Transition QHP* must cover that drug as it would any other similar tier drug (same cost sharing) for a period of time as determined by a transition plan dictated by medical necessity, potential side effects, etc.;
- 1.8.9 Cover any benefit required to be covered by Vendor's MCOs, that is not otherwise part of Nevada's Essential Health Benefits package, for a period of time as determined by a transition plan dictated by medical necessity, potential side effects, etc.; and
- 1.8.10 Be priced reasonably as compared to other QHPs available on the Exchange. To be "priced reasonably," *MCO Transition QHP* premiums (before the Federal Advanced Premium Tax Credit is applied) must be no more than 15% greater than the median premium offered on the Exchange for similarly situated individuals (based on age, smoking status, family size and geographic location).

The Vendor is not required to offer QHPs on the SHOP Exchange of the State-designated HIX at this time. The Vendor is not required to offer platinum, bronze or catastrophic QHPs on the State-designated HIX at this time. This requirement does not preclude the Vendor from offering other QHPs at any of the metal tiers on the Individual or SHOP Exchanges within the State-designated HIX. Additionally, the Vendor may designate other QHPs (at any of the metal tiers on the Individual or SHOP Exchanges within the State-designated HIX) as *MCO Transition QHPs* if such QHPs meet the requirements described in this section. The *MCO Transition QHP* designation may be displayed on the website of the State-designated HIX where QHPs are sold, as other quality indicators may be displayed, at the discretion of the State-designated HIX.

Please provide a statement indicating your willingness to comply with this section. Please provide sample transition plans for drugs and services that may be covered by the MCO but not covered by the *MCO Transition QHP*. Please provide any additional criteria that should be included to minimize the adverse impacts of churn.

The DHCFP reserves the right to modify this Section to meet the requirements and regulations of the State and/or federal HIX, as determined by the Nevada Governor, the Nevada State Legislature, the Center for Consumer Information and Insurance Oversight (CCIIO), and/or other federal government entities.

2. OPTIONAL PROPOSAL OPPORTUNITY

2.1 OVERVIEW OF OPTIONAL OPPORTUNITY: PUBLIC EMPLOYEES BENEFIT PLAN INSURANCE COVERAGE

The State of Nevada, Purchasing Division, on behalf of the Public Employees' Benefits Program (PEBP), headquartered in Carson City, Nevada, is soliciting proposals for fully insured Health Maintenance Organization (HMO) services for all counties in the State of Nevada. Vendors may choose to bid on this optional component of the RFP.

PEBP currently contracts with two HMO's, Hometown Health Plan HMO in northern Nevada (13 counties) and Health Plan of Nevada in southern Nevada (4 counties). Dental benefits are offered through PEBP's self-funded PPO dental plan. Information about the current plan design can be found on the PEBP website at www.pebp.state.nv.us.

2.2 SCOPE

PEBP encourages Vendors to provide alternatives to the current HMO plan designs.

2.2.1 PEBP is committed to providing the highest quality health benefits with an emphasis on customer service, preventive and wellness benefits, utilization management and promoting informed health care utilization while preserving individual choices and options. PEBP is soliciting proposals from vendors who will work in partnership with PEBP, provide exemplary services and make the desires and goals of this agency a priority.

2.2.2 HMO participants should have access to a comprehensive choice of providers within the covered service as well as outside of Nevada for emergency and

specialized care. The plans should include a full complement of reputable, qualified professionals, a variety of specialists and include centers of excellence.

2.2.3 All plans shall include, but not be limited to, the following services and plan provisions:

- 2.2.3.1 Customer Service;
- 2.2.3.2 Utilization Review;
- 2.2.3.3 Concurrent Review;
- 2.2.3.4 Disease Management;
- 2.2.3.5 Large Case Management;
- 2.2.3.6 Wellness Benefits;
- 2.2.3.7 Vision Benefits; and
- 2.2.3.8 Mandated Health Benefits.

2.3 EFFECTIVE DATE

The effective date of the contract resulting from this RFP is anticipated to be July 1, 2013; however, the State reserves the right to initiate service at an earlier date. The contract term will be Four (4) years with a possible one (1) year extension. No contract is deemed effective unless and until approved by the Nevada State Board of Examiners (NRS 284.1729).

2.4 SYSTEM OF RECORD

2.4.1 PEBP maintains the system of record for participant eligibility, which means that PEBP has the responsibility of eligibility final determination, maintenance of eligibility records, and reporting of eligibility for its participants and their dependents. Please confirm your organization's willingness to accept these terms. For information on PEBP's eligibility requirements, please refer to the Master Plan Document at www.pebp.state.nv.us/.

2.4.2 Employees (regardless of Medicare eligibility) who cover a dependent who has Medicare Part A and retirees who are not eligible for free Medicare Part A and who cover a dependent who has Medicare Part A may enroll in the PEBP PPO or HMO plan. For information on PEBP's eligibility requirements, please refer to the Master Plan Document at www.pebp.state.nv.us.

2.5 BACKGROUND ON PEBP

The PEBP oversees the administration of the health insurance programs offered to eligible individuals. Eligible individuals include full-time state employees, certain non-state local government agencies, full-time employees of the Nevada System of Higher Education, and members of the Nevada Senate and Assembly. Dependents of the above-mentioned groups may also be covered. Benefits are also extended to retirees who are not participating in the Medicare Exchange and are receiving benefits from specified public retirement systems and their surviving spouses and/or eligible dependent children.

3. ACRONYMS/DEFINITIONS

For the purposes of this RFP, the following acronyms/definitions will be used:

Acronym	Description
<i>Access</i>	A recipient's ability to obtain medical care. The ease of access is determined by components such as the availability of medical services and their acceptability to the recipient, the location of health care facilities, transportation, and hours of operation and cost of care.
<i>Action</i>	The denial or limited authorization of a requested service, including: (1) the type or level of service; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a service; (4) The failure to provide services in a timely manner, as defined by the State; or (5) For a resident of rural area with only one Vendor, the denial of a Medicaid enrollee's request to exercise his or her right, to obtain services outside the network.
<i>Administrative Cut-Off Date</i>	A date each month selected by DHCFP. Changes made to the Medicaid recipient eligibility system prior to this date are effective the next month and are shown on the recipient's Medicaid card. Changes made to the computer system after this date become effective the first day of the second month after the change was made.
<i>Advance Directive</i>	An Advance Directive refers to a written statement, completed in advance of a serious illness or condition, which allows the recipient to direct health care decisions when the recipient is unable to do so. The advance directive allows the recipient to make decisions regarding the use or refusal of life sustaining treatments. An Advance Directive consists of Declarations (Living Wills) and Durable Powers of Attorney for Health Care Decisions, recognized under Nevada State law, which relate to the provision of care when an individual 18 years of age and older has an incurable or irreversible condition, and is unable to communicate health care decisions verbally.
<i>Adverse Determination</i>	Refers to a denial, termination, reduction, or suspension of an applicant or recipient's request for service or eligibility determination. The term also refers to a determination made by Nevada Medicaid against a provider or provider applicant to deny, terminate, suspend, or lock out a provider application.
<i>AFDC</i>	Aid to families with dependent children. Refer to definition for TANF.
<i>AFDC-UP</i>	Aid to families with dependent children – Unemployed Parent Program. Refer to definition for two parent TANF
<i>AFDC – RMO</i>	Aid to families with dependent children related to Medicaid only.
<i>Age/Sex Rates</i>	A set of rates for a given group product in which there is a separate rate for each grouping of age and sex categories.

Acronym	Description
<i>Appeal</i>	A request for review of an action as “action” is defined here in.
<i>Appropriate</i>	Refers to the Division of Health Care Financing and Policy’s ability to provide coverage for medically necessary services to a recipient based on regulations, and the Division’s available resources and utilization control procedures.
<i>Assessment</i>	An assessment is a process that is conducted by Nevada Medicaid and/or its contractors to evaluate the medical necessity of an individual’s request for a Nevada Medicaid covered service.
<i>Assumption</i>	An idea or belief that something will happen or occur without proof. An idea or belief taken for granted without proof of occurrence.
<i>Authorized Representative</i>	An authorized representative is an individual who has been designated by an applicant or recipient as having authority to act on behalf of the applicant or recipient.
<i>Awarded Vendor</i>	The organization/individual that is awarded and has an approved contract with the State of Nevada for the services identified in this RFP.
<i>BBA</i>	Balanced Budget Act. A congressional law and set of statutes that amends and modifies Medicaid regulations. The rules can be found in 42 CFR Part 438, Subparts A through J.
<i>BBS</i>	Bulletin Board System. A secure File Transfer Protocol (FTP) site on which provider and recipient files are posted for access by contracted health plans and the DHCFP.
<i>Benefit</i>	A Service authorized by the plan.
<i>BOE</i>	State of Nevada Board of Examiners
<i>Capitation Payment</i>	A payment the State agency makes periodically to a contractor on behalf of each recipient enrolled under a contract for the provision of medical services under the State Plan. The State agency makes the payment regardless of whether the particular recipient receives services during the period covered by the payment.
<i>Cardholder</i>	Means the person named on the face of a Medicaid card to whom or for whose benefit the Medicaid card is issued by the DWSS.
<i>Care-Coordinator</i>	A professional, whose background is most frequently anchored in the disciplines of social work and/or nursing, who assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual’s health needs. Care coordination links persons who have complex personal or social circumstances or health needs, which place them at risk of not receiving appropriate services. It also ensures coordination of these services.

Acronym	Description
<i>Case-Management</i>	Case management is a process by which an individual’s needs are identified and social and medical services to meet those needs are located, coordinated, and monitored. Case Management may be targeted to certain populations and in certain areas of the State under the authority of Section 1905(a) (19) of the Social Security Act.
<i>CFR</i>	Code of Federal Regulations
<i>CHAP</i>	<p>Child Health Assurance Program – This is a federally required coverage group for:</p> <p>(1) Pregnant women and children through age five (5) who meet eligibility requirements. Once a pregnant woman is eligible, she remains eligible during her pregnancy and the postpartum period regardless of change in income.</p> <p>(2) Children age six (6) or older born after September 30, 1983 who meet eligibility requirements are eligible for Medicaid under CHAP</p>
<i>CHIP</i>	A program of health care services for children birth to 19 years of age whose parents and/or legal guardians are living at 200 to 250 percent of the federal poverty level. See also Nevada Check Up.
<i>Claim</i>	Means (1) a bill for services; (2) a line item of services; or (3) all services for one recipient within a bill. “Claim” is further defined as communication, whether oral, written, electronic or magnetic, which is used to identify specific goods, items or services as reimbursable pursuant to the plan, or which states income or expense and is or may be used to determine a rate of payment pursuant to the plan.
<i>Clean-Claim</i>	Means a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
<i>Clinic Services</i>	<p>As amended by the Deficit Reduction Act of 1984, section 1905(a) (9) describes clinic services as “services furnished by or under the direction of a physician without regard to whether the clinic itself is administered by a physician.” Regulations at 42 CFR 440.90 define clinic services as preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:</p> <p>(1) Are provided to outpatients;</p> <p>(2) Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and,</p>

Acronym	Description
	(3) Except in the case of nurse-midwife services, as specified in 42CFR 440.165, are furnished by or under the direction of a physician or dentist.
<i>CMS</i>	Medicaid and CHIP programs are administered by the states with the Centers for Medicare and Medicaid Services formerly known as the Health Care Financing Administration, Department of Health and Human Services. CMS has responsibility for monitoring State compliance with federal requirements and providing federal financial participation (FFP). CMS monitors State programs to assure minimum levels of service are provided, as mandated in the Code of Federal Regulations (CFR's).
<i>COB</i>	Coordination of Benefits Means an individual has personal medical health insurance coverage that is or may be liable to pay all or part of the expenditures for medical assistance furnished under the State Medicaid Plan. COB includes cost avoidance and recovery when other medical health insurance exists.
<i>Cold Call Marketing</i>	Any unsolicited personal contact by the Vendor or contractor with the potential enrollee for the purpose of marketing as defined in this section
<i>Competent</i>	Properly or well qualified and capable.
<i>Confidential Information</i>	Any information relating to the amount or source of any income, profits, losses or expenditures of a person, including data relating to cost or price submitted in support of a bid or proposal. The term does not include the amount of a bid or proposal. Refer NRS 333.020(5) (b).
<i>Confidentiality</i>	Confidentiality pertains to all safeguards required to protect all information which concerns Medicaid and SHCIP applicants and recipients, Medicaid providers, and any other information which may not be disclosed by any party pursuant to federal and State law, and Medicaid Regulations, including, but not limited to NRS Chapter 422, and 42 CFR 431.
<i>Contract Approval Date</i>	The date the State of Nevada Board of Examiners officially approves and accepts all contract language, terms and conditions as negotiated between the State and the successful vendor.
<i>Contract Award Date</i>	The date when vendors are notified that a contract has been successfully negotiated, executed and is awaiting approval of the Board of Examiners.
<i>Contractor</i>	The company or organization that has an approved contract with the State of Nevada for services identified in this RFP. The contractor has full responsibility for coordinating and controlling all aspects of the contract, including support to be provided by any subcontractor(s). The contractor will be the sole point of contact with the State relative to contract performance.

Acronym	Description
<i>Covered Services</i>	Covered services are those services for which Nevada Medicaid may reimburse providers.
<i>Cross Reference</i>	A reference from one document/section to another document/section containing related material.
<i>CSHCN</i>	Children who have, or are at risk for, chronic physical, developmental, behavioral, or emotional conditions; and also require health and related services of a type and amount beyond that required by children in general; and are receiving services through family-centered, community-based, coordinated care systems receiving grant funds, under Section 501 (a)(1)(D) of Title V of the Social Security Act (known as Nevada Early Intervention Program); or children self-identified by parents/guardians as potentially having special health care needs.
<i>Customer</i>	Department, Division or Agency of the State of Nevada.
<i>Cultural competency</i>	An awareness and appreciation of customs, values, and beliefs and the ability to incorporate them into the assessment, treatment and interaction with any individual.
<i>Culture</i>	The integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. Culture defines the preferred ways for meeting needs, and may be influenced by factors such as geographic location, lifestyle and age.
<i>DCFS</i>	The Division of Child and Family Services.
<i>Denied Service</i>	Any medical service requested by a provider for a Medicaid recipient for whom the Contractor denies approval for payment.
<i>Dental Director</i>	The Contractor's Director of Dental Services, who is required to be a Doctor of Dental Science or a Doctor of Medical Dentistry and licensed by the Nevada Board of Dentistry, designated by the Contractor to exercise general supervision over the provision of dental services by the Contractor.
<i>Dental-Related Services</i>	These may include radiology, physician, anesthesiologist, outpatient facility and pharmacy related to a covered medically necessary dental service or procedure.
<i>Dental Services</i>	These include covered diagnostic, preventive or corrective services or procedures that include treatment of the teeth and associated structures of the oral cavity for disease, injury or impairment that may affect the oral or general health of the eligible Medicaid recipient up to age 21 years and eligible Nevada Check Up recipients up to the birth month of their 19 th year; and dentures, emergency extractions and palliative care for 21 years old and older. The Vendor is responsible for covered dental services as described in

Acronym	Description
	Chapter 1000 of the Medicaid Services Manual and the DHCFP Managed Care Contract.
<i>Dentist</i>	A person licensed to practice dentistry or dental surgery as defined in Nevada Revised Statutes 631.215.
<i>DHCFP</i>	Nevada Division of Health Care Financing and Policy.
<i>DHHS</i>	The State of Nevada Department of Health and Human Services
<i>Disenrollment</i>	Process of terminating individuals or groups from enrollment with a Managed Care Plan. Except where expressly required by federal or state regulations, disenrollment may not occur mid-month. Under most circumstances, requests for disenrollment are effective the first day of the month following receipt of the request, providing that the request is within policy/contract guidelines and is submitted before the administrative cut-off date.
<i>Division/Agency</i>	The Division/Agency requesting services as identified in this RFP.
<i>DME</i>	Durable Medical Equipment, Devices and Gases - Durable medical equipment is defined as equipment, devices, and gases which can withstand repeated use, and is primarily and customarily used to serve a medical purpose, and generally is not useful to a person in the absence of illness or injury.
<i>Eligibility</i>	Term that references a person's status to receive Medicaid program benefits.
<i>Emergency Medical Condition</i>	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 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.
<i>Emergency Medical Transportation</i>	Emergency medical transportation is use of a ground or air ambulance, as medically necessary, to transport a recipient with an emergency medical condition. A ground or air ambulance resulting from a "911" communication is considered emergency medical transportation, as specified in Medicaid Services, Chapter XIX.
<i>Emergency Services</i>	Emergency services means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a provider qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition. The Contractor must not require the services to be prior or post-authorized.

Acronym	Description
<i>Encounter</i>	A covered service or group of services delivered by a provider to a recipient during a visit, or as a result of a visit (e.g., pharmacy) between the recipient and provider.
<i>Encounter Data</i>	Data documenting a contact of service delivered to an eligible recipient by a provider.
<i>Enrollee</i>	A Medicaid or Nevada Check UP recipient who is enrolled in a managed care program.
<i>EPSDT</i>	Early and Periodic Screening, Diagnosis and Treatment - A preventive health care program, the goal of which is to provide to eligible children under the age of 21 the most effective, preventive health care through the use of periodic examinations, standard immunizations, diagnostic services, and treatment services which are medically necessary and designed to correct or ameliorate defects in physical or mental illnesses or conditions. 42 U.S.C. Section 1396d (a) (4) (B).
<i>EQR</i>	External Quality Review - The review and evaluation by an External Quality Review Organization of information on quality, timeliness, and access to the health care and services that a Vendor, or their contractor(s), furnish to Medicaid recipients.
<i>EQRO</i>	External Quality Review organization – An organization that meets the competence and independence requirements set forth in CFR 438.354, and performs external quality review, and other EQR-related activities as set forth in CFR 438.358, or both.
<i>Essential Community Providers</i>	A healthcare provider that (a) has historically provided services to underserved populations and demonstrates a commitment to serve low-income, underserved populations who make up a significant portion of its patient population or, in the case of a sole community provider, serves underserved patients within its clinical capability; and (b) waives charges or charges for services on a modified sliding fee scale based on income and does not restrict access or services because of a client’s financial limitations.
<i>Evaluation Committee</i>	An independent committee comprised of a majority of State officers or employees established to evaluate and score proposals submitted in response to the RFP pursuant to NRS 333.335.
<i>EVE</i>	Electronic Verification of Eligibility - A means to verify an individual’s eligibility for services covered by the State of Nevada’s Medicaid program, via the Internet.
<i>Exception</i>	A formal objection taken to any statement/requirement identified within the RFP.

Acronym	Description
<i>External Quality Review Protocols</i>	A series of procedures or rules to monitor, measure, and document information on quality, timeliness, and access to the health care and services that an Vendor or their contractors furnish to Medicaid and Nevada Check Up recipients.
<i>Family Planning Services</i>	<p>Section 1905(a)(4)(C) of the Social Security Act requires states to provide family planning services and supplies (directly or under arrangements with others) to individuals of childbearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies. Section 1902(a) (10) (A) specifies family planning services be made available to categorically needy Medicaid recipients while §1902(a) (10) (C) indicates the services may be provided to medically needy Medicaid recipients at the State’s option.</p> <p>The term "family planning services" is not defined in the law or in regulations. However, Congress intended that emphasis be placed on the provision of services to "aid those who voluntarily choose not to risk an initial pregnancy," as well as those families with children who desire to control family size. In keeping with congressional intent, these services may be defined as narrowly as services, which either prevent or delay pregnancy, or they may be more broadly defined to also include services for the treatment of infertility. However, the Medicaid definition must be consistent with overall State policy and regulation regarding the provision of family planning services.</p>
<i>FFP</i>	Federal Financial Participation - Usually expressed as a percentage or fraction of certain expenditures for which DHCFP is entitled to reimbursement by the federal government in accordance with applicable laws and regulations.
<i>FFS</i>	Fee for Service Reimbursement- A health care delivery program whereby DHCFP medical assistance program recipients are served by health care providers reimbursed on a per service or point of service basis.
<i>First Step Program</i>	The Division of Child and Family Services (DCFS) early intervention services for families and their children, ages birth through two (2) years (to third birthday), with suspected or confirmed developmental delays.
<i>Fiscal Agent</i>	<p>The program's fiscal agent is an entity under contract to the DHCFP with responsibility for the prompt and proper processing of all claims for payment of covered services in accordance with policies and procedures established by Nevada Medicaid. In addition, the fiscal agent may:</p> <ol style="list-style-type: none"> (1) Provide the auditing function for providers under cost reimbursement; (2) Perform a cursory pre-payment review on all claims;

Acronym	Description
	<p>(3) Trace, identify and apply any and all prior resources, including third-party liability and subrogation;</p> <p>(4) Supply provider education and provider services; and,</p> <p>(5) Other administrative services.</p>
FMC	Family Medical Category – Applications for Medicaid are treated as application for Family Medical Coverage.
Fraud	An intentional misrepresentation of truth for the purpose of inducing another in reliance upon it to part with some valuable thing belonging to him or to surrender a legal right. A false representation of a matter of fact, whether by words or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed, which deceives and is intended to deceive another so that he shall act upon it to his legal injury.
FQHC	Federally Qualified Health Center - Means an entity as defined in 42 CFR 405.2401(b). An FQHC is located in a rural or urban area designated as either a shortage area, or an area that has a medically underserved population and has a current provider agreement with DHCFP.
Geographic Service Area	The Vendor can elect to offer health care services to recipients residing in any or all towns, cities, and/or counties in Nevada for which the Vendor has been certified by the Nevada State Insurance Commissioner. The Vendor must meet the requirements of NAC 695c.160.
Grievance	Means any oral or written communications made by an enrollee, or a provider acting on behalf of the enrollee with the enrollee’s written consent, to any DHCFP managed care health plan employee or its providers expressing dissatisfaction with any aspect of the Medicaid managed care health plan or provider’s operations, activities or behavior, regardless of whether the communication requests any remedial actions.
HCBS	Home and Community Based Services.-Section 1915(c) of the Act authorizes the Secretary of Health and Human Services (HHS) to waive certain Medicaid statutory requirements to enable States to cover a broad array of home and community-based services as an alternative to institutionalization. These waivers include state wideness, comparability and categorical eligibility of institutional Medicaid which allows States to offer a wide array of services, defined by the State, to those recipients who may otherwise require institutionalization.
Health Care Plan	An arrangement whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services, and at least part of the arrangement consists of arranging for, or the provision of, health care services paid for by, or on behalf of, the recipient on a periodic prepaid

Acronym	Description
	basis (according to NRS 695C.030.4).
<i>Health Care Services</i>	Any services included in the furnishing to any natural person of medical or dental care or hospitalization or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person any other services for the purpose of preventing, alleviating, curing or healing human illness or injury (according to NRS 695C.030.5).
<i>Healthy Kids</i>	The Division refers to the EPSDT program as Healthy Kids.
<i>Hearing</i>	A hearing is an orderly, readily available proceeding before a hearing officer, which provides for an impartial process to determine the correctness of an agency action (See Chapter 3100). Recipients and Medicaid providers are afforded an opportunity for hearing in certain circumstances and when requested in a timely manner. An agency or HMO adverse determination made against a recipient's request for service or payment as well as a determination against a provider that terminates or denies a provider application may provide opportunity for hearing.
<i>HEDIS</i>	Healthcare Effectiveness Data and Information Set - HEDIS is the performance measurement tool of choice for more than 90 percent of the nations managed care organizations. It is a set of standardized measures that specifies how health plans collect; audit and report on their performance in important areas ranging from breast cancer screening, to helping patients control their cholesterol to customer satisfaction. Purchasers and others use HEDIS data to compare plan performance.
<i>HEDIS Compliance Audit</i>	A comprehensive assessment by a HEDIS Certified Auditor using findings from the HEDIS Baseline Assessment Tool (BAT), from audits in prior years (if applicable) and the HEDIS logical measure groups to select a core set of measures from all Vendor-reported measures. The auditor evaluates the core set of measures across all applicable domains described in the HEDIS specifications and extrapolates findings from the core set to all measures reported by the Vendor.
<i>HIX</i>	Health Insurance Exchange
<i>HMO</i>	Health Maintenance Organization A Health Maintenance Organization, by Nevada Medicaid standards, is an entity that must provide its Medicaid or CHIP enrollees inpatient hospital, outpatient hospital, laboratory, x-ray, family planning, physician, and home health services. The HMO provides these services for a premium or capitation fee, whether or not the individual enrollee receives services.
<i>Home Health Services</i>	Home health services are a mandatory benefit for individuals entitled to nursing facility services under the State's Medicaid plan. Services must be provided at a recipient's place of residence and must be ordered by a physician as part of a plan of care that the physician reviews every sixty

Acronym	Description
	<p>days. Home health services must include nursing services, as defined in the State's Nurse Practice Act, that are provided on a part-time or intermittent basis by a home health agency, home health aide services provided by a home health agency, and medical supplies, equipment, and appliances suitable for use in the home. Physical therapy, occupational therapy, speech pathology, and audiology services are optional services States may choose to provide. To participate in the Medicaid program, a home health agency must meet the conditions of participation for Medicare.</p>
<i>Hospital</i>	<p>Hospital means an inpatient medical facility licensed to provide services at an acute level of care for the diagnosis, care and treatment of human illness primarily for patients with disorders other than mental diseases. For purposes of Medicaid, a "hospital" must meet the requirements for participation in Medicare as a hospital. It is not an Institution for Mental Diseases (IMD), a Nursing Facility (NF), or an Intermediate Care Facility for the Mentally Retarded (ICF/MR), regardless of name or licensure.</p>
<i>Indian Health Care Services</i>	<p>These are services that the United States Government provides to federally recognized American Indian Tribes and Alaska Native Villages ("Indian tribes") based on a special government-to-government relationship. This relationship is the result of treaties between the federal government and Indian tribes and federal legislation. The Indian Health Services (IHS) is the primary source of medical and other health services for American Indian and Alaska Native people living on federal Indian reservations and other communities serviced by the IHS. The HIS delivery system includes over 500 health care facilities, including 51 hospitals, operated directly by the IHS or by Indian tribes or tribal organizations under agreements (contracts, grants, or compacts) authorized by Title I or III of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended).</p>
<i>Inpatient Hospital Services</i>	<p>"Inpatient hospital services" means services ordinarily furnished in a hospital for the care and treatment of an inpatient under the direction of a physician or dentist and furnished in an institution that (a) is maintained primarily for the care and treatment of patients with disorders other than tuberculosis; (b) is licensed as a hospital by an officially designated authority for State standard-setting; (c) meets the requirements for participation in Medicare; and (d) has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of 42 CFR 482.30, 42 CFR 456.50-456.145 and 42 CFR 440.10 Inpatient hospital services do not include Skilled Nursing Facilities (SNF) or Intermediate Care Facilities (ICF) services furnished by a hospital with swing bed approval.</p>
<i>Institutions for Mental Diseases</i>	<p>In 1988, P.L. 100-360 defined an institution for mental diseases as a hospital, nursing facility, or other institution of more than 16 beds primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.</p>

Acronym	Description
	This definition is in §1905(I) of the Act and in 42 CFR 435.1009. The regulations also indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases.
Key Personnel	Vendor staff responsible for oversight of work during the life of the project and for deliverables.
LCB	Legislative Counsel Bureau
LEP	Limited English Proficiency – inability to read, write or understand the English language at a level that permits one to interact effectively with health care providers or the vendor.
Licensure	The act or practice of granting licenses as to practice a profession.
Lock out	Refers to a provider sanction that suspends the Medicaid agreement between the State Nevada Medicaid Program and the provider for a set period of time.
LOI	Letter of Intent - notification of the State’s intent to award a contract to a vendor, pending successful negotiations; all information remains confidential until the issuance of the formal notice of award.
Managed Care	A system of health care delivery that influences utilization and cost of services and measures performance. The goal is a system that delivers value by giving people access to quality, cost-effective health care.
Managed Health Plan	Provides one or more products which: 1) integrate financing and management with delivery of health care services to an enrolled population; 2) employ or contract with an organized provider network which delivers services and (as a network or individual provider) shares financial risk or has some incentive to deliver quality, cost-effective services; and 3) use an information system capable of monitoring and evaluating patterns of covered persons’ uses of medical services and the cost of those services.
Marketing	Any communication from the HMO, including its employees, affiliated providers, agents or contractors, to a Medicaid or Nevada Check Up recipient who is not enrolled with the HMO that can reasonably be interpreted as intended to influence the recipient to enroll with the HMO or either not to enroll in or to disenroll from another HMO’s plan.
Marketing Materials	Means materials that are produced in any medium, by or on behalf of HMO that can reasonably be interpreted as intended to market to potential enrollees.
Maternity Kick Payment	The Maternity Kick Payment is payment made to the HMO which intended to reimburse the health plans for costs associated specifically with covered

Acronym	Description
(SOBRA)	delivery costs and postpartum care.
May	Indicates something that is recommended but not mandatory. If the vendor fails to provide recommended information, the State may, at its sole option, ask the vendor to provide the information or evaluate the proposal without the information.
Medicaid	Title XIX of the Social Security Act is a federal program which pays for medical benefits to eligible low-income persons needing health care. In Nevada, it is administered by the Department of Health and Human Services, Division of Health Care Financing and Policy, subject to oversight by CMS. The program costs are shared by the federal and State governments.
Medicaid or Nevada Check Up Billing Number	The Billing Number is an eleven digit number in one of the following forms: 12345600010 or 00000123456 used to identify Medicaid recipients or, the same type of numbering order ending in '999' used to identify Nevada Check Up recipients. Providers use the billing number when submitting claims for payment on services provided to eligible program recipients.
Medicaid and Nevada Check Up Card	Medicaid and Nevada Check Up Card means an instrument or device evidencing eligibility for receipt of Medicaid or Nevada Check Up covered services. It is issued by the Fiscal Agent for the use of the cardholder in obtaining the types of medical and remedial care for which assistance may be provided under the Plan.
Medicaid Fraud Control Unit - MFCU	MFCU is a federally funded and mandated State fraud unit, independent of the State Medicaid agency and authorized by the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977. The purpose of MFCU is to investigate and prosecute provider fraud in the Medicaid program. In Nevada, MFCU was established by the 1991 Legislature within the Office of the Attorney General.
Medical Assistance to the Aged, Blind and Disabled.- MAABD	MAABD is a Medicaid eligibility category which provides medical coverage for certain persons who are eligible for and/or may be receiving Supplemental Security Income (SSI), persons who qualify for Home and Community Based Services (HCBS), certain persons who qualify for Medicare coverage, and certain disabled children who would be eligible for nursing facility placement but who are being cared for in their home for less cost than what would be incurred in such placement.
Medical Care Advisory Committee- MCAC	MCAC is a federally mandated advisory committee whose purpose is to act in an advisory capacity to the State Medicaid Administrator.
Medical Home	Refers to inclusion of a program recipient on the patient panel of a Primary Care Physician (PCP) or a Primary Care Site (PCS) and the ability of the

Acronym	Description
	recipient to rely on the PCP/PCS for access to and coordination of their medical care.
Medical Necessity	<p>To be considered a medical necessity (medically necessary) items and services must have been established as safe and effective as determined by Nevada Medicaid. The items and services must be:</p> <ol style="list-style-type: none"> (1) Consistent with the symptoms or diagnosis of the illness or injury under treatment; (2) Necessary and consistent with generally accepted professional medical standards; (3) Not furnished for the convenience of the recipient, the attending physician, the caregiver, or to the physician supplier; and, (4) Furnished at the most appropriate level that can be provided safely and effectively to the recipient. Medicaid will only cover items and services that are appropriate and necessary for the diagnosis or treatment of an illness or an injury, or to improve the functioning of a malformed body part. <p>The DHCFP will only cover items and services which are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.</p>
MHDS	The Nevada Division of Mental Health and Developmental Services
Mid Level Practitioner	Includes physician assistants and nurse practitioners (advanced practice nurses).
Must	Indicates a mandatory requirement. Failure to meet a mandatory requirement may result in the rejection of a proposal as non-responsive.
NAC	Nevada Administrative Code –All applicable NAC documentation may be reviewed via the internet at: www.leg.state.nv.us
NCQA	An organization that develops health care measures that assess the quality of care and services that commercial and Medicaid managed care clients receive.
Nevada Check Up	Children’s Health Insurance Program (CHIP) provided under Title XXI of the Social Security Act to children whose families exceed Medicaid limits, but is equal to or less than 200% of the federal poverty level.
Nevada Early Intervention Program	Clinics operating to serve children, from birth to their third (3 rd) birthday, providing early intervention services for children with known or suspected developmental delays. These clinics receive Title V funding.

Acronym	Description
<i>Nevada Division of Welfare and Supportive Services</i>	<p>The Nevada Division of Welfare and Supportive Services (DWSS) provides eligibility determinations and services enabling Nevada families, the disabled and elderly to receive temporary cash and/or medical assistance, in an effort to achieve their highest level of self-sufficiency.</p> <p>The DWSS administers the Food Stamp and Temporary Assistance to Needy Families (TANF) programs and determines eligibility for the Nevada Medicaid program.</p>
<i>NOA</i>	Notice of Award – formal notification of the State’s decision to award a contract, pending Board of Examiners’ approval of said contract, any non-confidential information becomes available upon written request.
<i>Non-Emergency Transportation (NET) Broker</i>	A NET Broker contracts with individual transportation companies who provide transportation for eligible recipients of the DHCFP medical assistance programs. The NET Broker manages, authorizes, and coordinates NET services for these recipients. The NET Broker also provides various utilization management reports to Nevada Medicaid for quality assurance purposes. The NET Broker may perform the transportation services with limitations.
<i>NRS</i>	Nevada Revised Statutes – All applicable NRS documentation may be reviewed via the internet at: www.leg.state.nv.us .
<i>Orthodontics</i>	The branch of dentistry used to correct malocclusions (the "bite") of the mouth and restore it to proper alignment and function. Nevada Medicaid authorizes payment for orthodontics for qualified Medicaid recipients less than 21 years of age and for qualified Nevada Check Up recipients up to the birth month of their 19 th year of age.
<i>Other Health Care Coverage (OHC)</i>	As defined by Nevada Medicaid, OHC means any private health coverage plan or policy which provides or pays for health care services. Exclusions to OHC include but are not limited to Medicaid managed care, automobile insurance, and life insurance.
<i>Out of Network Provider</i>	These are certain types of providers with whom formal contracts may not be in place with the Contractor. However, the Contractor benefit package includes Medicaid services for which the Contractor will reimburse for specific services. The Contractor must either negotiate a rate with out-of-network providers or pay the FFS rate.
<i>Outpatient Services</i>	Outpatient services are those medically necessary services provided for the diagnosis and/or treatment of an illness or disease for which the patient will not require care in a facility for more than 24 hours.
<i>Pacific Time (PT)</i>	Unless otherwise stated, all references to time in this RFP and any subsequent contract are understood to be Pacific Time.

Acronym	Description
<i>Parity</i>	Parity is a state of uniformity or similarity.
<i>Patient Liability</i>	Patient Liability is that portion of a recipient's income that must be paid toward the cost of care.
<i>Performance Improvement Project (PIP)</i>	Activities conducted by managed care organizations designed to improve the quality of care or services received by managed care enrolled recipients.
<i>Performance Indicators</i>	Performance indicators are preset criteria which involve the recipient or provider and show the outcomes and impact level of Contract performance on specified sets of the population.
<i>Personal Care Services</i>	<p>Personal care services are an optional Medicaid benefit provided to individuals who are not inpatients or residents of a hospital, nursing facility, intermediate care facility for the mentally retarded or institution for mental disease. Personal care services must be:</p> <ol style="list-style-type: none"> (1) Authorized for an individual by a physician in a plan of treatment or in accordance with a service plan approved by the State; (2) Provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (3) Furnished in a home or other location. <p>These services may include a range of human assistance provided to persons, of all ages, with disabilities and chronic conditions which enable them to accomplish tasks that they would normally do for themselves if they did not have a disability.</p>
<i>Personal Representative</i>	<p>A personal representative is:</p> <ol style="list-style-type: none"> (1) A parent, including a parent who is an emancipated minor; (2) A guardian of the person as defined in NRS Chapter 159, an executor or administrator; (3) A person who has authority to make health care decisions under a power of attorney for health care; or (4) A person who is designated, in writing, as a personal representative for a Medicaid or Nevada Check Up recipient (this authority may be granted only by the recipient or, in the case of a minor child or adult who is adjudicated incompetent, his/her parent or guardian).
<i>Plan of Correction (POC)</i>	A detailed written plan describing the actions and/or procedures to remedy deviation from the stated standard(s) or contractual and/or legal mandates.

Acronym	Description
<i>Post-Stabilization Services</i>	Means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.
<i>Potential Enrollee</i>	A Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific Vendor. (Potential enrollee definition is applicable to the Information Requirements – in 42 CFR 438.10, not to the Marketing section – in 42 CFR 438.104.)
<i>Prepaid Benefits Package</i>	The set of health care-related services for which plans will be capitated and responsible to provide.
<i>Primary Care Provider (PCP)</i>	Physicians who practice general medicine, family medicine, general internal medicine, general pediatrics, or osteopathic medicine. Physicians who practice obstetrics and gynecology may function as PCPs for the duration of the health plan member's pregnancy.
<i>Primary Care Site (PCS)</i>	A location, usually a clinic, where a recipient chooses to access primary health care. The recipient's medical record is maintained at this location, and a rotating staff of physicians manages and coordinates the recipient's medical needs.
<i>Prior Resources</i>	Prior resources are any non-Medicaid coverage, public or private, which can be used to pay for medical services. These resources and benefits are payable before Medicaid benefits are paid.
<i>Private Duty Nursing Services</i>	<p>Private duty nursing is an optional Medicaid service which States may elect to provide. Chapter 42 CFR 440.80 defines private duty nursing services as nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or nursing facility, and are provided through an agency:</p> <ul style="list-style-type: none"> (1) By a registered nurse or a licensed practical nurse; (2) Under the direction of the recipient's physician; and (3) At the State's option, to a recipient in one or more of the following locations: <ul style="list-style-type: none"> (a) his or her own home; (b) hospital; or, (c) nursing facility.
<i>Proprietary Information</i>	Any trade secret or confidential business information that is contained in a bid or proposal submitted on a particular contract. (Refer to NRS 333.020 (5) (a).

Acronym	Description
<i>Provider</i>	Any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services. This includes: a person who has applied to participate or who participates in the plan as a provider of goods or services; or a private insurance carrier, health care cooperative or alliance, health maintenance organization, insurer, organization, entity, association, affiliation, or person, who contracts to provide or provides goods or services that are reimbursed by or are a required benefit of the plan. (1) For the fee-for-service program any individual or entity furnishing Medicaid services under an agreement with the Division is a provider. (2) For the managed care program, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services is a provider.
<i>Provider Dispute</i>	The term provider dispute encompasses both grievances and appeals. An appeal is a request to review an action as an “action” is described herein. A grievance is an expression of dissatisfaction with any aspect of the Medicaid managed care health plan’s operations, activities or behavior, regardless of whether the communication requests any remedial actions.
<i>Provider Exclusion</i>	Refers to an action taken by the federal Office of the Inspector General (OIG) of the United States Department of Health and Human Services, which prohibits individual practitioners and/or providers from participating in providing services under and submitting claims for such services for reimbursement from any and all federally funded health care programs. An exclusionary action by the OIG is immediate grounds for termination of a State Medicaid Provider Agreement and Vendor subcontractor agreement and offers no opportunity for hearing with Nevada Medicaid.
<i>Prudent Layperson</i>	A person who possesses an average knowledge of health and medicine, who could reasonably expect the absence of immediate medical attention to result in 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.
<i>Public Record</i>	All books and public records of a governmental entity, the contents of which are not otherwise declared by law to be confidential must be open to inspection by any person and may be fully copied or an abstract or memorandum may be prepared from those public books and public records. (Refer to NRS 333.333 and NRS 600A.030 [5]).
<i>Qualified Clinical Staff</i>	Those who are appropriately licensed or certified to perform medically necessary services or render clinical expertise, evaluation, and judgment in accordance with State and federal laws.
<i>Quality Assurance</i>	A formal set of activities to review and affect the quality of services

Acronym	Description
<i>(QA)</i>	provided. Quality assurance includes quality assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services.
<i>Quality Improvement</i>	A continuous process that identifies problems in organizational systems, including health care delivery systems which tests solutions to those problems and constantly monitors the solutions for improvement.
<i>Quality Improvement Organization (QIO)</i>	<p>Titles XI and XVIII of the Social Security Act (the Act) provide the statutory authority for the broad objectives and operations of the Utilization and Quality Control Quality Improvement Organization (QIO) program. The Peer Review Improvement Act of the Tax Equity and Fiscal Responsibility Act of 1982 established utilization and quality control Quality Improvement Organizations (QIOs).</p> <p>QIOs operate under contract with the Secretary of Health and Human Services to review Medicare services, once so certified by CMS. They may also contract with State Medicaid agencies and private insurers. The utilization review/control requirements of 42 CFR 456, are deemed met if a State Medicaid agency contracts with a Medicare certified QIO, designated under Part 475, to perform review/control services (42 CFR 431.630).</p>
<i>Reasonable Promptness/Timeliness</i>	All service request determinations will be issued within a reasonable promptness by Nevada Medicaid and its contractors. Reasonable promptness means Nevada Medicaid and its contractors will take action to approve, deny, terminate, reduce or suspend service(s) within fourteen (14) calendar days from the date the service authorization request is received.
<i>Recipient</i>	Means a natural person who receives benefits pursuant to the plan.
<i>Records</i>	Means medical, professional or business records relating to the treatment or care of a recipient, or to goods or services provided to a recipient, or to rates paid for such goods or services, and records required to be kept by the plan.
<i>Redacted</i>	The process of removing confidential or proprietary information from a document prior to release of information to others.
<i>Referral</i>	The recommendation by a physician, dentist and/or Contractor, and in certain instances, the recommendation by a parent, legal guardian and/or authorized representative, for a covered recipient to receive medically necessary care from a different provider.
<i>Regulation</i>	A U.S. Department of Health and Human Services statement of general applicability designed to implement or interpret federal law, policy or procedure; or a statement of Nevada Medicaid of general applicability designed to implement or interpret State or federal law, policy or procedure.

Acronym	Description
<i>Reinsurance</i>	Insurance purchased by a Contractor, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the claims of its participating providers, policyholders, or employees and covered dependents.
<i>Request for Hearing</i>	A clear, written request from either a provider or Medicaid recipient to the Division or its HMO contractor(s) for a hearing relating to a sanction and/or adverse determination. In the case of a provider sanction or adverse determination, it is a request made after all HMO and Division remedies have been exhausted by the provider.
<i>RFP</i>	Request for Proposal - a written statement which sets forth the requirements and specifications of a contract to be awarded by competitive selection as defined in NRS 333.020(8).
<i>Risk Contract</i>	Means under which the contractor assumes risk for the costs of the services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the contract.
<i>Rural Health Clinic (RHC)</i>	Rural Health Clinic (RHC), defined in 42 CFR 491.2, means a clinic that is located in a rural area designated as a shortage area. It is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.
<i>Sanction</i>	A sanction refers to an action taken either by Nevada Medicaid or the Office of Inspector General (OIG) against a provider or provider applicant.
<i>SB99</i>	Prompt pay bill now incorporated into the Nevada Revised Statutes as NRS 695C.185.
<i>Secretary</i>	The Secretary of the United States Department of Health and Human Services.
<i>Seriously Emotionally Disturbed (SED)</i>	This determination can only be made by a qualified provider on behalf of a minor child.
<i>Serious Mental Illness (SMI)</i>	This determination can only be made by a qualified provider on behalf of an adult.
<i>Service</i>	Means any procedure, intervention, or item reimbursable under Medicaid or CHIP.
<i>Service Area</i>	The geographic area served by the Contractor as approved by State regulatory agencies and/or as detailed in the certificate of authority.
<i>Service Authorization Request (SAR)</i>	A Service Authorization Request (SAR) is a request for the provision of a service made on behalf of a managed care enrollee. The request may be made by the enrollee, a provider, or some other entity or individual acting

Acronym	Description
	on behalf of the enrollee. A SAR may be made either in writing or orally.
<i>Service Levels</i>	Service levels are various measurable requirements that pertain to the delivery system structure of the contract and are used for evaluating contract performance and compliance.
<i>SFY</i>	State Fiscal Year, July 1 st through June 30 th .
<i>Shall</i>	Indicates a mandatory requirement. Failure to meet a mandatory requirement may result in the rejection of a proposal as non-responsive.
<i>Should</i>	Indicates something that is recommended but not mandatory. If the vendor fails to provide recommended information, the State may, at its sole option, ask the vendor to provide the information or evaluate the proposal without the information.
<i>State</i>	The State of Nevada and any agency identified herein.
<i>Statement of Work</i>	A statement of the work or services which the Contractor is to perform under any contract awarded, and which is generally in the form of an exhibit attached to the contract.
<i>State Plan (aka "The Plan")</i>	<p>The State Plan is a comprehensive statement submitted by the state Medicaid agency describing the nature and scope of its program and giving assurance that it will be administered in conformity with the specific requirements stipulated in the pertinent title of the Act, and other applicable official issuances of the Department of Health and Human Services (HHS). The State Plan contains all information necessary for the Department to determine whether the plan can be approved, as a basis for Federal Financial Participation (FFP) in the State program.</p> <p>The State Plan consists of written documents furnished by the State to cover each of its programs under the Act including the medical assistance program (Title XIX). After approval of the original plan by HHS, all relevant changes, required by new statutes, rules, regulations, interpretations, and court decisions, are required to be submitted currently so HHS may determine whether the plan continues to meet federal requirements and policies. Determinations regarding State Plans (including plan amendments and administrative practice under the plans) originally meet, or continue to meet, the requirements for approval based on relevant federal statutes and regulations.</p>
<i>State Quality Assessment and Performance Improvement Strategy</i>	A written document that describes methods DHCFP uses to assess and improve the quality of managed care services offered by all managed care organizations.
<i>Subcontractor</i>	Third party, not directly employed by the contractor, who will provide

Acronym	Description
	services identified in this RFP. This does not include third parties who provide support or incidental services to the contractor.
<i>Subrogation</i>	Subrogation is the principle under which an insurer that has paid a loss under an insurance policy is entitled to all the rights and remedies belonging to the insured against a third party with respect to any loss covered by the policy.
<i>Supplemental Omnibus Budget Reconciliation Act of 1996 (SOBRA)</i>	Legislation of the Omnibus Budget Reconciliation Act (OBRA) of 1986.
<i>Surveillance and Utilization Review Subsystem (SURS)</i>	SURS is the acronym for Surveillance and Utilization Review Subsystem of the Division of Health Care Financing and Policy. It is an integral part of the automated Medicaid Management Information System (MMIS) which is used to monitor service utilization and abuse.
<i>Targeted Case Management</i>	<p>Targeted case management is a service that refers to the identification of a “target” group for whom case management services will be provided. This targeting may be done by age, type or degree of disability, illness or condition, or another identifiable characteristic or combination thereof. These services are defined as “services which assist an individual, eligible under the plan, in gaining access to needed medical, social, educational and other service.” The intent of these services is to allow States to reach beyond the usual bounds of the Medicaid program to coordinate a broad range of activities and services necessary to the optimal functioning of the Medicaid recipient.</p> <p>Targeted case management has a specific meaning for Nevada Medicaid & Nevada Check Up. TCM, as defined by Medicaid Services manual, Chapter 2500, is carved out of the managed care contracts. Case management, which differs from Targeted Case Management, is required from the contracted managed care organization.</p>
<i>Temporary Assistance for Needy Families (TANF)</i>	Medicaid eligibility category which became effective January 1, 1997 as a result of the Personal Responsibility and Work Opportunity Act of 1996. TANF eligibility allows for cash payments. In addition, States have the option of including Medicaid eligibility as a program benefit. Nevada has elected to include Medicaid coverage under this eligibility option.
<i>Third Party Liability (TPL)</i>	Means any individual, entity (e.g., insurance company) or program (e.g., Medicare), including group health plans, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974 [29 USC and 1167 (1)] service benefits plans and Section 6035 of the Deficit Reduction Act of 2005. TPL includes COB cost avoidance and COB recovery.
<i>Trade Secret</i>	Information, including, without limitation, a formula, pattern, compilation, program, device, method, technique, product, system, process, design,

Acronym	Description
	prototype, procedure, computer programming instruction or code that derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by the public or any other person who can obtain commercial or economic value from its disclosure or use; and is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.
USC	United States Code
User	Department, Division, Agency or County of the State of Nevada.
Utilization	The statewide surveillance and utilization program that safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments; assesses the quality of those services; provides for the control of the utilization of, including inpatient services provided in accordance with 42 CFR 456 Subpart B.
Utilization control	"Utilization Control" refers to the federally mandated methods and procedures that may include utilization review to safeguard against unnecessary or inappropriate utilization of care and services to Medicare and Medicaid recipients. (42 CFR 456.50-456.145).
Utilization review	A formal assessment of medical necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.
Vendor	Organization/individual submitting a proposal in response to this RFP.
Will	Indicates a mandatory requirement. Failure to meet a mandatory requirement may result in the rejection of a proposal as non-responsive.

3.1 STATE OBSERVED HOLIDAYS

The State observes the holidays noted in the following table. *Note: When January 1st, July 4th, November 11th or December 25th falls on Saturday, the preceding Friday is observed as the legal holiday. If these days fall on Sunday, the following Monday is the observed holiday.*

Holiday	Day Observed
New Year's Day	January 1
Martin Luther King Jr. Birthday	Third Monday in January
Presidents' Day	Third Monday in February
Memorial Day	Last Monday in May
Independence Day	July 4
Labor Day	First Monday in September
Nevada Day	Last Friday in October

Holiday	Day Observed
Veterans' Day	November 11
Thanksgiving Day	Fourth Thursday in November
Family Day	Friday following the Fourth Thursday in November
Christmas Day	December 25

4. SCOPE OF WORK

DHCFP intends to contract with highly qualified and experienced Vendors, which will administer a managed care program to assist DHCFP in reaching its goal to expand enrollment of the targeted populations into a managed care entity.

Authorization to operate as a certified Vendor in the State of Nevada with the projected number of Medicaid and Nevada Check Up recipients by the United States Secretary of Health and Human Services and the Insurance Commissioner of the State of Nevada are conditions precedent to the contract and shall continue as conditions during the term of any contract. The Vendor must hold a current certificate of authority from the Nevada State Insurance Commissioner for the applicable contract period and throughout the contract period, or have a written opinion from the Insurance Commissioner that such a certificate is not required. The awarded Vendor must provide proof of a valid certificate of authority prior to the contract readiness review.

The Vendor must agree to meet all requirements of the ACA, whether it is in effect at the time of the contract signing, including any future amendments to the ACA, for the duration of the contract, including any contract extensions. Other than adjustments to the capitation rates that maintain actuarial soundness, the cost of meeting any existing or new ACA requirements will be the sole responsibility of the Vendor.

The geographic service areas included in the contracts will be urban Clark and Washoe Counties; however, other counties, or the entire State, may become mandatory managed care during the period of this contract and will be considered as part of the service area for this RFP.

At the sole discretion of the DHCFP, this contract may be expanded to include services to Medicaid Aged, Blind, and Disabled recipients. Vendor must propose to provide services in all geographic service areas. DHCFP and the vendor will negotiate mutually agreed on, actuarially sound capitated payment rates for the expansion areas at least ninety (90) days prior to the effective date in of the new service area.

At the State's sole option, the Vendor may be required to contract with other agencies within the DHHS, the Juvenile Justice system, or various Washoe and Clark County entities in providing medically necessary services, including behavioral health services. If this option is exercised and there is any resulting expense incurred by the Vendor, the DHCFP will adjust the capitation rate so that it remains actuarially sound.

The contract resulting from this RFP shall be effective from July 1, 2013, to June 30, 2017 with the possibility of a one (1) year extension if in the best interest of the State. An open enrollment process will be conducted prior to full implementation of all contracts that result from this RFP.

4.1 VENDOR DUTIES AND RESPONSIBILITIES

The Vendor's senior staff and other key staff as identified by the Vendor shall participate in all meetings scheduled by DHCFP. The purpose of these meetings includes, but is not limited to, the discussion of contract compliance, DHCFP auditing functions and responsibilities, and any other applicable issues concerning administration and management of the contract as well as program and service delivery. The frequency of such meetings may include, at a minimum, monthly teleconferences and/or videoconferences in addition to quarterly on-site meetings. The location of the on-site meetings will be at either the DHCFP administrative offices in Carson City or a site in Las Vegas. It is the sole responsibility of the DHCFP to provide reasonable advanced notice of such meetings, including location, time, date, and agenda items for discussion.

4.2 MEDICAL SERVICES

Except as otherwise provided in this RFP, the Vendor's benefits package provided to DHCFP members shall not be less in amount, duration, and scope than those covered services specified in the respective State Plans for Title XIX and XXI programs and the Nevada Medicaid Service Manual, but may be more than stated therein. The Vendor shall not issue any insurance certificate or evidence of insurance to any Medicaid or Nevada Check Up recipient. Any insurance duty shall be construed to flow to the benefit of DHCFP and not to the Medicaid or Nevada Check Up enrolled recipient. Any changes in benefit amount, duration, or scope shall be preceded by a review of impact on capitation amounts.

4.2.1 Vendor Managed Care Benefit Package

Each Vendor must provide, either directly or through subcontractors, the managed care benefit package, as described in this RFP, to enrolled recipients to ensure all medically necessary services covered under the State Plan are available and accessible to them. The State of Nevada Title XIX State Plan can be accessed on the DHCFP's website at <http://dhcfp.state.nv.us/>. The State of Nevada Title XXI State Plan can be accessed on the Nevada Check Up website at www.nevadacheckup.nv.gov.

The Vendor must abide by all ACA requirements, including the provision of Essential Health Benefits (EHBs), as defined in the ACA.

The Vendor must furnish services in the same amount, duration and scope as services furnished to recipients under fee-for-service Medicaid as set forth in 42 CFR 440.230, which states that the vendor:

- 4.2.1.1 Must ensure the services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished;
- 4.2.1.2 May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member;

- 4.2.1.3 May place appropriate limits on a service on the basis of criteria applied under the State plan, such as medical necessity, or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in Section 4.2.2;
- 4.2.1.4 Must specify what constitutes “medically necessary services” in a manner that is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures, including the Medicaid Services Manual (MSM). The State of Nevada Title XIX State Plan can be accessed on the DHC FP’s website at <http://dhcftp.state.nv.us/>.
- 4.2.1.5 The State of Nevada Title XXI State Plan can be accessed on the Nevada Check Up website at www.nevadacheckup.nv.gov. The Vendor shall address the extent to which it is responsible for covering services related to the following:
- A. The prevention, diagnosis, and treatment of health impairments;
 - B. The ability to achieve age-appropriate growth and development; and
 - C. The ability to attain, maintain or regain functional capacity.
- 4.2.1.6 Must, for itself and its subcontractors, have in place and follow, written policies and procedures for the processing of requests for initial and continuing authorizations of services.

The Vendor must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and consult with the requesting and/or servicing provider, when necessary.

The Vendor shall monitor prior authorization requests. DHC FP, at its sole discretion, may require removal of the prior authorization requirement for various procedures based on reported approval data and any other relevant information.

Any decision made by the Vendor to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the member’s condition or disease.

The Vendor shall coordinate prior authorizations and edit patterns with those used in the fee-for-service program.

- 4.2.1.7 Must maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for both the TANF/CHAP and CHIP (Nevada Check Up) populations. In establishing and maintaining the network, the Vendor must consider the following:
- A. The anticipated DHCFP recipient managed care enrollment;
 - B. The numbers of network providers who currently are and are not accepting new Medicaid and Nevada Check Up recipients;
 - C. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid and Nevada Check Up populations represented in the RFP;
 - D. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid covered services; and
 - E. The geographic location of providers and enrolled recipients, considering distance (pursuant to NAC 695C.160), travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities.
- 4.2.1.8 Must allow each member to choose his or her health care professional, including primary care provider (PCP), to the extent possible and appropriate.
- A. Members with disabilities, chronic conditions, or complex conditions shall be allowed to select a specialist as their PCP. These members shall be allowed to select a State-operated clinic as their PCP.
 - B. Members with disabilities must be given an additional 30 days to select a PCP.
 - C. Vendor must allow for continued use of a member's provider(s) until the member can be transferred to an appropriate network provider(s).
 - D. Vendor must allow for a pregnant member's continued use of their OB/GYN, if at all possible.
- 4.2.1.9 Must provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This

is in addition to the member's designated primary care provider (PCP), if that source is not a women's health specialist.

- 4.2.1.10 Must cover these services out of network for the member adequately and timely for as long as the Vendor is unable to provide them. If the network is unable to provide necessary services covered under the contract to a particular member, the Vendor must coordinate with out- of-network providers with respect to payment.
- 4.2.1.11 Must provide for a second opinion from a qualified health care professional within the network, or arrange for the member to obtain one outside of the network, at no cost to the member.
- 4.2.1.12 Must coordinate with out-of-network providers with respect to payment.
- 4.2.1.13 Must demonstrate that its providers are credentialed as required by 42 CFR 438.214 and Sections 4.5 and 4.8.15 of this RFP.
- 4.2.1.14 Must ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid FFS, if the provider services only Medicaid members pursuant to 42 CFR 438.206; must meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services; must make services included in the RFP available twenty-four (24) hours per day, seven (7) days per week, when medically necessary; must establish mechanisms to ensure compliance by providers; monitor providers regularly to ensure compliance; and, must take corrective action if there is a failure to comply.
- 4.2.1.15 Must provide emergency coverage twenty-four (24) hours per day, seven (7) days per week. The Vendor must have written policies and procedures describing how recipients and providers can obtain urgent coverage and emergency services after business hours and on weekends. Policies and procedures must include provision of direct contact with qualified clinical staff. Urgent coverage means those problems which, though not life-threatening, could result in serious injury or disability unless medical attention is received.

4.2.1.16 The Vendor must participate in State and federal efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds pursuant to MSM Chapter 100, Section 103.6. For the purposes of this RFP, the State has identified the prevalent non-English language in Nevada to be Spanish. The BBA Regulations: Title 42 of the Code of Federal Regulations (42 C.F.R.) 438.206(c) (2), and DHCFF requires that vendors offer accessible and high quality services in a culturally competent manner.

A. Cultural Competency Plan

Each Vendor must have a comprehensive cultural competency program, which is described in a written plan. The Cultural Competency Plan (CCP) must describe how care and services will be delivered in a culturally competent manner. The CCP must identify the goals and objectives of the Vendor's cultural competency program and encompass the goals and objectives described in the DHCFF Quality Assessment and Performance Improvement Strategy (QAPIS). The CCP must be reviewed and updated annually and submitted to DHCFF in the second quarter of each calendar year.

The Vendor must identify a staff person, title or position responsible for the CCP. If there is a change in the staff member responsible for the CCP, the Vendor must notify the DHCFF.

B. The CCP must contain a description of Staff Recruitment and Retention:

The Vendor must demonstrate how it plans to recruit and retain staff who can meet the cultural needs of the Vendor's members. Cultural competence is part of job descriptions.

C. Education and Training

1. The training program consists of the methods the Vendor will use to ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery to members of all cultures. The Vendor regularly assesses the training needs of the staff and updates the training programs, when appropriate. Trainings are also customized to staff based on the nature of the contacts they have with providers and/or members.

2. The education program consists of methods the Vendor will use for providers and other subcontractors with direct member contact. The education program will be designed to make providers and subcontractors aware of the importance of providing services in a culturally competent manner. The Vendor must also make additional efforts to train or assist providers and subcontractors in receiving training in how to provide culturally competent services.

D. Culturally Competent Services and Translation/Interpretation Services

The Vendor describes the method for the ongoing evaluation of the cultural diversity of its membership, including maintaining an up-to-date demographic and cultural profile of the Vendor's members. A regular assessment of needs and/or disparities is performed, which is used to plan for and implement services that respond to the distinct cultural and linguistic characteristics of the Vendor's membership. Culturally competent care requires that the Vendor regularly evaluate its network, outreach services and other programs to improve accessibility and quality of care for its membership. It must also describe the provision and coordination needed for linguistic and disability-related services.

A Vendor, at the point of contact, must make members aware that translation services are available. The services that are offered must be provided by someone who is proficient and skilled in translating language(s). The availability and accessibility of translation services should not be predicated upon the non-availability of a friend or family member who is bilingual. Members may elect to use a friend or relative for this purpose, but they should not be encouraged to substitute a friend or relative for a translation service.

The Vendor must demonstrate that they use a quality review mechanism to ensure that translated materials convey intended meaning in a culturally appropriate manner. The Vendor must provide translations in the following manner:

1. All materials shall be translated when the Vendor is aware that a language is spoken by 3,000 or 10% (whichever is less) of the Vendor's members who also have Limited English Proficiency (LEP) in that language.

2. All vital materials shall be translated when the Vendor is aware that a language is spoken by 1,000 or 5% (whichever is less) of the Vendor's members who also have LEP in that language. Vital materials must include, at a minimum, notices for denial, reduction, suspension or termination of services, and vital information from the member handbook.
3. All written notices informing members of their right to interpretation and translation services in a language shall be translated into the appropriate language when the Vendor is aware that 1,000 or 5% (whichever is less) of the Vendor's members speak that language and have LEP.

E. Evaluation and Assessment of CCP

The Vendor must evaluate the CCP to determine its effectiveness and identify opportunities for improvement. Evaluations are completed on an annual basis and a copy of the evaluation is sent to DHCFP. The evaluation may, for example, focus on: comparative member satisfaction surveys, outcomes for certain cultural groups, member complaints, grievances, provider feedback and/or Vendor employee surveys. If issues are identified, they are tracked and trended, and actions are taken to resolve the issue(s).

- 4.2.1.17 The Vendor shall adhere to professional standards of medical or paramedical care and services, and comply with all local, state and federal statutes, rules and regulations relating to the Vendor's performance under the contract, including, but not limited to, non-interference with recipient/health care provider communications and prohibitions against factoring and accepting or paying kickbacks for services provided to DHCFP members.

4.2.2 Vendor Covered Services

No enrolled recipient shall receive fewer services in the managed care program than they would receive in the current State Medicaid Plan, except for excluded services in **Section 4.2.3, Excluded Services and Coverage Limitations** below.

At a minimum, the Vendor must provide directly, or by subcontract, all covered medically necessary services, which shall include, but may not be limited to, the following:

- 4.2.2.1 Ambulatory Surgery Centers;
- 4.2.2.2 Alcohol and Substance Abuse Treatment, including;
- 4.2.2.3 Intensive Outpatient Treatment;
- 4.2.2.4 Case Management;
- 4.2.2.5 Certified Registered Nurse Practitioner;
- 4.2.2.6 Chiropractor (for EPSDT eligible recipients);
- 4.2.2.7 Dental and Dental Related Services, including Orthodontia;
- 4.2.2.8 Disposable Medical Supplies;
- 4.2.2.9 Durable Medical Equipment;
- 4.2.2.10 Early Periodic Screening, Diagnosis and Treatment (EPSDT);
- 4.2.2.11 Emergency Transportation;
- 4.2.2.12 End Stage Renal Disease Facilities;
- 4.2.2.13 Family Planning Services;
- 4.2.2.14 Hearing Aid Dispenser and Related Supplies;
- 4.2.2.15 Home Health Agency;
- 4.2.2.16 Hospital Inpatient;
- 4.2.2.17 Hospital Outpatient;
- 4.2.2.18 Hospice;
- 4.2.2.19 Inpatient Medical Rehabilitation Center or Specialty Hospital;
- 4.2.2.20 Intermediate Care Facility;
- 4.2.2.21 Intravenous Therapy (TPN);
- 4.2.2.22 Laboratory - Pathology/Clinical;
- 4.2.2.23 Medical Rehabilitation Center or Specialty Hospital;
- 4.2.2.24 Mental Health Services:
 - A. Inpatient Psychiatric Hospital;
 - B. Mental Health Outpatient Clinic;
 - C. Mental Health Rehabilitative Treatment;
 - D. Services;
 - E. Psychologist;
 - F. Outpatient Psychiatric;
 - G. Residential Treatment Center (RTC);
 - H. Case Management;
 - I. Habilitation services: Instrumental Activities of Daily Living (IADL)/ Activities of Daily Living (ADL); and
 - J. Medication Management.

- 4.2.2.25 Methadone Treatment;
- 4.2.2.26 Nursing Facilities;
- 4.2.2.27 Nurse Anesthetist;
- 4.2.2.28 Certified Nurse Midwife;
- 4.2.2.29 Opticians/Optometrists;
- 4.2.2.30 Outpatient Surgery;
- 4.2.2.31 Personal Care Aide;
- 4.2.2.32 Pharmacy;
- 4.2.2.33 Physician/Osteopath;
- 4.2.2.34 Physician Assistants;
- 4.2.2.35 Podiatrist (for EPSDT eligible recipients);
- 4.2.2.36 Private Duty Nursing;
- 4.2.2.37 Prosthetics;
- 4.2.2.38 Radiology and Noninvasive Diagnostic Centers;
- 4.2.2.39 Residential Treatment Centers;
- 4.2.2.40 Rural Health Clinics and Federally Qualified Health Centers;
- 4.2.2.41 Skilled Nursing Facility;
- 4.2.2.42 Special Clinics;
- 4.2.2.43 Swing Beds Stays;
- 4.2.2.44 Therapy:
 - A. Audiology;
 - B. Occupational;
 - C. Physical;
 - D. Respiratory;
 - E. Speech; and,
 - F. Other services as defined in the Medicaid Services Manual (MSM).

- 4.2.2.45 Transitional Rehabilitative Center;

- 4.2.2.46 Transplantation of State Plan covered organs and tissue, and related immunosuppressant drugs. The State of Nevada Title XIX State Plan can be accessed on the DHCFP's website at <http://dhcfp.state.nv.us/>. Any new services added or deleted from the DHCFP medical assistance programs benefit package will be analyzed for inclusion or exclusion in the Vendor benefit package. DHCFP via its Title XIX State Plan Attachment 3.1.E covers Corneal, Kidney, Liver and Bone Marrow transplants and associated fees for adults. For children up to age 21 any medically necessary transplant that is not experimental will be covered. The health plan may claim transplant case reimbursement from DHCFP for in-patient medical expenses above the threshold of \$100,000 in a one-year period (State Fiscal Year). 75% of the expenses above \$100,000 are reimbursed to the health plan;

- 4.2.2.47 Court-ordered treatment, if it is a medically necessary, covered service;

- 4.2.2.48 Institutions for Mental Diseases (IMDs); and

4.2.2.49 The IMDs are a Vendor covered service. The DHCFP reserves the right to develop a partial risk arrangement with the Vendor for recipient inpatient IMD medical costs.

4.2.3 Excluded Services and Coverage Limitations

The following services are either excluded as a Vendor covered benefit or have coverage limitations. Exclusions and limitations are identified as follows:

4.2.3.1 All services provided at Indian Health Service Facilities and Tribal Clinics

All Native Americans may access and receive covered medically necessary services at Indian Health Service (IHS) facilities and Tribal Clinics. Native Americans who are eligible as Nevada Check Up (Title XXI) recipients are mandatorily enrolled in managed care. Native Americans who are eligible as Nevada Medicaid (Title XIX) recipients may choose to be voluntarily enrolled in managed care. If a Native American who is enrolled in managed care seeks covered services from IHS, the Vendor should request and receive medical records regarding those covered services/treatments provided by IHS. If covered services are recommended by IHS and the member seeks those services through the Vendor, the Vendor must either provide the service or must document why the service is not medically necessary. The documentation may be reviewed by DHCFP or other reviewers. The Vendor is required to coordinate all services with IHS. If a Nevada Medicaid (Title XIX) eligible Native American recipient elects to disenroll from the Vendor, the disenrollment will commence no later than the first day of the second administrative month after which all covered medically necessary services will be reimbursed by FFS.

4.2.3.2 Non Emergency Transportation (NET)

The DHCFP contracts with a NET Broker who authorizes and arranges for all covered medically necessary non-emergency transportation. The Vendor and its subcontractors shall coordinate with the NET Broker, if necessary, to ensure NET services are secured on behalf of enrolled recipients. The Vendor and its subcontractors must also verify medical appointments upon request by DHCFP or the NET Broker.

4.2.3.3 School-Based Child Health Services (SBCHS) with Limitations

DHCFP has provider contracts with several school districts to provide certain medically necessary covered services through School Based Child Health Services (SBCHS) to eligible Title XIX Medicaid and Title XXI Nevada Check Up recipients.

Eligible Medicaid members who are three (3) years of age and older can be referred by their primary care physician (PCP), school physician, special education teacher, school nurse, school counselor, parent or guardian, or social worker to school based child health services for an evaluation. If the child is found eligible for these services, then an Individual Education Plan (IEP) is developed for the child. The IEP specifies services needed for the child to meet his/her educational goals. A copy of the IEP will be sent to the child's PCP within the managed health care plan, and maintained in the member's medical record.

The school districts provide, through school district employees or contract personnel, the majority of specified medically necessary covered services. Nevada Medicaid reimburses the school districts for these services in accordance with the school districts' provider contract. The Vendors will provide covered medically necessary services beyond those available through the school districts, or document why the services are not medically necessary. The documentation may be reviewed by DHCFP or its designees. Title XIX Medicaid-eligible children are not limited to receiving health services through the school districts. Services may be obtained through the Vendor rather than the school district if requested by the parent/legal guardian. The Vendor must reimburse School-Based Child Health services provided by a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC). These services must not have restrictions of prior authorization or PCP referral requirements. The Vendor case manager shall coordinate with the school district in obtaining any services which are not covered by the plan or the school district.

The Vendor will stay up-to-date on efforts to promote State standards for School-Based Health Services. The Vendor will ensure their delivery systems support the integration of School-Based Health Services with Medicaid managed care services.

4.2.3.4 Intermediate Care Facility for the Mentally Retarded (ICF/MR)

Members requiring this service are not eligible for managed care.

4.2.3.5 Adult Day Health Care

Members requiring this service are not eligible for managed care.

4.2.3.6 Home and Community Based Waiver Services

4.2.3.7 Pre-Admission Screening and Resident Review (PASRR) and Level of Care (LOC) Assessments

All PASRR and LOC are performed by the State's fiscal agent.

4.2.3.8 Seriously Emotionally Disturbed (SED)/Severely Mentally Ill (SMI), with Limitations

The Vendor must ensure that members, who are referred for evaluation for SED/SMI, or who have been determined SED/SMI, are obtaining the medically necessary evaluations by a network PCP, and that the member is receiving covered medically necessary medical, mental health and mental health rehabilitation services.

The Vendor or its identified subcontractors/network providers must ensure that the parent/guardian of a minor member who is referred for SED assessment, or an adult who is referred for SMI assessment, is fully informed of the reason why the assessment is necessary, and must obtain authorization from the minor member's parent/guardian or from the enrolled adult or his/her personal representative to conduct the assessment and to release the determination to the DHCFP and/or its designee.

(Note: Policy regarding who the DHCFP recognizes as a “personal representative” is defined in the DHCFP HIPAA Privacy Rule Manual. This manual, as well as a sample personal representative designation form, is available upon request.)

The Vendor and its identified subcontractors/network providers are the only entities that have the authority to make the SED or SMI determination for its enrolled recipients. If any entity other than the Vendor or its identified subcontractors/network providers makes a determination on behalf of a Medicaid recipient who is enrolled in managed care at the time such determination is made, the determination will be rejected and the entity will be directed to refer the enrolled recipient to the Vendor for a determination and services. SED or SMI determinations made by authorized entities referenced in Chapter 400 of the Nevada Medicaid Services Manual under Fee-for-Service Medicaid will be considered valid for members who transition from Fee-for-Service Medicaid to managed care. Likewise, determinations made by the Vendor or its identified subcontractors/network providers will be considered valid for members who transition from managed care to Fee-for-Service Medicaid. SED or SMI determinations made by appropriately licensed mental health practitioners within the 12-month period preceding initial Medicaid eligibility will be considered valid for either Fee-for-Service Medicaid or managed care members.

If an enrolled recipient is determined to be either SED or SMI, the Vendor must ensure that DHCFP requirements for data collection are met.

Pursuant to the State of Nevada Title XIX State Plan, Medicaid recipients have the option of disenrolling from managed care, if

determined to be SED or SMI. The State may, at its sole discretion, remove the option for these Medicaid recipients determined SED to be voluntarily disenrolled from managed care in the future.

Pursuant to the State of Nevada Title XXI State Plan, in urban areas only, Nevada Check Up recipients must remain enrolled with the managed care organization that is responsible for ongoing patient care.

Recipients who receive either an SED or SMI determination must be redetermined at least annually. For recipients who have voluntarily elected to remain enrolled in managed care, the process for these redeterminations is the same as for the initial SED or SMI determination as stated above.

Forms to obtain consent for an SED/SMI evaluation, to document the determination, and to disenroll from Medicaid managed care are located in Section 5 of the Forms and Reporting Guide.

4.2.3.9 Targeted Case Management

Targeted case management has a specific meaning for Nevada Medicaid & Nevada Check Up. TCM, as defined by Chapter 2500 in the Medicaid Services Manual, is carved out of the managed care contracts. Case management, which differs from Targeted Case Management, is required from the contracted Vendors.

4.2.3.10 Child Welfare

Recipients in Child Welfare, including those under juvenile justice and foster care programs, are excluded from Managed Care at this time.

4.2.4 EPSDT Services (Medicaid) & Well Baby/Child Services (Nevada Check Up)

The Vendor will be required to conduct Early Periodic Screening Diagnostic and Treatment (EPSDT) screenings of its recipients under the age of twenty-one (21) years. The screening must meet the EPSDT requirements found in the Medicaid Services Manual (MSM) Chapter 1500; as well as 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Social Security Act, and 42 CFR 441.50 through 441.63. The Vendor must conduct all interperiodic screening on behalf of recipients, as defined in the Medicaid Services Manual (MSM) Chapter 1500.

Medically necessary screening, diagnostic and treatment services identified in an EPSDT periodic or interperiodic screening must be provided to all eligible Medicaid children under the age of 21 years if the service is listed in 42 U.S.C. § 1396 d(a). For Title XIX children, the Vendor is responsible for reimbursement of all medically necessary services under EPSDT whether or not the service is in the State Plan. The Vendor is responsible for the oral examination component of the EPSDT physical exam and referral to a dental provider, as per the dental

periodicity schedule or when medically necessary. The Vendor is responsible for the coordination of care in order to ensure all medically necessary coverage is being provided under EPSDT. The services which need to be provided through the Vendor include, but are not limited to, the following in accordance with 1905(r) of the Social Security Act and the MSM Chapter 1500:

EPSDT screens (for Nevada Medicaid recipients) and Well baby/Well child screens (for Nevada Check Up recipients) are basically one and the same and are billed using the same codes with the same reimbursement. Because Nevada Check Up can no longer reimburse for any treatments outside of the state plan, (as EPSDT allows), their screenings cannot be called “EPSDT”, and thus the term Well baby/Well child is used. The Vendors are not required to pay for any treatments outside of the state plan for Nevada Check Up members.

- 4.2.4.1 Screening services which include a comprehensive health and developmental history (including assessment of both physical and mental health development);
- 4.2.4.2 A comprehensive, unclothed physical exam;
- 4.2.4.3 Age-appropriate immunizations (according to current American Committee On Immunization Practices – ACIP - schedule);
- 4.2.4.4 Laboratory tests (including blood lead level assessment appropriate to age and risk as directed by current federal requirements);
- 4.2.4.5 Health education;
- 4.2.4.6 Vision services;
- 4.2.4.7 Dental services;
- 4.2.4.8 Hearing services; and
- 4.2.4.9 Other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Medicaid Plan.

The Vendor is not required to provide any items or services determined to be unsafe or ineffective, or which are considered experimental. However, as long as there are peer reviewed studies showing the treatment to be effective in the case, this provides the basis for approval as non-experimental. Appropriate limits may be placed on EPSDT services based on medical necessity.

The Vendor is required to provide information and perform outreach activities to eligible enrolled children for EPSDT services. These efforts may be reviewed and audited by DHCFP or its designee. Refer to the Medicaid Services Manual

(MSM), federal documents cited in this Section, and *Section 4.4.1, Information Requirements* of this RFP.

4.2.5 Additional Preventive Services

The Vendor is encouraged to offer additional preventive or cost-effective services to enrolled recipients if the services do not increase the cost to the State.

4.2.6 Dental Services

Dental services are included in the managed care benefit package in urban Washoe and Clark Counties. The geographic service areas included in the contracts will be urban Clark and Washoe Counties; however, other counties, or the entire state, may become mandatory managed care during the period of this contract and dental services will be included in the managed care benefit package for these areas. The Vendor will be responsible for all covered medically necessary dental services which are covered under FFS. The Vendor is required to cover any diagnostic, preventive, or corrective procedures that include the treatment of the teeth and associated structures of the oral cavity for disease, injury or impairment which may affect the oral or general health of children and any emergency services for adults. In Clark and Washoe, a Title XIX recipient is enrolled in the Fee for Service (FFS) benefit plan during their first month of eligibility. When the recipient is in the FFS benefit plan, claims must be submitted to DHCFP's fiscal agent. After the first month, the recipient is required to choose a Managed Care Organization ("Vendor"). Absent a choice, DHCFP's fiscal agent assigns the recipient to a Vendor. Once enrolled in a Vendor, dental services are prior-authorized through the Vendor and claims are submitted to the Vendor for payment. Emergent services (e.g., emergency extractions, palliative care and necessary dentures) are covered regardless of the benefit plan in which the recipient is enrolled.

Nevada Check Up members are enrolled in managed care immediately and do not go through the fee-for-service choice period.

Pending approval of a Section 1115 Research and Demonstration Waiver by CMS, DHCFP may require recipients to choose a Medicaid MCO Vendor as part of their eligibility application or be auto-assigned immediately upon approval of Medicaid eligibility. Recipients would be allowed a 90-day period to change MCOs without cause.

In addition, currently, recipients who temporarily lose eligibility but return within 60 calendar days are automatically re-assigned to their prior MCO Vendor. Those recipients who return after 60 days are given a 30 day choice period during which they may select enrollment in either Vendor. Under the 1115 Waiver, the DHCFP is seeking to modify this so that all returning Medicaid recipients are auto-assigned to their prior Vendor, regardless of the length of the break in eligibility, as long as that Vendor is still contracted with the State.

4.2.6.1 Vendor-Covered Dental Services

At a minimum, the Vendor must provide directly, or by subcontract, all covered medically necessary dental services to Title XIX Medicaid-eligible enrolled children under the age of twenty-one (21) and Title XXI Nevada Check Up-eligible children through their eighteenth year and emergency services for adults, as outlined in the Medicaid Services Manual (MSM), Chapter 1000, entitled “Dental Services”.

4.2.6.2 Vendor, Subcontractor and Dentist Responsibilities

Dentist-To-Recipient Ratios: The Vendor must have at least one (1) full-time equivalent (FTE) dentist per one thousand five hundred (1,500) recipients per geographic service area. The Vendor’s dental provider network must also include at a minimum one (1) pediatric dentist, one (1) dental hygienist, and one (1) oral surgeon. In clinic practice settings where a dentist provides direct supervision of dental residents who have a temporary permit from the State Board of Dentistry in good standing, the Vendor may request and DHCFP may authorize the capacity to be increased as follows: one (1) dental resident per one thousand (1,000) recipients per Vendor. The dentist shall be immediately available for consultation, supervision, or to take over treatment as needed. Under no circumstances shall a dentist relinquish or be relieved of direct responsibility for all aspects of care of the recipients enrolled with the dentist.

In order to increase capacity, the Vendor shall submit for prior approval by DHCFP a detailed description of the dentist delivery system to accommodate an increased patient load, work flow, professional relationships, work schedules, coverage arrangements, and a twenty-four-hour (24-hour) access system.

4.2.6.3 Dental Director's Office

The Vendor shall have staff designated to the dental program, including but not limited to a Dental Director. The Dental Director shall be responsible for the oversight of development, implementation and review of the Vendor's internal quality assurance program for the dental program, including adherence to any plan of correction (POC). The Dental Director need not serve full time or be a salaried employee of the Vendor, but the Vendor must be prepared to demonstrate it is capable of meeting all requirements using a part-time or contracted non-employed director. The Vendor may also use assistant or associate Dental Directors to help perform the functions of this office. The Dental Director and the Vendor's utilization management and quality assurance committee must be accountable to the Vendor's governing body. The Dental Director must be licensed to practice in the State of

Nevada and be board-certified or board-eligible in his or her field of specialty.

The responsibilities of the Dental Director must include the following:

- A. Serves on the Vendor's applicable utilization review/quality assurance committee(s);
- B. Directs the development and implementation of the Vendor's Internal Quality Assurance Plan (IQAP) and utilization management activities, and monitors the quality of the dental care that Vendor recipients receive regarding dental services;
- C. Oversight of the development and revision of the Vendor's dental care standards, practice guidelines and protocols;
- D. Reviews all potential quality-of-care problems regarding dental services, and oversees development and implementation of plans of correction;
- E. Oversight of the Vendor's referral process for specialty and out-of-network services. All services prescribed by a dentist or requested by an enrolled recipient which are denied by the Vendor must be reviewed by a dentist; the reason for the denial must be documented and logged; all denials must identify appeal rights of the recipient;
- F. Oversight of the Vendor's dental provider recruiting and credentialing activities;
- G. Serves as a liaison between the Vendor and its dental providers, communicating regularly with the Vendor's dental providers, including oversight of provider education, in-service training and orientation; and
- H. Availability to the Vendor's medical staff for consultation on referrals, denials, grievances, and appeals, and problems regarding dental services.

4.2.7 Pharmacy Services

Pharmacy services are included in the Vendor benefit package. The Vendor may design its own pharmacy formulary based on clinical guidelines. Medications not covered in the Vendor's formulary must be available through a non-formulary request process based on physician certification and justification of medical necessity. Pharmacy coverage benefits are based on Attachment 3.1A (Section 12a) of the Nevada Medicaid State Plan. The State of Nevada Title XIX State Plan can be accessed on the DHCFP's website at <http://dhcftp.state.nv.us/>.

The Vendor may use generic substitutions unless the physician/dentist justifies the medical necessity of the brand-name pharmaceutical.

The Vendor must have a policy for transitioning a recipient's prescriptions from FFS, or another Vendor, to the Vendor. The Vendor will not terminate a current prescription without consulting with the prescribing provider. The Vendor must then document the reasons a drug is not medically necessary if a current prescription is terminated.

The DHCFP shall approve the Vendor's formulary prior to implementation. The Medicaid Services Manual Chapter 1200 Section 1203.1B (4) stipulates the conditions with which a prescriber must comply to certify that a specific brand of medication is medically necessary for a particular patient. The physician should document in the patient's medical record the need for the brand-name product in place of the generic form. The procedure of the certification must comply with the following: certification must be in the physician's own handwriting; certification must be written directly on the prescription blank; and a phrase indicating the need for a specific brand is required. (An example would be "Brand Medically necessary.") Substitution of generic drugs prescribed by brand name must also comply with NRS 639.2583.

The Vendors shall submit all pharmacy encounters and outpatient administered drug encounters to DHCFP or its vendor and DHCFP shall submit these encounters for rebate from manufacturers and the Secretary pursuant to the Section 2501 of the ACA effective from an April 1, 2010 date of service. The encounters shall be submitted in a mutually agreed upon format and in a mutually agreed upon timeframe, but no later than quarterly. The Vendors agree to modify the medical claims system to mandate providers submit National Drug Code (NDC) codes and related information necessary for DHCFP to process the claim for rebates. The Vendors agree to modify the pharmacy claims processing systems to accommodate additional data elements in compliance with current National Council for Prescription Drug Programs (NCPDP) transactions standards and guidelines, such that pharmacy encounters can be submitted by DHCFP for rebates.

Within 60 calendar days of receipt of any disputed encounter file from DHCFP or its vendor, the Vendors shall, if needed, correct and resubmit any disputed encounters and send a response file that includes 1) corrected and resubmitted encounters and/or 2) an explanation of why the disputed encounters could not be corrected.

4.2.8 Children with Special Health Care Needs (CSHCN) and Mental Health Services for Adults

The Vendor benefit package includes certain services for members with special health care needs, including CSHCN, Early Intervention, and mental health services for adults. The Vendor must reimburse certain types of providers with whom formal contracts may not be in place and coordinate these services, including but not limited to occupational, Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL), speech and physical therapies, with other services in the Vendor benefit package.

The Vendor must implement mechanisms to assess each member identified to the Vendor as an individual with special health care needs in order to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.

The Vendor must produce a treatment plan for members with special health care needs who are determined through an assessment to need a course of treatment or regular care monitoring. The treatment plan must be:

- 4.2.8.1 Developed by the member's primary care provider with member participation, and in consultation with any specialists caring for the member;
- 4.2.8.2 Approved by the Vendor in a timely manner, if approval is required by the Vendor; and
- 4.2.8.3 In accordance with any applicable State quality assurance and utilization review standards.

For members with special health care needs who are determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, the Vendor must have a mechanism in place to allow these members access to a specialist through a standing referral or an approved number of visits, as deemed appropriate for the member's condition and identified needs.

The Vendor is required to adhere to MSM Chapter 400, Section 4.2.3.3 of this RFP, and Section 5 of the Forms and Reporting Guide of this RFP for all SED and SMI referrals and determinations, and must reimburse providers of these services pursuant to the referenced Nevada Medicaid policies and procedures. Pursuant to Section 4.2.3.8 of this RFP, Title XIX Medicaid eligible recipients have the option of disenrolling from the Vendor if determined to be SED or SMI (unless the DHCFP, at its sole discretion, removes the option for these Medicaid recipients determined SED to be voluntarily disenrolled from managed care in the future). Title XXI Nevada Check Up recipients must remain enrolled with the Vendor who is responsible for ongoing patient care.

4.2.9 Transplantation of Organs and Tissue, and Related Immunosuppressant Drugs

These services are covered, with limitations, when medically necessary. Coverage limitations for these services are defined in the Title XIX State Plan. The State of Nevada Title XIX State Plan can be accessed on the DHCFP's website at <http://dhcfp.state.nv.us/>. DHCFP via its Title XIX State Plan Attachment 3.1.E covers Corneal, Kidney, Liver and Bone Marrow transplants and associated fees for adults. For children up to age 21 any medically necessary transplant that is not experimental will be covered. The health plan may claim transplant case reimbursement from DHCFP for in-patient medical expenses above the threshold of \$100,000 in a one-year period (State Fiscal Year). 75% of the expenses above \$100,000 are reimbursed to the health plan.

4.2.10 Out-of-Network Services

If the Vendor's provider network is unable to provide medically necessary services covered under the plan to a particular member, the Vendor must adequately and timely cover these services out of network for the member for as long as the Vendor is unable to provide them. The Vendor benefit package includes covered medically necessary services for which the Vendor must reimburse certain types of providers with whom formal contracts may not be in place. The Vendor must also coordinate these services with other services in the Vendor benefit package. The services/providers are as follows:

4.2.10.1 Out-of-Network Providers

When it is necessary for enrolled recipients to obtain services from out-of-network providers (i.e. the member needs to see a specialist for which the Vendor has no such specialist in its network), the Vendor must:

- A. Coordinate with out-of-network providers with respect to payment;
- B. Offer the opportunity to the out-of-network provider to become part of the network; and
- C. Negotiate a contract to determine the rate prior to services being rendered or pay a rate not to exceed the FFS rate paid by DHCFP.

4.2.10.2 Emergency Services

The Vendor must cover and pay for emergency services regardless of whether the provider who furnished the services has a contract with the Vendor. The Vendor must pay the out-of-network provider for emergency services, applying the "prudent layperson" definition of an emergency, rendered at a rate equivalent to that paid by DHCFP, unless otherwise mutually agreed to between the Vendor and the party(s) rendering service.

No prior or post-authorization can be required for emergency care provided by either network or out-of-network providers. The Vendor may not deny payment for treatment obtained when the member has an emergency medical condition and seeks emergency services, applying the "prudent layperson" definition of an emergency; this includes the prohibition against denying payment in those instances in which the absence of immediate medical attention would have resulted in placing the health of the member in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily part or organ. The Vendor may not deny payment for emergency services treatment when a representative of the Vendor instructs the member to seek emergency services care.

Pursuant to 42 CFR 438.114, the Vendor may not limit what constitutes an emergency medical condition as defined in this section on the basis of lists of diagnoses or symptoms, nor refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agency not notifying the member's PCP, Vendor, or the DHCFP of the member's screening, and treatment within ten (10) calendar days of the presentation for emergency services.

A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. The attending physician or the provider actually treating the member is responsible for determining when the member is sufficiently stabilized for transfer or discharge and that determination is binding on the Vendor.

4.2.10.3 Post-Stabilization Services

The Vendor is financially responsible for:

- A. Post-stabilization services obtained within or outside the network that are pre-approved by a network provider or organization representative;
- B. Post-stabilization services obtained within or outside the network that are not pre-approved by a network provider or other organization representative, but administered to maintain the member's stabilized condition within one (1) hour of a request to the Vendor for pre-approval of further post-stabilization care services; and
- C. Post-stabilization care services obtained within or outside the network that are not pre-approved by a network provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if Vendor does not respond to a request for pre-approval within one (1) hour, or the Vendor cannot be contacted or the Vendor and the treating physician cannot reach an agreement concerning the member's care and a network provider or other organization representative is not available for consultation. In this situation, the Vendor must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the member until a network physician is reached or one of the criteria in 42 CFR 438.114(e) and 42 CFR 422.113 is met.

Pursuant to 42 CFR 438.114(e) and 42 CFR 422.113, the Vendor's financial responsibility for post-stabilization care it has not pre-approved ends when a network physician with privileges at the

treating hospital assumes responsibility for the member's care or a network physician assumes responsibility for the member's care through transfer or the Vendor and the treating physician reach an agreement concerning the member's care or the member is discharged.

Pursuant to CFR 438.114(e), the Vendor charges for post stabilization care services provided by an out-of-network provider to a beneficiary may be no greater than the amount the vendor would charge if the services had been obtained in network.

4.2.10.4 Federally Qualified Health Center (FQHC) and (RHC)

The Vendor must pay for services provided by a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC), including dental care. Vendors may enter into contracts with FQHCs or RHCs provided that payments are at least equal to the amount paid other providers for similar services. If the Vendor does not have a contract with an FQHC or RHC, the Vendor must pay at a rate equivalent to that paid by the DHCFP (i.e. FFS rate). This does not apply to out of network providers of emergency services. The Vendor must demonstrate a good faith effort to negotiate a contract with FQHCs and RHCs and include all licensed and qualified FQHC and RHC providers in the Vendor's network. Contracting with just one provider at each FQHC or RHC does not constitute a good faith effort to include the FQHC or RHC in the Vendor's network. The Vendor must report to DHCFP payments and visits made to FQHCs and/or RHCs.

4.2.10.5 Out-Of-State Providers

When it is necessary for recipients to obtain emergency or urgent services from an out-of-state (OOS) provider, the Vendor must negotiate a contract to determine the rate prior to services being rendered. The Vendor must inform the provider to accept Vendor reimbursement as payment in full. The only exception is for third-party liability. The provider must not bill, accept or retain payments from Medicaid or Nevada Check Up recipients.

4.2.11 Obstetrical/GYN Services

The Vendor will make a good faith effort to screen Title XIX and Title XXI pregnant women enrolled in the Vendor for maternal high risk factors. The Maternity Risk Screening Form helps identify the need for medical and non-medical services. These services are defined as preventive and/or curative services and may include, but are not limited to, patient education, nutritional services, personal care services or home health care, substance abuse services, and care coordination services, in addition to maternity care. The Vendor may use the Maternity Risk Screening Form or its own in-house form in conducting the screening. Any identification of high-risk factors will require the PCP, OB

provider, case manager or other health care professional to refer the woman who is determined to be at risk for preterm birth or poor pregnancy outcome to the Vendor's Case Manager. As appropriate, the Vendor shall assist the recipient in contacting appropriate agencies for care coordination of non-covered/carved-out plan services or community health information. The Vendor's Case Manager will begin medical case management services for those risk factors identified on the maternity Risk Screen. A sample Maternity Risk Screen form is included in the Forms and Reporting Guide.

DHCFP and/or the External Quality Review Organization (EQRO) will conduct on-site reviews as needed to validate coordination and assess medical management of prenatal care and high-risk pregnancies.

4.2.11.1 Obstetrical Global Payment

Length of time that the pregnant woman is enrolled with the Vendor is not a determining factor in payment to the obstetrician. Payment to the delivering obstetrician for normal routine pregnancy shall be based upon the services and number of visits provided by the obstetrician to the pregnant woman through the course of pregnancy. Payments are determined by Current Procedural Terminology (CPT) codes submitted by the provider. The Vendor must provide separate payment for covered medically necessary services required as a result of a non-routine pregnancy.

A Global Payment will be paid to the delivering obstetrician, regardless of network affiliation, when the member has been seen seven (7) or more times. If the obstetrician has seen the member less than seven (7) times, the obstetrician may be paid according to a negotiated rate of less than the FFS rates established for pregnancy-related CPT codes.

A. Network Providers

For all cases, the Vendor must have policies and procedures in place for transitioning the eligible pregnant recipient to a network provider.

1. Vendor must allow for a pregnant member's continued use of their OB/GYN, if at all possible.

B. Non-network Providers

The Vendor may reimburse a non-network provider at a negotiated rate of less than the FFS rates established for pregnancy-related CPT codes.

C. New Members within the Last Trimester of Pregnancy

A pregnant woman who is enrolled with the Vendor within the last trimester of pregnancy must be allowed to remain in the care of a non-network provider if she so chooses. The Vendor must have policies and procedures for this allowance.

D. Prior Authorization

The Vendor's prior authorization policies and procedures must be consistent with the provision of prenatal care in accordance with community standards of practice. DHCFP, at its discretion, may require removal of the prior authorization requirement for various procedures based on reported approval data and any other relevant information. The Vendor is required to provide written notification to all affected network providers within thirty (30) days of the end of a reported quarter regarding the elimination of the prior authorization requirement.

4.2.11.2 Certified Nurse Midwife Services

The Vendor must make certified nurse midwife services available to members if such services are available in the Vendor's service area. If the Vendor does not have a contract for said services, the Vendor may pay the certified nurse midwife provider according to a negotiated rate not to exceed the FFS rates established for pregnancy-related CPT codes.

4.2.11.3 Maternity Kick Payment (Sixth Omnibus Budget Reconciliation Act aka SOBRA)

When a recipient gives birth to a live infant of any gestational age, and there is an accompanying provider claim for the delivery, the Vendor will receive the full Maternity Kick payment. In order for the Vendor to qualify for a Maternity Kick payment for either a miscarriage or stillbirth, the recipient must be in the third trimester of pregnancy, which commences with the twenty-seventh (27th) week of gestation, when the miscarriage or stillbirth occurs. However, only one Maternity Kick payment will be processed per delivery episode regardless of how many babies are delivered. Maternity Kick claim adjudication will be initiated upon electronic receipt of birth information via the Provider Supplied Data File. The Provider Supplied Data File will specifically include: Provider Number, Record Type, Record Creation Date, Recipient Billing ID Number, Recipient Name, Recipient SSN, Delivery Date, Birth Indicator, Gender, Birth Provider Number, Birth Location, and Gestational Weeks Pregnant. Additional birth information may be requested to complete SOBRA financial reporting. Vendor shall provide documentation required for verification within 21 calendar

days of request by DHCFP. Failure to comply may result in rejection of the SOBRA claim in question.

Maternity Kick Payment requests must be submitted within 270 days from date of delivery. The DHCFP will process and pay requests for payment within 30 days of receipt of the verifiable SOBRA request as defined in the *Attachment I Forms & Reporting Guide*.

The Maternity Kick Payment is intended to offset most of the costs to the Vendors for costs associated specifically with the covered delivery of a child, including prenatal and postpartum care. Ante partum care is included in the capitation rate paid for the mother. Costs of care for the newborn are included in the newborn capitation rate.

It is not the intent of the DHCFP to pay a SOBRA payment in a situation where there is no accompanying provider claim for the delivery.

4.2.11.4 Family Planning Services

Federal regulations grant the right to any member of childbearing age to receive family planning services from any qualified provider, even if the provider is not part of the Vendor's provider network. The Vendor may not require family planning services to be prior authorized. Family planning services are provided to members who want to control family size or prevent unwanted pregnancies. Family planning services may include education, counseling, physical examinations, birth control devices, supplies, and Norplant.

Pursuant to MSM Chapter 600, tubal ligations and vasectomies are included for recipients twenty-one (21) years of age or older. Tubal ligations and vasectomies to permanently prevent conception are not covered for any recipient under the age of twenty-one (21) or any recipient who is adjudged mentally incompetent or is institutionalized.

The Vendor must, at a minimum, pay qualified out-of-network providers for family planning services rendered to its members at the FFS rate paid by DHCFP. The Vendor will be responsible for coordinating and documenting out-of-plan family planning services provided to its recipients and the amounts paid for such services.

4.2.11.5 Low Birth Weight Babies

The capitation payment for the 0 - 1 age group will be adjusted to allow funding for a low birth-weight supplemental payment for vendors. This amount will be determined by the State's actuary, and will remain budget neutral to the State. Money drawn from the 0 - 1

age group will be distributed in an actuarially sound manner to offset expenses to either Vendor that receives a disproportionately large number of low birth weight babies. It is not expected that the money will end up evenly distributed between the Vendors, nor is it expected that these supplemental payments will fully offset the actual medical cost of these low birth-weight babies.

Once determined and agreed upon by the submitting Vendor and DHCFP as meeting the criteria for payment, any claims will be paid out within 30 days of receipt by the DHCFP. The distribution will be incident based throughout the year and there will be no requirement for bundling of claims by the Vendors. Although incident based, it is not limited by birth episode criteria but rather will be paid out for each child delivered; i.e. twice for twins, three times for triplets, etc. The weight to be considered low birth weight will be determined by the State with the mutual agreement of the State's actuary and both vendors, and with the understanding that the actual weight in grams may be considered very low birth weight, or worse, by some national standards.

The low birth weight funds determined by the State's actuary are drawn from what would otherwise be paid in the form of capitation. Because the methodology applied must be neutral to the State, and there exists the possibility that, should enrollment trend exceed expectations, a deficit or surplus may occur. The number of low birth weight payments made during a plan year will be a function of caseload using a methodology determined by DHCFP and its actuary and will adjudicate in accordance with birth date and time. No supplemental payments will be made for deliveries beyond the number funded. Conversely, should deliveries fall short of the number funded, any surplus will be paid back to the plans as in a manner determined by the State's actuary, and mutually agreed upon by the Vendors.

4.2.12 Coordination with Other Vendors and Other Services

Pursuant to 42 CFR 438.208(b) (2), (3), and (4) the Vendor is required to implement procedures to coordinate services it may provide to the member with the services the member may receive from any other Vendor. Upon request or notification of need, the Vendor is required to communicate with other Vendors serving the member the results of its identification and assessment of any special health care needs to ensure that services are not duplicated, and to ensure continuity of care. The Vendor's procedures must ensure that, in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164 [(the Health Insurance Portability and Accountability Act (HIPAA))].

The Vendor case managers will be responsible for coordinating services with other appropriate Nevada Medicaid and non-Medicaid programs. This

coordination includes referral of eligible members, to appropriate community resources and social service programs, including supportive housing.

In addition to routine care coordination with other Vendors, the Vendor is responsible for designating a specific clinician or case manager to ensure continuity of services for members with special needs. These members may include, but are not limited to: juveniles temporarily detained by a state or county agency (See Section 3); Seriously Emotionally Disturbed children and adults with Severe Mental Illness (see Section 4.2.3.8); Children With Special Health Care Needs (see Section 4.2.8); and, women with high-risk pregnancies (see Chapter 600, Section 603.4 of the Medicaid Services Manual). Care coordination must address critical issues such as out-of-home placement, specialized mental health services and therapies, and needs that may typically be filled by community resources and social service programs.

4.2.13 Immunizations

The Vendor shall require its network providers to enroll in the Vaccines for Children Program (VFC), which is administered by the Nevada State Health Division. Providers licensed by the State to prescribe vaccines may request to be enrolled in the Nevada State Health Division's VFC Program. The Immunization Program will review and approve provider enrollment requests. The Vendor shall require VFC enrolled providers to cooperate with the Nevada State Health Division for purposes of performing orientation and monitoring activities regarding VFC Program requirements.

Upon successful enrollment in the VFC Program, providers may request state-supplied vaccine to be administered to members through eighteen (18) years of age in accordance with the most current Advisory Committee on Immunization Practices (ACIP) schedule and/or recommendation, and following VFC program requirements as defined in the VFC Provider Enrollment Agreement.

The Vendors shall require VFC-enrolled network providers to participate in the Nevada State Health Division's Immunization Registry to ensure the DHCFP's goal to fully immunize children up to the age of two (2) years. Vendors must reimburse the Washoe County and Clark County Health Departments for the administration of vaccinations when immunizations were provided to their enrolled recipients.

4.2.14 Mental Health Services

Mental health is an integral part of holistic health care. The Vendor shall take affirmative steps to ensure that covered, medically necessary mental health services are provided to enrolled recipients. The Vendor shall provide the following services:

4.2.14.1 Inpatient Psychiatric Hospital;

The Vendor is required to contract with Southern Nevada Adult Mental Health Services (SNAMHS) and Northern Nevada Adult

Mental Health Services (NNAMHS) (the DHCFP reserves the right to change this requirement, pending the decision of the Governor and the Legislature to expand the Medicaid enrollment to childless adults, per the ACA).

4.2.14.2 Mental Health Outpatient Clinic;

The Vendor shall develop incentives encouraging diversions from emergency rooms and psychiatric hospital placement into outpatient clinics, when appropriate.

4.2.14.3 Mental Health Rehabilitative Treatment Services;

4.2.14.4 Psychologist;

4.2.14.5 Outpatient Psychiatric;

4.2.14.6 Residential Treatment Center (RTC);

The Vendor is responsible for reimbursement of all RTC charges including admission, bed day rate, and ancillary [i.e., physician services, optometry, laboratory, dental and x-ray services, etc.] services.

4.2.14.7 Case Management;

4.2.14.8 Habitation Services: Instrumental Activities of Daily Living/ Activities of Daily Living (IADL/ADL);

The DHCFP reserves the right to change this requirement, pending the decision of the Governor and the Legislature to expand the Medicaid enrollment to childless adults, per the ACA.

4.2.14.9 Methadone Treatment; and

4.2.14.10 Alcohol and Substance Abuse Treatment, including Intensive Outpatient Treatment.

4.3 ENROLLMENT AND DISENROLLMENT REQUIREMENTS AND LIMITATIONS

The eligibility and enrollment functions are the responsibility of DHCFP and the Division of Welfare and Supportive Services (DWSS). The Vendor shall accept each recipient who is enrolled in or assigned to the Vendor by DHCFP and/or its enrollment sections and/or for whom a capitation payment has been made or will be made by the DHCFP to the Vendor. The first date a Medicaid or Nevada Check Up-eligible recipient will be enrolled is not earlier than the applicable date in the Vendor's specified contract.

The Vendor must accept recipients eligible for enrollment in the order in which they apply without restriction, up to the limits set under the contract. The Vendor acknowledges that

enrollment is mandatory except in the case of voluntary enrollment programs that meet the conditions set forth in 42 CFR 438.50(a). The Vendor will not, on the basis of health status or need for health services, discriminate against recipients eligible to enroll. The Vendor will not deny the enrollment nor discriminate against any Medicaid or Nevada Check Up recipients eligible to enroll on the basis of race, color or national origin and will not use any policy or practice that has the effect of discrimination on the basis of race, color or national origin. If the recipient was previously disenrolled from the Vendor as the result of a grievance filed by the Vendor, the recipient will not be re-enrolled with the Vendor unless the recipient wins an appeal of the disenrollment. The recipient may be enrolled with another Vendor.

The Vendor is not financially responsible for any services rendered during a period of retroactive eligibility. However, the Vendor is responsible for services rendered during a period of retroactive enrollment in situations where errors have caused an individual to not be properly enrolled with the Vendor. The DHCFP is responsible for payment of applicable capitation for the affected months. As described in Section 3603.15 (B) (1) of the Medicaid Services Manual, the Vendor is responsible for Medicaid newborns as of the date of birth, whether retroactive eligibility, retroactive enrollment, or both are involved. The Vendor must notify a recipient that any change in status, including family size and residence, must be immediately reported by the recipient to their DWSS eligibility worker. The Vendor must provide DHCFP with notification of all births and deaths and demographic changes.

4.3.1 Enrollment of Pregnant Women

The eligibility of Medicaid applicants is determined by the DWSS. DWSS notifies the State's fiscal agent, who enrolls the applicant. Letters are sent to the new recipients requiring them to select a vendor or have a vendor automatically assigned. The Vendor must have written policies and procedures for pregnant women. The chosen Vendor will be notified of the pregnant women's choice by the State's fiscal agent. The Vendor shall be responsible for all covered medically necessary obstetrical services and pregnancy-related care commencing at the time of enrollment.

4.3.2 Enrollment of Program Newborns

The Vendor must have written policies and procedures for enrolling newborns of enrolled recipients. The Vendor is required to report births electronically on a weekly basis to the DHCFP via the Provider Supplied Data file located on the File Transfer Protocol (FTP) site. The Vendor will be responsible for all covered medically necessary services included in the Vendor benefit package to the qualified newborn.

4.3.2.1 Medicaid-Eligible Newborns

Unless there are overriding enrollment conditions, all Title XIX Medicaid eligible newborns born to enrolled recipients are enrolled effective the date of birth if the mother of the newborn was enrolled with the vendor as of the newborn's date of birth. The newborn will

remain enrolled with the vendor for as long as it maintains its Vendor enrollment eligibility.

The Vendor is not financially responsible for any services rendered during a period of retroactive eligibility. However, as described herein, the Vendor will be responsible for all Medicaid newborns as of the date of birth if the mother of the newborn was enrolled with, or should have been enrolled with, the Vendor as of the newborn's date of birth. In situations where it is determined that eligibility decisions were made that caused incorrect enrollment decisions, the MMIS may be corrected to show correct enrollment. In this situation, the Vendor will be responsible for services rendered during this corrected timeframe. The timeframe to make such corrections will be limited to 180 days from any incorrect enrollment date.

4.3.2.2 Nevada Check Up/CHIP Newborns

The Head of Household/Mother must notify the DHCFP of the newborn within 14 days following the delivery in order to qualify to receive coverage from the date of birth. If the family into which the baby is born is a Nevada Check Up family currently receiving coverage from the Vendor for a sibling of the newborn, and the newborn is qualified to receive coverage from the date of birth and is eligible for Nevada Check Up, the Vendor shall receive a capitation payment and provide coverage for the month of birth. The Vendor will also receive a capitation payment and provide coverage for all subsequent months that the child remains enrolled with the Vendor. If notification is not received as required herein, the newborn will be enrolled as of the first day of the next administrative month from the date of notification.

If the mother has other health insurance coverage that provides for 30 days of coverage for the newborn, the newborn will be enrolled as of the first day of the next administrative month. If the coverage extends beyond that 30 day period the child will not be eligible for Nevada Check Up until after the insurance expires and the child's eligibility is determined under Nevada Check Up eligibility rules.

4.3.3 Auto Assignment Process

For Medicaid recipients who do not select a Vendor, DHCFP will assign the recipient to a Vendor, based upon federally required enrollment default criteria that include:

4.3.3.1 The maintenance of existing provider, individual relationships or relationships with traditional Medicaid providers; and

4.3.3.2 Distributing the recipients among the Vendors based upon an algorithm developed by DHCFP when maintaining such

relationships is not possible. In order to serve the best interests of the State, the algorithm will give weighted preference to any new Vendor as well as Vendors with significantly lower enrollments, based on a formula developed by DHCFP. The DHCFP reserves the right to adjust the auto-assignment algorithm in consideration of the Vendors' clinical performance measure results or other measurements, as deemed by DHCFP.

The algorithm is as follows:

Auto Assignment Algorithm if combined Medicaid and NV Check Up Enrollment differs by >10%		
Number of Vendors in Geographic Service Area	Percentage of Recipients Assigned to Largest Vendor	Percentage of Recipients Assigned to 2nd Largest Vendor
2 plans	34%	66%
The function of the algorithm is to ultimately achieve no more than a 10% differential in combined Medicaid and Nevada Check Up enrollment between Vendors. At the end of the open enrollment period, if the enrollment differential between the two Vendors is greater than 10%, the algorithm will assign both Medicaid & Nevada Check Up members exclusively to the Vendor with the smaller enrollment until the differential between the Vendors' enrollments is 10%. The algorithm will then assign equally to the two Vendors. Assignment is by head of household.		

4.3.3.3 The Vendor will accept as enrolled all members appearing on monthly enrollment reports and infants enrolled by virtue of the enrollment status of the mother. The Vendor may not discriminate against beneficiaries on the basis of health needs or health status. The Vendor may not encourage a member to disenroll because of health care needs or a change in health care status. Further, a member's health care utilization patterns may not serve as the basis for disenrollment from the Vendor. An auto assignment algorithm of 1:1 will be applied for all families who do not choose or are otherwise assigned to a specific Vendor. The algorithm will remain 1:1 as long as both vendors enrollment is within 10% of each other. The algorithm will become 2:1 if either plan should fall outside the 10% range and will return to the 1:1 ratio the month following the lower enrollment plan reaching parity (10%). The DHCFP reserves the right to adjust the auto-assignment algorithm in consideration of the Vendors' clinical performance measure results or other measurements.

Nevada Check Up is limited in its ability to adjust the algorithm and will only assign 100% of new members who do not select to the transitioning in Vendor until parity is reached. At that point Nevada Check Up members who do not select will be assigned on a 1:1 basis even if a Vendor falls outside the 10% variance.

4.3.4 Automatic Reenrollment

A recipient who has been disenrolled solely because he or she loses Medicaid or Nevada Check Up eligibility for a period of two (2) months or less will be auto-assigned with the Vendor once they are redetermined as eligible in the third month.

Pending approval of a Section 1115 Research and Demonstration Waiver by CMS, DHCFP may require recipients to choose a Medicaid MCO Vendor as part of their eligibility application or be auto-assigned immediately upon approval of Medicaid eligibility. Recipients would be allowed a 90-day period to change MCOs without cause.

In addition, currently, recipients who temporarily lose eligibility but return within 60 calendar days are automatically re-assigned to their prior MCO Vendor. Those recipients who return after 60 days are given a 30 day choice period during which they may select enrollment in either Vendor. Under the 1115 Waiver, the DHCFP is seeking to modify this so that all returning Medicaid recipients are auto-assigned to their prior Vendor, regardless of the length of the break in eligibility, as long as that Vendor is still contracted with the State.

4.3.5 Disenrollment Requirements and Limitations

4.3.5.1 Disenrollment at the Request of the Member

Recipients are locked into their Vendor, with the exceptions of disenrollment due to good cause and during an annual open enrollment period.

New recipients to Medicaid are always given their choice of two health plans and have 90 days from notice of enrollment to change their Vendor before they are locked in.

Recipients who lose eligibility and regain eligibility will be auto assigned to a Vendor on the criteria of family members in a Vendor, previous enrollment history in a Vendor, or random assignment.

DHCFP will hold an open enrollment period at least once per year. During open enrollment, recipients are free to change Vendors or to remain with their current Vendor. Those recipients who elect to change will have 90 days to return to their previous Vendor.

Once locked in to a Vendor, a member may request disenrollment from the Vendor with cause at any time. Once locked in to a Vendor, if a recipient wishes to disenroll during the lock-in period, they must notify their Vendor in writing. The Vendor will determine if there is good cause to allow disenrollment. Switching Vendors to access a specific provider or facility will generally not be considered good cause.

Good cause for disenrollment as defined in 42CFR438.56 includes:

- A. The recipient moves out of the Vendor service area.
- B. The plan does not, because of moral or religious objections, cover the service the recipient seeks.
- C. The recipient needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the recipient's primary care provider or another provider determines that receiving the services separately would subject the recipient to unnecessary risk.
- D. Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the recipient's health care needs.
- E. If the Vendor determines that there is sufficient cause to disenroll, they will notify DHCFP's Business Lines Unit by fax using the form supplied in **Attachment S, Disenrollment Form** of this RFP. The Vendor must make a determination as expeditiously as the member's health requires and within a timeline that may not exceed fourteen (14) calendar days following receipt of the request for disenrollment.
- F. A Notice of Decision (NOD) must be sent in writing by the Vendor to the recipient within ten (10) calendar days of the decision.

DHCFP's Business Lines Unit will notify the States Fiscal Agent to effect the disenrollment at the first of the next administrative month. If the Vendor denies the request for disenrollment for lack of good cause, a Notice of Decision must be sent in writing to the recipient within 10 days of the decision. Appeals rights must be included with the Notice of Decision. The Vendor is required to inform the member of their right to a State Fair Hearing, how to obtain such a hearing, and representation rules must be explained to the member and provided by the Vendor pursuant to 42 CFR 431.200(b); 42 CFR 431.220(5); 42 CFR 438.414; and 42 CFR 438.10(g)(1). The State ensures access to State fair hearing for any recipient dissatisfied with a determination that there is not good cause for disenrollment.

The DHCFP requires that the recipient seek redress through the Vendors grievance system before making a determination on the recipient's request. The grievance process, if used, must be completed in time to permit the disenrollment (if approved) to be effective no later than the first day of the second month following the month in which the recipient files the request.

If, as a result of the grievance process, the Vendor approves the disenrollment, the State agency is not required to make a determination. If the Vendor cannot make a determination, the Vendor may refer the request to the State.

If the Vendor or State agency (whichever is responsible) fails to make a disenrollment determination so that the recipient can be disenrolled within the timeframes specified, the disenrollment is considered approved.

If the State Agency receives a request directly from the recipient, the recipient will be directed to begin the process by requesting disenrollment through their Vendor.

A recipient who is disenrolled at their request will be automatically enrolled with the other contracted Vendor at the beginning of the next administratively possible month.

Disenrollment procedures are pursuant to 42CFR438.56(d).

4.3.5.2 Disenrollment at the Request of the Vendor

The Vendor may request disenrollment of a recipient if the continued enrollment of the member seriously impairs the Vendor's ability to furnish services to either this particular member or other members. In addition, the Vendor must confirm the member has been referred to the Vendor's Enrollee Services Department and has either refused to comply with this referral or refused to act in good faith to attempt to resolve the problem. Prior approval by DHCFP of a Vendor's request for the member's disenrollment is required. If approval is granted, the member will be given notice by the Vendor that disenrollment will occur effective the first day of the next month following administrative cut off.

DHCFP will make a determination on such a request within five (5) days. If approval is granted, the member will be given notice by the Vendor that disenrollment will occur effective the first day of the next month following administrative cut off. In the event DHCFP fails to make a disenrollment determination within the timeframes specified, the disenrollment shall be considered approved.

A Vendor may not request disenrollment of a member for any of the following reasons:

- A. An adverse change in the member's health status;
- B. Pre-existing medical condition;
- C. The member's utilization of medical services;

- D. Diminished mental capacity;
- E. Uncooperative or disruptive behavior resulting from his/her special needs (except when continued enrollment of such a member seriously impairs the Vendor's ability to furnish services to either this particular member or other members);
- F. A member's attempt to exercise his/her grievance or appeal rights; or
- G. Based on the member's national origin, creed, color, sex, religion, age, pursuant to Section 3.2 of this RFP and applicable CFR's.

4.3.5.3 Disenrollment Pursuant to a Finding of SED or SMI Status or Children With Special Health Care Needs (CSHCN) and Mental Health Services for Adults: See Section 4.2.8 of this RFP. The State may, at its sole discretion, remove the option for these Medicaid recipients determined SED to be voluntarily disenrolled from managed care in the future.

4.3.5.4 Disenrollment due to the member relocating outside of the Vendor's service area, pursuant to 42 CFR 438.56(d)(2).

4.3.6 Enrollment, Disenrollment and Other Updates

The Vendor must have written policies and procedures for receiving monthly updates from DHCFP of recipients enrolled in, and disenrolled from, the Vendor, and other updates pertaining to these recipients. The updates will include those newly enrolled with the Vendor. The Vendor must incorporate these updates into its management information system.

4.3.6.1 An open enrollment period will be held annually. The open enrollment period may be changed solely at the State's discretion. During the open enrollment period, a member may disenroll from their Vendor without cause.

4.3.6.2 Notice of termination rights — The State shall, through its fiscal agent, provide for notice to each such individual of the opportunity to terminate (or change) enrollment under such conditions. Such notice shall be provided at least 60 days before each annual enrollment opportunity described in subparagraph (A)(ii)(II) of the Social Security Act of 1932.

4.3.7 Enrollment Interface

Upon initiation of the transition phase for a new Vendor, the Vendor must furnish the technical means by which the Vendor's Enrollment Sections can:

4.3.7.1 Determine the number of recipients each enrolled PCP will accept as new patients; and

4.3.7.2 Transmit member elections regarding PCP assignment for the forthcoming month.

4.3.8 Provider Enrollment Roster Notification

The Vendor must either notify or provide the means for providers to verify recipients' PCP selection. The Vendor must establish and implement a mechanism to inform each PCP about any newly enrolled recipients assigned to the PCP on at least a monthly basis. This information must be made available to each PCP within five (5) business days of the Vendor receiving the Membership File. The Enrollment Sections will pass the Membership File through the system for verification of eligibility prior to distribution to the Vendor, who will in turn be responsible for keeping individual participating providers informed. The Vendor may elect to update its Membership File more frequently to keep PCPs informed of the enrollment activity.

4.3.9 Change in a Recipient's Status

Within seven (7) calendar days of becoming aware of any changes in a recipient's status, including changes in family size and residence, the Vendor must electronically report the change(s) to DHCFP via the provider supplied data file.

4.3.10 Transitioning/Transferring of Recipients

4.3.10.1 Transitioning Recipients into Vendors

The Vendor will be responsible for recipients as soon as they are enrolled and the Vendor is aware of the member in treatment. The Vendor must have policies and procedures for transitioning recipients currently receiving services in the FFS program into the Vendor's plan. The Vendor must have policies and procedures including, without limitation, the following to ensure a recipient's smooth transition from FFS to the Vendor:

A. Recipients with medical conditions such as:

1. Pregnancy (especially if high risk);
2. Major organ or tissue transplantation services in process;
3. Chronic illness;
4. Terminal illness; and/or
5. Intractable pain.

- B. Recipients who, at the time of enrollment, are receiving:
 - 1. Chemotherapy and/or radiation therapy;
 - 2. Significant outpatient treatment or dialysis;
 - 3. Prescription medications or durable medical equipment (DME); and/or
 - 4. Other services not included in the State Plan but covered by Medicaid under EPSDT for children.

- C. Recipients who at enrollment:
 - 1. Are scheduled for inpatient surgery(s);
 - 2. Are currently in the hospital;
 - 3. Have prior authorization for procedures and/or therapies for dates after their enrollment; and/or,
 - 4. Have post-surgical follow-up visits scheduled after their enrollment.

4.3.10.2 Transferring Recipients between Vendors

It may be necessary to transfer a recipient from one Vendor to another or to FFS for a variety of reasons. When notified that a member has been transferred to another plan or to FFS, the Vendor must have written policies and procedures for transferring/receiving relevant patient information, medical records and other pertinent materials to the other plan or current FFS provider. This includes any Care Management Organizations (CMOs) providing services to the FFS population.

Prior to transferring a recipient, the Vendor (via their subcontractors when requested by the Vendor) must send the receiving plan or provider information regarding the recipient's condition. This information shall include the name of the assigned PCP, as well as the following information, without limitation, as to whether the recipient is:

- A. Hospitalized;
- B. Pregnant;
- C. Receiving dialysis;
- D. Chronically ill (e.g., diabetic, hemophilic, etc.);

- E. Receiving significant outpatient treatment and/or medications, and/or pending payment authorization request for evaluation or treatment;
- F. On an apnea monitor;
- G. Receiving behavioral or mental health services;
- H. Receiving Nevada Early Intervention Services in accordance with an Individualized Family Service Plan (IFSP), which provides a case manager who assists in developing a plan to transition the child to the next service delivery system. For most children, this would be the school district and services are provided for the child through an Individual Education Program (IEP);
- I. Involved in, or pending authorization for, major organ or tissue transplantation;
- J. Scheduled for surgery or post-surgical follow-up on a date subsequent to transition;
- K. Scheduled for prior authorized procedures and/or therapies on a date subsequent to transition;
- L. Referred to a Specialist(s);
- M. Receiving substance abuse treatment for recipients twenty-one (21) and older;
- N. Receiving prescription medications;
- O. Receiving durable medical equipment or currently using rental equipment;
- P. Currently experiencing health problems; or
- Q. Receiving case management (including the case manager's name and phone number).

When a recipient changes Vendors or reverts to FFS while hospitalized, the transferring Vendor shall notify the receiving Vendor, the receiving provider, or the DHCFP Quality Improvement Organization (QIO) as appropriate, of the change within five (5) calendar days.

4.3.10.3 Transitioning Recipients between Vendor and the State Designated Health Insurance Exchange (HIX)

A recipient may need to be transitioned between Medicaid and the State-designated Health Insurance Exchange (HIX), due to changes

in eligibility. When notified that a member is being transferred to the HIX, the Vendor must have written policies and procedures for transferring/receiving relevant patient information and other pertinent materials to/from the HIX. This must be done in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other privacy laws.

4.4 RECIPIENT SERVICES

4.4.1 Information Requirements

The Vendor must have written information about its services and access to services available upon request to members and potential members. This written information must also be available in the prevalent non-English languages, as determined by the State, in its particular geographic service area. The Vendor must make free, oral interpretation services available to each member and potential member. This applies to all non-English languages, not just those that the State identifies as prevalent.

The Vendor is required to notify all members and potential members that oral interpretation is available for any language and written information is available in prevalent languages. The Vendor must notify all members and potential members how to access this information.

The Vendor's written material must use an easily understood format. The Vendor must also develop appropriate alternative methods for communicating with visually and hearing-impaired members, and accommodating physically disabled recipients in accordance with the requirements of the Americans with Disabilities Act of 1990. All members and potential members must be informed that this information is available in alternative formats and how to access those formats. The Vendor will be responsible for effectively informing Title XIX Medicaid members who are eligible for EPSDT services, regardless of any thresholds.

4.4.1.1 Member Handbook

The Vendor must provide all members with a Member Handbook. The Vendor can meet this requirement by sending the Member Handbook to the head of the household. The handbook must be written at no higher than an eighth (8th) grade reading level and must conspicuously state the following in bold print.

“THIS HANDBOOK IS NOT A CERTIFICATE OF INSURANCE AND SHALL NOT BE CONSTRUED OR INTERPRETED AS EVIDENCE OF INSURANCE COVERAGE BETWEEN THE VENDOR AND THE ENROLLEE.”

- A. The Vendor must submit the Member Handbook to DHCFFP before it is published and/or distributed. DHCFFP will review the handbook and has the sole authority, in conjunction with

the Medical Care Advisory Committee (MCAC), to approve or disapprove the handbook and the Vendor's policies and procedures. The Vendor must agree to make modifications in handbook language if requested by the DHCFP, in order to comply with the requirements as described above or as required by CMS or State law. In addition the Vendor must maintain documentation that the handbook is updated at least once per year. Prior to contract start date, the initial handbook must be submitted to DHCFP for its MCAC review. Thereafter, annual updates must be submitted to DHCFP for approval before publication and/or distribution.

- B. The Vendor must mail the handbook to all members within five (5) business days of receiving notice of the recipient's enrollment and must notify all members of their right to request and obtain this information at least once per year or upon request. The Vendor will also publish the Member Handbook on the Vendor's Internet website upon contract implementation and will update the website at least monthly, as needed, to keep the Member Handbook current. At a minimum, the information enumerated below must be included in the handbook.
- C. Explanation of benefits and how to obtain benefits, including out-of-plan benefits, and how to access them, the address and telephone number of the Vendor's office or facility, and the days the office or facility is open and services are available.
- D. The role of the primary care provider (PCP) and a description of how the enrolled recipient will receive confirmation of their selection of a PCP, if a PCP was designated at the time of enrollment.
- E. Note: Confirmation of the member's PCP selection may be via an ID card and not printed directly in the member handbook.
- F. A list of current network PCPs who are and who are not accepting new patients in the member's service area, including their board certification status, addresses, telephone numbers, availability of evening or weekend hours, all languages spoken, with information on specialists and hospitals. The list may be supplied as a separate document from the member handbook. The provider list shall be updated by the Vendor monthly.
- G. Any restrictions on the member's freedom of choice among network providers.

- H. Procedures for changing a PCP.
- I. Member rights and protections as specified in 42 CFR 438.100.
- J. The amount, duration and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled.
- K. Procedures for obtaining benefits, including authorization requirements.
- L. The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers.
- M. Procedures for disenrollment without cause during the 90 day period beginning on the date the enrollee receives notice of enrollment and the annual open enrollment period. The handbook must also have procedures for disenrolling with cause.
- N. A recipient who has been disenrolled solely because he or she loses Medicaid or Nevada Check Up eligibility will be auto-assigned as follows: by family affiliation (if other family members are enrolled); by history (assigned to the last Vendor in which the recipient was enrolled); or randomly.
- O. The extent to which, and how, after-hours and emergency coverage are provided including: what constitutes an emergency medical condition; emergency and post stabilization services with reference to the definitions in 42 CFR 438.114; the fact that prior authorization is not required for emergency services; the process and procedures for obtaining emergency services, including the 911-telephone system or its local equivalent; the locations of any emergency settings and other locations at which providers and hospitals furnish emergency and post stabilization services under the contract; the fact that, subject to regulatory limitations, the member has a right to use any hospital or other setting for emergency care.
- P. Explanation of procedures for urgent medical situations, and how to utilize services in other circumstances, including the recipient services telephone number; clear definitions of urgent care, emergency care, and emergency transportation, and clarification of the appropriate use of each.

- Q. Policy on referrals for specialty care and for other benefits not furnished by the member's PCP, including explanation of authorization procedures.
- R. How and where to access any benefits that are available under the Title XIX and Title XXI State Plans but are not covered under the contract, including any cost sharing, and how transportation is provided. For a counseling or referral service that the Vendor does not cover because of moral or religious objections, the Vendor need not provide the information on how or where to obtain the service. The Vendor must notify the State regarding services that meet this criteria and in those instances, the State must provide the information on where and how to obtain the service.
- S. Procedures for accessing emergency and non-emergency services when the recipient is in and out of the Vendor service area.
- T. Information on grievance and fair hearing procedures in Section 4.11 of this RFP, as specified in 42 CFR 438.10(g).
- U. Information on procedures for recommending changes in policies and services.
- V. The Vendor must provide adult members with written information on advance directives' policies and include a description of applicable State law. This information must reflect changes in State law as soon as possible but no later than 90 days after the change. The Vendor must ask each health care practice to ensure that a signed "Acknowledgment of Patient Information on Advance Directives" form is included in the recipient's medical record. (A sample form is available online at <http://dhcfp.state.nv.us/advancedirectives.htm>).
- W. To the extent available, quality and performance indicators, including member satisfaction.
- X. The Vendor is also required to provide to the member upon request, information on the structure and operation of the Vendor and information about physician incentive plans as set forth in 42 CFR 438.6(h).

- Y. The member handbook must include a distinct section for eligible recipients which explains the EPSDT program and includes a list of all the services available to children; a statement that services are free and a telephone number which the member can call to receive assistance in scheduling an appointment.
- Z. Information regarding prescription coverage.
- AA. Notification of the member's responsibility to report any ongoing care corresponding to a plan of care at the time of enrollment, and their right to continue that treatment under the Vendor on a transitional basis.
- BB. Notification of the member's responsibility to report any third-party payment service to the Vendor and the importance of doing so.
- CC. The Vendor must give each member written notice of any significant change, as defined by the State, in any of the enumerations noted above. The Vendor shall issue updates to the Member Handbook on a monthly basis when there are material changes that will affect access to services and information about the Managed Care Program; this includes additions and changes to the provider network. The Vendor shall also provide such notices in its semi-annual recipient newsletters and shall maintain documentation verifying handbook updates.
- DD. The Vendor must give written notice of termination of a contracted provider, within fifteen (15) business days after receipt or issuance of the termination notice. This notice shall be provided to each member who received his/her primary care from, or was seen on a regular basis by, the terminated provider.
- EE. Explanation of fraud and abuse and how to report suspected cases of fraud and abuse, including hotlines, e-mail addresses and the address and telephone number of the Vendor's fraud and abuse unit.

4.4.1.2 Advance Directives Requirements

Pursuant to Section 1902(w)(1) of the Social Security Act, the Patients' Self-Determination Act, including advance directives, Vendors must have written policies and procedures with respect to all emancipated adult members receiving medical care through the Vendor. Specifically, this act requires the Vendor:

- A. To provide written information to each member at the time of enrollment concerning:
 - 1. The member's rights, under State law, to make decisions concerning medical care, including the right to accept or refuse medical treatment and the right to formulate advance directives;
 - 2. The Vendor's policies with regard to a member's right to execute an advance directive, including a requirement that the network provider present a statement of any limitations in the event the provider cannot implement an advance directive on the basis of conscience. At a minimum, the provider's statement of limitation, if any, must:
 - a. Clarify any differences between institution-wide conscience objections and those that may be raised by individual network providers;
 - b. Identify the State legal authority pursuant to NRS 449.628 permitting such objections; and
 - c. Describe the range of medical conditions or procedures affected by the conscience objection.
- B. Vendor will educate the member to inform his/her provider to document in the member's medical record whether the member has executed an advance directive;
- C. Not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
- D. To ensure compliance with requirements of State laws regarding advance directives, including informing members that any complaints concerning the advance directives requirements may be filed with the appropriate State agency which regulates Vendors; and
- E. To educate Vendor staff and providers on issues concerning advance directives, at least annually.

Sample advance directives policies, procedures and forms, as well as patient information concerning Nevada law, are available on the DHCFP's website: <http://dhcfp.state.nv.us/advancedirectives.htm>.

4.4.2 Enrollee Services Department

The Vendor shall maintain a Enrollee Services Department (aka, Member Services Department) that is adequately staffed with qualified individuals who shall assist enrolled recipients, enrolled recipients' family members, or other interested parties (consistent with laws on confidentiality and privacy) in obtaining information and services under the Vendor's plan. The Enrollee Services Department is to be operated at least during regular business hours.

At a minimum, Enrollee Services Department staff must be responsible for the following:

Explaining the operation of the Vendor;

- 4.4.2.1 Assisting members in selecting and/or changing PCPs or Primary Care Sites (PCSs). The Vendor must report any PCP/PCS changes electronically to the DHCFP;
- 4.4.2.2 Explaining covered benefits;
- 4.4.2.3 Assisting members to make appointments and obtain services;
- 4.4.2.4 Resolving, recording and tracking member grievances and appeals in a prompt and timely manner;
- 4.4.2.5 Responding to member inquiries; and
- 4.4.2.6 Assisting members in obtaining out-of-area and out-of-network care.

While the Enrollee Services Department will not be required to operate after business hours, the Vendor must comply with the requirement to provide urgent care and emergency coverage twenty-four (24) hours per day, seven (7) days per week. The Vendor must have written policies and procedures describing how enrolled recipients and providers can obtain urgent coverage and emergency services after business hours and on weekends. Policies and procedures must include provision of direct contact with qualified clinical staff. Urgent coverage means those problems which, though not life-threatening, could result in serious injury or disability unless medical attention is received.

4.4.3 Medical Provider Requirements

4.4.3.1 Primary Care Provider (PCP) or Primary Care Site (PCS)

The Vendor shall allow each enrolled recipient the freedom to choose from among its participating PCPs and change PCPs as requested.

Each enrolled recipient must be assigned to a PCP or Primary Care Site (PCS), within five (5) business days of the effective date of enrollment. Members with disabilities, chronic conditions, or

complex conditions must be allowed to select a specialist as their PCP. Members with disabilities must be given an additional 30 days to select a PCP. The Vendor may auto-assign a PCP or PCS that has traditionally served the Medicaid population to an enrolled recipient who does not make a selection at the time of enrollment. If the enrolled recipient desires, the Vendor shall allow him or her to remain with his or her existing PCP if the PCP is a member of Vendor's primary care network.

4.4.3.2 Twenty-Five (25) Mile Rule

The Vendor must offer every enrolled recipient a PCP or PCS located within a reasonable distance from the enrolled recipient's place of residence, but in any event, the PCP or PCS may not be more than twenty-five (25) miles from the enrolled recipient's place of residence per NAC 695C.160 without the written request of the recipient.

4.4.3.3 Assignment of a PCP or PCS

If an enrolled recipient does not choose a PCP, the Vendor shall match enrolled recipients with PCPs by one or more of the following criteria:

- A. Assigning enrolled recipients to a provider from whom they have previously received services, if the information is available;
- B. Designating a PCP or PCS who is geographically accessible to the enrolled recipient per NAC 695C.160 (25 Mile Rule);
- C. Assigning all children within a single family to the same PCP;
- D. Assigning a Child with Special Health Care Needs (CSHCN) to a practitioner experienced in treating that condition, if the Vendor knows of the condition; and/or
- E. Assigning a member to a PCP upon receipt of a claim for services rendered by a PCP to the member.

The Vendor shall ensure that enrolled recipients receive information about where they can receive care during the time period between enrollment and PCP selection/assignment. The Vendor shall notify the enrolled recipient in writing of his or her assigned PCP within five (5) business days of assignment.

4.4.3.4 Changing a PCP or PCS

- A. An enrolled recipient may change a PCP or PCS for any reason. The Vendor shall notify enrolled recipients of procedures for changing PCPs. The materials used to notify enrolled recipients shall be approved by DHCFP prior to publication and/or distribution.
- B. In cases where a PCP has been terminated, the Vendor must notify enrolled recipients in writing and allow recipients to select another primary care provider, or make a re-assignment within fifteen (15) business days of the termination effective date, and must provide for urgent care for enrolled recipients until re-assignment.
- C. The Vendor may initiate a PCP or PCS change for an enrolled recipient under the following circumstances:
 - 1. Specialized care is required for an acute or chronic condition;
 - 2. The enrolled recipient's residence has changed such that distance to the PCP is greater than twenty-five (25) miles. Such change will be made only with the consent of the member;
 - 3. The PCP ceases to participate in the Vendor's network;
 - 4. Legal action has been taken against the PCP, which excludes provider participation; or
 - 5. The recipient will be given the right to select another PCP or PCS within the Vendor network.
- D. The Vendor shall document the number of requests to change PCPs and the reasons for such requests.

4.4.3.5 Use of Medical Homes and Accountable Care Organizations

- A. The Vendor is required to use existing patient-centered medical homes/health homes, when available and appropriate.
- B. Vendor should use supportive provider services and contracting to support the expansion of patient-centered medical homes/health homes.
- C. Vendor shall use Accountable Care Organizations (ACOs) and other innovative models, when available and appropriate.

4.5 NETWORK

The Vendor is required to establish and manage provider networks in geographically accessible locations as specified in NRS 695C.070.11 and 695C.080.2 (a). The Vendor shall maintain a network of physicians, hospitals, and other health care professionals and ancillary services through which it provides the items and services included in covered benefits in a manner that complies with the requirements of this section and meets access standards described in Section 4.5.5 of this RFP. The Vendor shall ensure that its network providers are appropriately credentialed and well coordinated with other network services and services available outside of the health plan network. The network shall include an adequate number of PCPs, specialists, and hospitals appropriately credentialed as health care professionals located in geographically and physically accessible locations to meet the access standards specified in this RFP. The Vendor's management oversight includes, but is not limited to, credentialing, maintenance, provider profiling, peer review, dispute resolution and Medical Director Services.

Network providers will be required to use designated practice guidelines and protocols mutually agreeable to the Vendor and DHCFP. Prior to the contract start date the Vendor shall identify the practice guidelines it intends to use for acceptance by DHCFP. Submission shall occur after awarded contract. The State shall accept or reject within ten (10) business days of receipt.

4.5.1 The Vendor must adopt practice guidelines and protocols which:

- 4.5.1.1 Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
- 4.5.1.2 Consider the needs of the Vendor's members;
- 4.5.1.3 Are adopted in consultation with contracting health care professionals; and
- 4.5.1.4 Are reviewed and updated periodically as needed to reflect current practice standards.

4.5.2 The Vendor must:

- 4.5.2.1 Disseminate its practice guidelines to all affected providers prior to the contract start date and, upon request, to members and potential members, including prior authorization policies and procedures;
- 4.5.2.2 Ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines;
- 4.5.2.3 Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services;

- 4.5.2.4 Ensure that its providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid FFS, if the provider serves only Medicaid members;
- 4.5.2.5 Make services included in the contract available twenty-four (24) hours per day, seven (7) days a week, when medically necessary;
- 4.5.2.6 Establish mechanisms to ensure compliance by providers;
- 4.5.2.7 Monitor providers regularly to determine compliance;
- 4.5.2.8 Take corrective action if there is a failure to comply by network providers; and
- 4.5.2.9 Participate in state and federal efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

The Vendor may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification. If the Vendor declines to include an individual or groups of providers in its network, it must give the affected network provider(s) written notice of the reason for its decision. 42 CFR 438.12 (a) may not be construed to require the Vendor to contract with providers beyond the number necessary to meet the needs of its members; or, preclude the Vendor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or, preclude the Vendor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.

The Vendor must provide to the State supporting documentation, in a format specified by the State, which demonstrates it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care. Such documentation must demonstrate that the Vendor offers an appropriate range of preventive, primary care, and specialty services and 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 Vendor must submit such documentation at the time it enters into a contract with the State and at anytime thereafter when there has been a significant change, as defined by the State, in the Vendor's operations that would affect adequate capacity and services. A significant change includes but may not be limited to: changes in the Vendor's services, benefits, geographic service area or payments; or, enrollment of a new population in the network.

4.5.3 Network Management

4.5.3.1 Primary Care Provider (PCP) or Primary Care Site (PCS) Responsibilities

The PCP or a physician in a PCS serves as the recipient's initial point of contact with the Vendor. As such, the PCP or the physician at the PCS is responsible for the following:

- A. Delivery of covered medically necessary, primary care services and preventive services, including EPSDT screening services;
- B. Provision of twenty-four (24)-hour, seven (7) days per week coverage;
- C. Referrals for specialty care and other covered medically necessary services in the managed care benefit package;
- D. Members shall be allowed to self-refer for family planning, obstetrical, gynecological, mental health and substance abuse services, within the Vendor's network;
- E. Continuity and coordination of the enrolled recipient's health care; and
- F. Maintenance of a current medical record for the enrolled recipient, including documentation of all services provided by the PCP, and specialty or referral services, or out-of-network services such as family planning and emergency services.

Although PCPs must be given responsibility for the above tasks, the Vendor must agree to retain responsibility for monitoring PCP and PCS activities to ensure they comply with the Vendor's and the State's requirements. The Vendor is prohibited from imposing restrictions on the above tasks.

4.5.3.2 Laboratory Service Providers

The Vendor shall ensure that all laboratory testing sites providing services under this contract have a valid Clinical Laboratory Improvement Amendments (CLIA) certificate, a CLIA identification number, and comply with CLIA regulations as specified by 42 CFR Part 493. The Vendor shall provide to DHCFP, on request, copies of certificates of any laboratories with which it conducts business.

4.5.3.3 Essential Community Providers

An essential community provider is defined as a provider:

- A. That accepts patients on a sliding scale fee, determined on the income of the patient;
- B. That does not restrict access or services due to financial limitations of a patient; and
- C. That can demonstrate to DHCFP that the restriction of patient base from this provider would cause access problems for either Medicaid or low-income patients.

The Vendor is required to negotiate in good faith with all of the following essential community providers who are located in the plan's geographic service area(s):

- D. A Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) to provide health care services;
- E. The University Medical Center of Southern Nevada to provide inpatient and ambulatory services;
- F. The University of Nevada School of Medicine (UNSOM) System, including Mojave Mental Health clinics, to provide health care and behavioral health care services;
- G. University of Nevada, Las Vegas, School of Dentistry;
- H. School-Based Clinics;
- I. Mental Health and Developmental Services Division (MHDS);
- J. Health Division;
- K. Substance Abuse Prevention and Treatment Agency (SAPTA);
- L. Division of Child and Family Services;
- M. County Child Welfare Agencies; and
- N. Any health provider designated by DHCFP as an essential community provider. DHCFP will notify the Vendor of providers designated by DHCFP as essential community providers.
- O. At the States option, the Vendor may be required to contract with other agencies within the DHHS, the Juvenile Justice system, Disproportionate Share Hospitals (DSH), or various Washoe and Clark County entities in providing medically

necessary services, including behavioral health. If this option is exercised and there is any resulting additional expense incurred by the vendor, the DHCFP will adjust the capitation rate so that it remains actuarially sound.

- P. Negotiating in good faith requires, at a minimum, offering contracts that are at least as beneficial to the provider as contracts with other providers in the same geographic area for similar services. Providers who work through one of the essential community providers must be negotiated in good faith.

4.5.4 Subcontractors

All Subcontracts, including delegation agreements, must be in writing, must be prior approved by the DHCFP, and must contain all applicable items and requirements as set forth in the DHCFP Managed Care Contract, as amended. The Vendor may not delegate any item or requirement in the DHCFP Managed Care Contract to any subcontractor or network provider without the express, written approval of the DHCFP. The Vendor's failure to obtain advance written approval of a Subcontract from the DHCFP will result in the application of a penalty equal to one (1) month's current capitation payment for an adult female TANF recipient for each day that the subcontractor was in effect without the DHCFP's approval. Without limitation the Vendor must make all Subcontracts available within five (5) business days of a request by the DHCFP. This includes but is not limited to administrative, technical and medical providers.

The Vendor may, as provided below, rely on subcontractors to perform and/or arrange for the performance of services to be provided to enrolled recipients on whose behalf the DHCFP makes Capitation payments to the Vendor. Notwithstanding the use of subcontractor(s), the Vendor accepts and acknowledges its obligation and responsibility under this Contract as follows:

4.5.4.1 For the provision of and/or arrangement for the services to be provided under this Contract;

4.5.4.2 For the evaluation of the prospective subcontractor's ability to perform the activities to be delegated; and

4.5.4.3 For the payment of any and all claims payment liabilities owed to providers for services rendered to enrolled recipients under this RFP, for which a subcontractor is the primary obligor provided that the provider has exhausted its remedies against the subcontractor; provided further that such Provider would not be required to continue to pursue its remedies against the subcontractor in the event the subcontractor becomes insolvent, in which case the provider may seek payment of such claims from the Vendor. For the purposes of this section, the term "Insolvent" shall mean:

- A. The adjudication by a court of competent jurisdiction or administrative tribunal of a party as a bankrupt or otherwise

approving a petition seeking reorganization, readjustment, arrangement, composition, or similar relief under the applicable bankruptcy laws or any other similar, applicable Federal or State law or statute; or

- B. The appointment by such a court or tribunal having competent jurisdiction of a receiver or receivers, or trustee, or liquidator or liquidators of a party or of all or any substantial part of its property upon the application of any creditor or other party entitled to so apply in any insolvency or bankruptcy proceeding or other creditor's suit.

4.5.4.4 For the oversight and accountability for any functions and responsibilities delegated to any subcontractor. The Vendor shall indemnify and hold the State of Nevada, the DHCFP and their officials, representatives and employees harmless from any and all liabilities, losses, settlements, claims, demands, and expenses of any kind (including but not limited to attorneys' fees) which are related to any and all claims payment liabilities owed to providers for services rendered to enrolled recipients under this RFP for which a subcontractor is the primary obligor, except to the extent that the Vendor and/or subcontractor has acted with respect to such provider claims in accordance with the terms of this RFP.

4.5.4.5 Subcontracts which must be submitted to the DHCFP for advance written approval include any subcontract between the Vendor, excluding network provider contracts, and any individual, firm, corporation or any other entity engaged to perform part or all of the selected Vendor's responsibilities under the DHCFP Managed Care Contract. This provision includes, but is not limited to, contracts for vision services, dental services, mental or behavioral health services, claims processing, member services, provider services, and/or pharmacy services. This provision does not include, for example, purchase orders. In addition, the Vendor must provide written information to the DHCFP prior to the awarding of any contract or Subcontract regarding the disclosure of the Vendor's ownership interests of five percent (5%) or more in any delegated entity or Subcontractor.

4.5.4.6 As part of its provider contracting and subcontracting, the Vendor agrees that it shall comply with the procedures set forth in ***Attachment D, Contract Form.***

4.5.4.7 Subcontractor contracts may not be structured to provide financial or other incentives to providers and subcontractors for denying or limiting services.

4.5.4.8 The use of "gag" clauses in subcontractor contracts is prohibited.

4.5.5 Access and Availability

The Vendor shall:

- 4.5.5.1 Ensure adequate physical and geographic access to covered services for enrolled recipients.
- 4.5.5.2 On a quarterly basis, use geo-access mapping and data-driven analyses to ensure compliance with access standards, and take appropriate corrective action, if necessary, to comply with such access standards.
- 4.5.5.3 Partner actively with DHCFP, community providers and stakeholders to identify and address issues and opportunities to improve health care access and availability for Medicaid and CHIP members.
- 4.5.5.4 The Vendor will assure access to health screenings, reproductive services and immunizations through county and state public health clinics.
- 4.5.5.5 Promotion of care management and early intervention services may be accomplished by completing welcome calls and/or visits to new members. This method ensures that an orientation with emphasis on access to care, choice of PCP and availability of an initial health risk screening occurs proactively with each member who becomes enrolled. If a screening risk level determines need for further care management a care management referral will be completed.
- 4.5.5.6 Maintain an adequate network that ensures the following:
 - A. PCP-To-Recipient Ratios

The Vendor must have at least one (1) full-time equivalent (FTE) primary care provider, considering all lines of business for that provider, for every one thousand five hundred (1,500) members per service area. However, if the PCP practices in conjunction with a health care professional the ratio is increased to one (1) FTE PCP for every one thousand eight hundred (1,800) recipients per service area.
 - B. PCP Network Requirements

Demonstrate that the capacity of the PCP network meets the FTE requirements for accepting eligible recipients per service area. This ratio cannot exceed the FTE requirement. In no case may a single provider accept more members than allowed by the FTE requirement.

C. Primary Care Provider Participation

Per geographic service area, at least fifty percent (50%) of all of the Network PCPs must contractually agree to accept eligible recipients. At least fifty percent (50%) of the aforementioned PCPs must accept eligible recipients at all times. If the Vendor has a contract with a Federally Qualified Health Center (FQHC) and/or the University of Nevada Medical School, the physicians of these two (2) organizations can be counted to meet the fifty percent (50%) participation and fifty percent (50%) acceptance requirement. DHCFP or its designee may audit the Vendor's network monitoring tool for compliance.

D. Physician Specialists

The Vendor must provide access to all types of physician specialists for PCP referrals, and it must employ or contract with specialists, or arrange for access to specialty care outside of the Vendor's network in sufficient numbers to ensure specialty services are available in a timely manner. The Vendor should provide access to at least two specialists/subspecialists in their service areas. The minimum ratio for specialists (i.e., those who are not PCPs) is one (1) specialist per one thousand five hundred recipients per service area (1:1,500).

These ratios may be adjusted by DHCFP for under-served areas, upon the analysis of physician specialist availability by specific service area.

4.5.5.7 Ensure enrolled recipients' access to covered services is consistent with the degree of urgency, as follows:

A. Emergency Services

Emergency Services shall be provided immediately on a twenty-four (24)-hour basis, seven (7) days a week, with unrestricted access, to enrolled recipients who present at any qualified provider, whether a network provider or a out-of-network provider.

B. PCP Appointments

1. Same-day, medically necessary, primary care provider appointments;
2. Urgent care PCP appointments are available within two (2) calendar days; and

3. Routine care PCP appointments are available within two (2) weeks. The two (2) week standard does not apply to regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every two (2) weeks.

C. Specialist Appointments

For specialty referrals to physicians, therapists, behavioral health services, vision services, and other diagnostic and treatment health care providers, the Vendor shall provide:

1. Same day, medically necessary appointments within twenty-four (24) hours of referral;
2. Urgent care appointments within three (3) calendar days of referral; and
3. Routine appointments within thirty (30) calendar days of referral.

Vendor must allow access to a child/adolescent specialist(s) if requested by the parent(s).

D. Prenatal Care Appointments

Initial prenatal care appointments shall be provided for enrolled pregnant recipients as follows:

1. First trimester within seven (7) calendar days of the first request;
2. Second trimester within seven (7) calendar days of the first request;
3. Third trimester within three (3) calendar days of the first request; and
4. High-risk pregnancies within three (3) calendar days of identification of high risk by the Vendor or maternity care provider, or immediately if an emergency exists.

E. Dental Appointments:

Dental care shall be provided immediately for dental emergencies, urgent care or referral appointments within three (3) calendar days and routine appointments with dentists and dental specialists shall be provided within thirty (30) calendar days or sooner if possible.

4.5.5.8 Appointment Standards

The Vendor shall have established written policies and procedures:

- A. Disseminating its appointment standards to all network providers, and must assign a specific staff member of its organization to ensure compliance with these standards by the network.
- B. Concerning the education of its provider network regarding appointment time requirements, the Vendor shall:
 - 1. Monitor the adequacy of its appointment process and compliance; and
 - 2. Implement a Plan of Correction (POC) when appointment standards are not met.

4.5.5.9 Office Waiting Times

The Vendor shall establish written guidelines that a recipient's waiting time at the PCP's or specialist's office is no more than one (1) hour from the scheduled appointment time, except when the provider is unavailable due to an emergency. Providers are allowed to be delayed in meeting scheduled appointment times when they "work in" urgent cases, when a serious problem is found, or when the patient has an unknown need that requires more services or education than was described at the time the appointment was scheduled.

4.5.5.10 Access Exceptions

Document and submit to DHCFP, in writing, justification for exceptions to access standards set forth in Section 4.5.5 of this RFP. Such justifications shall include alternative standards that are equal to or better than the usual and customary community standards for accessing care.

4.5.5.11 Provider Terminations

The Vendor must give written notice of termination of a contracted provider, within fifteen (15) days of receipt or issuance of the termination notice, to each member who received his/her primary care from, or was seen on a regular basis by the terminated provider.

4.5.5.12 Notification of Significant Network Changes

The Vendor will notify DHCFP's designated staff, within one (1) working day, of any unexpected change that would impair its provider network. This notification shall include:

- A. Information about the nature of the change and how the change will affect the delivery of covered services; and
- B. The Vendor's plans for maintaining the quality of member care if the provider network change is likely to result in deficient delivery of covered services.

The Vendor must notify DHCFP of any change in its network that will substantially affect the ability of recipients to access services as soon as the change is known, or not later than fourteen (14) days prior to the change.

4.5.5.13 Prohibited Practices

The Vendor shall take affirmative action so that recipients are provided access to covered medically necessary services without regard to race, national origin, creed, color, gender, sexual preference, religion, age, health status, physical or mental disability, except where medically indicated. Prohibited practices include, but are not limited to, the following:

- A. Denying or not providing an enrolled recipient a covered service or available facility;
- B. Providing an enrolled recipient a covered service which is different, or is provided in a different manner, or at a different time from that provided to other recipients, other public or private patients, or the public at large;
- C. Subjecting an enrolled recipient to segregation or separate treatment in any manner related to the receipt of any covered medically necessary service, except where medically indicated;
- D. The assignment of times or places for the provision of services on the basis of race, national origin, creed, color, gender, sexual preference, religion, age, physical or mental disability, or health status of the recipient to be served;
- E. The Vendor may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient:

1. For the member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
 2. For any information the member needs in order to decide among all relevant treatment options;
 3. For the risks, benefits, and consequences of treatment or non-treatment; and
 4. For the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- F. Charging a fee for a medically necessary covered service or attempting to collect a co-payment. Subject to the maximum allowable charges specified in 42 CFR 447.54 (a) and (b), Title XXI recipients may be required to pay income-related deductible, coinsurance or co-payment charges. In accordance with 42 CFR 447.50-60 the cost sharing for title XIX recipients under managed care will be no more than cost sharing permitted under FFS.

If the Vendor knowingly executes a subcontract with a provider with the intent of allowing, encouraging, or permitting the subcontractor to implement unreasonable barriers or segregate (i.e., the terms of the subcontract are more restrictive than the Vendor's contract with DHCFP or incentives or disincentives are structured to steer enrolled recipients to certain providers) the Vendor will be in default of its contract with DHCFP. In addition, if the Vendor becomes aware of any of its existing subcontractors' failure to comply with this section and does not take immediate action, it will be in default of its contract with DHCFP.

4.5.6 Provider Contracts

- 4.5.6.1 The Vendor will execute and maintain, for the term of the contract, written provider agreements with a sufficient number of appropriately credentialed, licensed or otherwise qualified providers to provide enrolled recipients with all medically necessary covered services.
- 4.5.6.2 The Vendor will provide, for DHCFP's review, a copy of its base provider contract prior to execution. In addition, prior to distributing or executing any substantive changes or amendments to the base contract, the Vendor shall submit drafts of standard language for any such contract to DHCFP for review. Provider contracts must meet all state and federal requirements. The Vendor

shall submit any of its provider contracts to the DHCFP upon request.

- 4.5.6.3 The timing and other events associated with provider recruitment must occur in a manner that will ensure meeting the objectives noted within this RFP. The effort must include outreach to providers who are not currently participating in DHCFP's medical assistance programs or have a signed agreement but do not actively accept eligible recipients.
- 4.5.6.4 Prior to becoming a network provider, a provider who is a non-Medicaid provider must be referred to DHCFP for completion of the Medicaid provider enrollment. However, Vendors may enter into single case agreements with non-Medicaid providers as needed. Any provider located outside of the state of Nevada must be licensed in their home state of practice in order to enter into a single case agreement with a Vendor.
- 4.5.6.5 The Vendor must also have written policies and procedures for monitoring its providers, and for disciplining providers who are found to be out of compliance with the Vendor's medical management standards.
- 4.5.6.6 The ACA requires increased payment to PCPs and certain specialty and subspecialty providers starting in 2014. The Vendor must work cooperatively with DHCFP and its actuary to develop a methodology for identifying which portions of the capitation payment are directly attributable to this increase. The Vendor must comply with all ACA requirements regarding the PCP payment increase, including, but not limited to, providing reports that prove the additional portion of capitation was distributed to the physicians entitled to receive the higher reimbursement.
- 4.5.6.7 If the Vendor has a physician incentive plan, it must comply with 1876(I) (8) and the reporting requirements outlined in 42 CFR 423.208 and 423.10. The Vendor must provide information regarding its physician incentive plan(s) to the State, CMS, and any Medicaid and Nevada Check Up recipient, upon request. The rules and guidelines for physician incentive plans also apply to the Vendor's subcontractors.
- 4.5.6.8 Provider contracts may not be structured to provide financial or other incentives to providers and subcontractors for denying or limiting services.
- 4.5.6.9 The use of "gag" clauses in Provider contracts is prohibited.

4.5.6.10 All provider contracts must be made available to the DHCFP, upon request. Refer to Section 4.13.3.11.

4.5.7 Provider Directory

The Vendor will publish its provider directory and any subcontractors' provider directory via an Internet website upon contract implementation and will update the web site on a monthly basis for all geographic service areas. The Vendor will provide DHCFP with the most current provider directory upon contract award for each geographic service area. Upon request by DHCFP, the Vendor must confirm the network adequacy and accessibility of its provider network and any subcontractor's provider network.

4.5.8 Provider and Recipient Communications

All general communications to providers and recipients including mass letter mailings, fax-blasts, brochures, batch e-mails and communications specifically mentioned in this contract must be submitted to DHCFP for approval prior to release. If DHCFP does not respond within ten (10) working days the Vendor may consider the communication approved. This provision does not pertain to communications on specific topics to individual providers and recipients.

4.5.8.1 Provider Policy and Procedure Manual

The Vendor must prepare, subject to the approval of DHCFP, a Provider Policy and Procedure Manual for each distinct class of provider. The Vendor shall document the approval of the provider manual by the Vendor's Medical Director, and shall maintain documentation verifying that the provider manual is reviewed and updated at least annually.

Upon approval of DHCFP, the Vendor may publish the manual material related to more than one category of provider in a single volume. The Vendor must furnish one (1) copy of the manual to each provider upon recruitment into the network, and must update all copies of the manual in each provider's possession when changes are made by the Vendor. Provider update notices sent via facsimile, mail, and e-mail may be utilized to update the provider manual when changes are made by the Vendor. The Vendor can meet this requirement by furnishing one (1) copy of the manual and one (1) copy of the manual updates to each provider practice where several providers within the practice are participants in the network. One (1) hard copy and one (1) electronic copy of the Provider Manual shall be provided to DHCFP. That electronic copy must be updated with the same frequency as the hardcopy manual copies furnished to providers. The manual shall include, at a minimum, the following information:

- A. The policies and procedures to be implemented by the Vendor to ensure provider contract compliance;
- B. The procedures governing verification of recipient eligibility and the process for receiving and disseminating recipient enrollment data to participating providers;
- C. Prior authorization procedures and requirements;
- D. The procedures for claims administration;
- E. Provider credentialing criteria;
- F. Provider network management;
- G. The benefits and limitations available to enrolled recipients under the program, including any restrictions on recipients' freedom of choice imposed by the program and any/all payment obligations;
- H. Administrative and billing instructions, including: a list of procedure codes; edits; units; payment rates; and all pertinent information necessary to submit a clean claim in a timely manner;
- I. Procedure to dispute adverse payment and contract decisions; and
- J. Policies and procedures to be implemented by the Vendor to manage quality improvement and member service utilization.

4.5.8.2 Provider and Recipient Communications Activities

A. Provider Workshops

The Vendor must conduct, at least annually, provider workshops in the geographic service area to accommodate each provider site. In addition to presenting education and training materials of interest to all providers, the workshops must provide sessions for each discrete class of providers whenever the volume of recent changes in policy or procedures in a provider area warrants such a session. All sessions should reinforce the need for providers to verify recipient eligibility and enrollment prior to rendering services in order to ensure that the recipient is Medicaid-eligible and that claims are submitted to the responsible entity. Individual provider site visits will suffice for the annual training requirement.

B. Provider Newsletter

The Vendor must, subject to the prior review and approval of DHCFP, publish a semi-annual newsletter for network providers. DHCFP must prior approve all provider announcements, regardless of method of dissemination. If the DHCFP does not respond within twenty (20) days, the newsletter will be considered approved.

C. Recipient Newsletter

The Vendor must, subject to the prior review and approval of DHCFP, publish a newsletter for enrolled recipients at least twice per year. The newsletter will focus on topics of interest to enrolled recipients and must be written at an eighth (8th) grade level of understanding reflecting cultural competence and linguistic abilities.

The Vendor must provide a draft copy of all newsletters to DHCFP for approval prior to publication and distribution. Additionally, these newsletters and announcements regarding provider workshops must be published on the Vendor's website.

4.5.9 Network Maintenance

4.5.9.1 Maintenance of the network includes, but is not limited to:

- A. Initial and ongoing credentialing;
- B. Adding, deleting, and periodic contract renewal;
- C. Provider education; and
- D. Discipline/termination, etc.

4.5.9.2 The Vendor must have written policies and procedures for monitoring its network providers, and for disciplining those who are found to be out of compliance with the Vendor's medical management standards.

4.5.9.3 The Vendor must take appropriate action related to dual FFS and managed care network providers, as follows:

- A. Upon the Vendor's awareness through public sources of any disciplinary action, or any sanction taken against a network provider, or any suspected provider fraud or abuse, the Vendor shall immediately inform DHCFP;

- B. The Vendor is required to check the Office of the Inspector General (OIG) website at least monthly to confirm its network providers have not been sanctioned by the OIG; and
- C. If the Vendor is notified or discovers that the OIG, DHCFP or another state Medicaid agency or certification/licensing entity has taken an action or imposed a sanction against a network provider, the Vendor shall review the provider's performance related to this RFP and take any action or impose any sanction, including disenrollment from the Vendor's Provider Network.

4.5.10 Provider Credentialing

The Vendor must have written credentialing and re-credentialing policies and procedures for determining and assuring that all providers under contract to the Vendor, including PCPs and PCSs, specialists, and other health care professionals, are licensed by the State and qualified to perform their services, excluding non-contracted obstetrical providers. The Vendor may not employ or contract with providers excluded from participation in federal health care programs under Section 1128 of the Social Security Act.

The Vendor shall provide Credentialing Criteria for review and approval by DHCFP and ensure that all network providers meet the criteria.

4.6 MEDICAL RECORDS

Complete medical records shall be maintained by the Vendor's contracted providers, for each enrolled recipient in accordance with Standard XII, Section 4.9.18 of this RFP. The records shall be available for review by duly authorized representatives of the State and CMS upon request.

The Vendor shall have written policies and procedures to maintain the confidentiality of all medical records and, pursuant to Standard XII, Section 4.9.18, accessibility and availability of medical records, record keeping, and record review process. Not more than ten (10) calendar days after submitting a request, the State shall have access to a member's medical record, whether electronic or paper, and has the right to obtain copies at the Vendor's expense.

The recipient's medical record is the property of the provider who generates the record. The Vendor shall assist the member or the parent/legal guardian of the member in obtaining a copy of the member's medical records, upon written request, from the provider. Records shall be furnished in a timely manner upon receipt of such a request but not more than thirty (30) calendar days from the date of request. Each member or parent/legal guardian of the member is entitled to one (1) free copy of the requested medical records. The fee for additional copies shall not exceed the actual cost of time and materials used to compile copy and furnish such records.

When an enrolled recipient changes primary care providers and/or health plans, the Vendor's contracted provider must forward all medical records in their possession to the new provider within ten (10) working days from receipt of the request.

4.7 QUALITY ASSURANCE STANDARDS

4.7.1 Overview

The common goal of the managed care program is a successful partnership with quality health plans to provide care to DHCFP members, while focusing on continuous quality improvement. The current member population encompasses the TANF/CHAP Medicaid eligibility category, as well as the Nevada Check Up/CHIP population. Traditionally, the Medicaid population is a high-risk, high-volume user of health care services.

The role of managed care is to ensure accessibility and availability to appropriate health care, provide for continuity of care, and provide quality care to enrolled recipients. A major focus of managed care is health promotion and disease prevention. The aforementioned populations mainly comprised of parents, pregnant women and/or children, benefit from targeted preventive health care services, the quality and availability of which are monitored and evaluated by the DHCFP in conjunction with the DHCFP's EQRO contractor. The Vendor is required to work collaboratively with the DHCFP and the EQRO in these quality monitoring and evaluation activities. By virtue of the DHCFP's contract with the EQRO and the federal regulations which set forth the State's mandates for an EQRO, the Vendor will be required to provide reporting data beyond that stipulated in this section and will participate in those additional EQRO activities as assigned and required by the DHCFP.

4.7.2 Quality Measurements

All Healthcare Effectiveness Data and Information Set (HEDIS) measures in this contract are to be reported for a calendar year, using the most current version of National Committee for Quality Assurance (NCQA) HEDIS specifications. HEDIS measures may not necessarily correspond to the contract periods, but may overlap them. DHCFP and/or the EQRO may conduct on-site review as needed to validate medical measures reported. The Vendor must use audited data, and is responsible for ensuring all updates to the measure are reflected in the final, reported rates. The DHCFP reserves the right to require the Vendor to report on additional quality measures not listed here.

4.7.2.1 Pregnancy

A. Standard

The Vendor shall take affirmative steps to ensure eligible pregnant Medicaid recipients are provided with quality prenatal care. Quality prenatal care provides for increased access to prenatal services, and ensures necessary monitoring of high-risk pregnancies to obtain healthy birth outcomes.

The Vendor's prior authorization policies and procedures must be consistent with the provision of prenatal care in accordance with community standards of practice and the Medicaid Services Manual.

B. Required Measures

The following HEDIS measures will be reported:

1. Prenatal and Postpartum Care
 - a. Timeliness of Prenatal Care
 - b. Postpartum Care
2. Weeks of Pregnancy at Time of Enrollment in the Vendor
3. Frequency of Ongoing Prenatal Care

This measure uses the same denominator and deliveries as the "Prenatal and Postpartum Care" measure.

Following HEDIS methodology, rates are to be reported as those women who received <21 percent, 21-40 percent, 41-60 percent, 61-80 percent, and 81-100 percent of the expected number of prenatal care visits.

4.7.2.2 Comprehensive Well Child Periodic and Interperiodic Health Assessments/Early Periodic Screening Diagnosis and Treatment (EPSDT)/Healthy Kids

A. Standard:

The Vendor shall take affirmative steps to achieve at least a participation rate greater than or equal to the national average for EPSDT screenings. Well Child Care promotes healthy development and disease prevention in addition to possible early discovery of disease and appropriate treatment.

B. Required Measures:

The following HEDIS measures will be reported:

1. Children's Access to Primary Care Providers

2. Well-Child Visits in the First 15 Months of Life
3. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life
4. Adolescent Well-Care Visits

DHCFP will require quarterly submission of progress reports outlining advances achieved in reaching the established EPSDT goals of the Vendor. The quarterly reports must address at a minimum these components: program monitoring, program evaluation, member outreach, provider education, and provider compliance with mandatory components of EPSDT visits. The progress report will determine the effectiveness of the Vendors interventions and is to be submitted in conjunction with the quarterly CMS 416 reports.

DHCFP and/or EQRO may conduct desk and/or on-site review as needed, to include, but not be limited to: policy/procedure for EPSDT, service delivery, data tracking and analysis, language in primary care provider contracts, and the process for notification of members. Vendor internal quality assurance of the EPSDT program shall include monitoring and evaluation of the referrals that are the result of an EPSDT screening.

The Vendor is required to submit the CMS 416 EPSDT Participation Report to the DHCFP for each quarter of the federal fiscal year (FFY), October 1st through September 30th. The Vendor is required to submit the final CMS 416 Report to the DHCFP no later than March 1st after the FFY reporting period concludes. The Vendor must send a quarterly report in order to track the progress the Vendor is making throughout the year. The Vendor is required to complete all line items of the CMS 416 Report and submit separate reports for the CHIP and TANF/CHAP populations.

If the Vendor cannot satisfactorily demonstrate to DHCFP at least a participation rate not less than the national baseline average, as determined by DHCFP or its contracted EQRO, the DHCFP may require the Vendor to submit a Plan of Correction (POC) to DHCFP. The POC should identify improvements and/or enhancements of existing outreach, education, and case management activities, which will assist the Vendor to improve the screening rate and increase the participation percentage.

4.7.2.3 Immunizations

A. Standard:

Immunization Age appropriate immunizations (according to current Advisory Committee on Immunization Practices (ACIP) schedule)

B. Required Measures:

The following HEDIS measures will be reported:

1. Childhood Immunization Status

Immunization status may be reviewed through EPSDT claims and encounter data, and/or through an annual immunization audit based on DHCFP's or its designee's random sampling of EPSDT information. In addition, DHCFP could collaborate with the Nevada Health Division to track and trend Immunization Registry data.

The Vendor's HEDIS immunization measurement rates must be comparable to the HEDIS National Medicaid average. If the Vendor has not satisfactorily demonstrated the ability to meet the HEDIS immunization national Medicaid average, the Vendor will be required to submit a POC to DHCFP. The POC should identify improvements/enhancements of existing outreach, education, case management activities, and the Vendor's staff person who is/are responsible for implementing and monitoring the POC.

4.7.2.4 Mental Health

A. Standard:

The Vendor shall take affirmative steps to ensure that covered medically necessary mental health and mental health rehabilitative services are provided to enrolled recipients as required in RFP Sections 4.2.2 and 4.2.8. Mental health is an integral part of holistic health care. The measurement methodology below demonstrates elementary steps toward continuing review of the quality and adequacy of mental health care services.

B. Required Measures

The following HEDIS measures will be reported:

1. Mental Health Utilization – Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services
2. Follow-Up After Hospitalization for Mental Illness
3. The percentage of discharges for members six (6) years of age and older who were hospitalized for treatment of selected mental health disorders, who were continuously enrolled for thirty (30) days after discharge (without gaps) and who were seen on an ambulatory basis or who were in day/night treatment with a mental health provider.
4. Two (2) separate calculations are required:
 - a. The percentage of discharges for members who had an ambulatory or day/night mental health visit on the date of discharge, up to thirty (30) days after hospital discharge, and
 - b. The percentage of discharges for members who had an ambulatory or day/night mental health visit on the date of discharge, up to seven (7) days after hospital discharge.

4.7.2.5 Dental Services

A. Dental Services Quality Improvement

The Vendor's Internal Quality Assurance Program Improvement (IQAP) Committee and IQAP Coordinator will review the Vendor's dental program quarterly to assure quality dental care is promoted through demonstration of oversight and monitoring of dental activities and ensure appropriate referrals are provided to the members when indicated.

B. Standard

The Vendor shall take action to ensure access to quality dental care for all eligible Medicaid and Nevada Check Up members. Vendor baselines will be established over the first contract year.

The following HEDIS measure will be reported:

1. Annual Dental Visit

The percentage of members, ages two (2) through twenty-one (21) years as of December 31st of the measurement year, who were continuously enrolled during the measurement year and who had at least one (1) dental visit during the measurement year. The DHCFP will also monitor utilization through reported encounter data.

C. Required Measures

The following State devised HEDIS-like measure will be reported:

1. Number of Children with Dental Sealants
2. The percentage of members ages six (6) through fourteen (14) years as of December 31st of the measurement year, who were continuously enrolled during the measurement year and who received at least one (1) dental sealant on a permanent molar tooth during the measurement year. The DHCFP will also monitor utilization through reported encounter data.
3. Based on the ADA guidelines permanent teeth begin to erupt anywhere from 6 to 12 years of age depending on the tooth. Not all 6 year olds will have their permanent teeth yet. CDT code D1351 should be accompanied by tooth numbers or letters to distinguish which tooth the sealant is placed on. The CDT code is billed in box 24 on the ADA form and the tooth number or letter will be in box 27. The tooth numbers or letters in box 27 will distinguish if the tooth is a permanent tooth.
4. Numerator: One (1) or more protective dental sealants administered on at least one (1) permanent molar tooth during the measurement year. A member had a dental sealant if a submitted claim/encounter contains CDT code D1351.
5. Denominator: The percentage of members who had at least one (1) visit with a dental practitioner during the measurement year, using the codes found in table ADV-A of the Annual Dental Visit HEDIS measure.

4.7.2.6 Use of Appropriate Medications for People with Asthma (ASM)

A. Required Measures

The percentage of members 5–56 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.

DHCFP and/or the EQRO may conduct on-site review as needed to validate medical measures reported.

4.7.2.7 Lead Screening in Children:

A. Required Measures

The percentage of children two years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.

4.7.2.8 Comprehensive Diabetes Care

A. Required Measures

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

1. Hemoglobin A1c (HbA1c) testing
2. HbA1c poor control (>9.0%)
3. HbA1c good control (<7.0%)
4. Eye exam (retinal) performed
5. LDL-C screening
6. LDL-C control (<100 mg/dL)
7. Medical attention for nephropathy
8. Blood pressure control (<130/80 mm Hg)
9. Blood pressure control (<140/90 mm Hg)

4.7.2.9 Plan of Correction (POC) Procedure

A Plan of Correction (POC) must include, but may not be limited to, the following:

- A. Specific problem(s) which require corrective action;
- B. The type(s) of corrective action to be taken for improvement;

- C. The goals of the corrective action;
- D. The time-table for action;
- E. The identified changes in processes, structure, internal/external education;
- F. The type of follow-up monitoring, evaluation and improvement; and
- G. The Vendor staff person(s) responsible for implementing and monitoring the POC.

H.
The POC should also identify improvements and enhancements of existing outreach, and case management activities, if applicable.

Unless otherwise specified by DHCFP, the Vendor has thirty (30) days from date of notification by DHCFP to submit a POC, as specified. The Vendor's POC will be evaluated by DHCFP to determine whether it satisfactorily addresses the actions needed to correct the deficiencies. If the Vendor's POC is unsatisfactory, DHCFP will indicate the section(s) requiring revision and/or necessary additions and request a satisfactory plan be submitted by the Vendor, unless otherwise specified, within thirty (30) days of receipt of DHCFP's second directive. If the Vendor's second plan is unsatisfactory, DHCFP may declare a material breach. Within ninety (90) calendar days after the Vendor has submitted an acceptable POC or one has been imposed, DHCFP will initiate a follow-up review, which may include an on-site review.

If the Vendor's non-compliance with the provision of covered medically necessary benefits and services becomes an impediment to ensuring the health care needs of recipients and/or the ability of providers to adequately attend to those health care needs, the DHCFP shall take administrative sanction against the Vendor. Such a sanction will disallow further enrollment and may also include adjusting auto-assignment formulas used for recipient enrollment purposes. Such sanctions will continue until Vendor compliance with the provision of benefits/services is achieved. Liquidated damages, as outlined in the General Terms of the contract, may also be assessed if other measures fail to produce adequate compliance results from the Vendor.

4.8 STANDARDS FOR INTERNAL QUALITY ASSURANCE PROGRAMS

Federal regulations (42 CFR 438.240) mandate that States must, through its contracts, require each managed care organization (Vendor) to have an ongoing quality assessment and performance improvement program for the services it furnishes its members. Internal Quality Assurance Programs (IQAPs) consist of systematic activities, undertaken by the

Vendor, to monitor and evaluate the care delivered to enrolled recipients according to predetermined, objective standards, and effect improvements as needed.

An annual review of the Vendor will be conducted by the DHCFP or its designee. In addition, DHCFP will monitor and analyze grievances and appeals, provider disputes and will periodically conduct patient and provider satisfaction surveys.

4.8.1 The Vendor must conduct performance improvement projects that focus on clinical and non-clinical areas and that involve the following:

4.8.1.1 Measurement of performance using objective quality indicators;

4.8.1.2 Implementation of system interventions to achieve improvement in quality;

4.8.1.3 Evaluation of the effectiveness of the interventions; and

4.8.1.4 Planning and initiation of activities for increasing or sustaining improvement.

The Vendor must have its own evaluation of the impact and effectiveness of its quality assessment and IQAP.

The Vendor must report the status and results of each project to the DHCFP as requested, including those that incorporate the requirements of 42 CFR 438.240 (a)(2). Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

4.8.2 The Vendor must:

4.8.2.1 Submit performance improvement measurement data annually using standard measures required by the DHCFP, including those that incorporate the requirements of 42 CFR 438.204 and 438.240(a)(2);

4.8.2.2 Submit to the DHCFP data specified by the DHCFP which enables the DHCFP to measure the Vendor's performance; or

4.8.2.3 Perform a combination of activities described in RFP Sections 4.8.2.1 and 4.8.2.2 above.

4.8.3 DHCFP will use the most current sources for the IQAP guidelines and the most current NCQA Standards and Guidelines.

4.8.4 The Vendor is required to maintain a health information system that collects, analyzes, integrates, and reports data in accordance with 42 CFR 438.242 and can achieve the objectives of the ongoing IQAP. The systems must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollment for other than the loss of program eligibility. The

basic elements of a health information system with which a Vendor must comply include the following:

- 4.8.4.1 Collect data on member and provider characteristics as specified by the DHCFP, and on services furnished to the members through an encounter data system or other methods as may be specified by the DHCFP;
- 4.8.4.2 Verify the data received from providers is accurate, complete, and timely; and in accordance with 42 CFR 438.242(b) (2); and
- 4.8.4.3 Make all collected data available to the DHCFP and upon request to CMS as required.

4.8.5 Standard I: Written IQAP Description

The Vendor has a written description of its IQAP. This written description meets the following criteria:

- 4.8.5.1 Goals and Objectives
- 4.8.5.2 The written description contains a detailed set of quality assurance (QA) objectives, which are developed annually and include a timetable for implementation and accomplishment.
- 4.8.5.3 Scope
 - A. The scope of the IQAP is comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service, such as and including: availability, accessibility, coordination, and continuity of care.
 - B. The IQAP methodology provides for review of the entire range of care provided by the Vendor, including services provided to CSHCN, by assuring that all demographic groups, care settings (e.g., inpatient, ambulatory, including care provided in private practice offices and home care); and types of services (e.g., preventive, primary, specialty care, and ancillary) are included in the scope of the review. The review of the entire range of care is expected to be carried out over multiple review periods and not on a concurrent basis.
- 4.8.5.4 Specific Activities

The written description specifies quality of care studies and other activities to be undertaken over a prescribed period of time, and methodologies and organizational arrangements to be used to accomplish them. Individuals responsible for the studies and other

activities are clearly identified and qualified to develop the studies and analyze outcomes.

4.8.5.5 Continuous Activity

4.8.5.6 The written description provides for continuous performance of the activities, including tracking of issues over time.

4.8.5.7 Provider Review

- A. Review by physicians and other health professionals of the process followed in the provision of health services; and
- B. to health professionals and Vendor staff regarding performance and patient health care outcomes.

4.8.5.8 Focus on Health Outcomes

The IQAP methodology addresses health outcomes to the extent consistent with existing technology.

4.8.6 Standard II: Systematic Process of Quality Assessment and Improvement

The IQAP objectively and systematically monitors and evaluates the quality and appropriateness of care and service provided to enrolled recipients through quality of care studies and related activities, and pursues opportunities for improvement on an ongoing basis. The IQAP has written guidelines for its Performance Improvement Projects (PIPs) and related activities. These guidelines include:

Specification of Clinical or Health Services Delivery Areas to be Monitored

4.8.6.1 The monitoring and evaluation of care reflects the population served by the Vendor in terms of age groups, disease categories and special risk status, including CSHCN.

4.8.6.2 For the TANF/CHAP and Nevada Check Up recipients, the IQAP will monitor and evaluate, at a minimum, care and services in certain priority areas of concern selected by the DHCFP. These were selected from among those identified by the Centers for Medicare and Medicaid Services (CMS) and the DHCFP.

The following are recommended clinical areas of concern and health services delivery areas of concern:

- A. Clinical Areas of Concern
 - 1. Childhood Immunizations (monitoring will be required by DHCFP for recipients);

2. Pregnancy (monitoring will be required by DHCFP for recipients);
3. Cervical Cancer/Pap Smears (monitoring will be required by the State of Nevada Health Division);
4. Comprehensive Well-Child Periodic Health Assessment (will be required by DHCFP for recipients);
5. Lead Toxicity (screening required under EPSDT guidelines);
6. Pregnancy Prevention and/or Family Planning (monitoring will be required by DHCFP for recipients); and
7. Hearing and Vision Screening and Services for Medicaid members less than twenty-one (21) years of age will be required by DHCFP for members.

B. Health Services Delivery Areas of Concern

1. Access to Care;
2. Utilization of Services;
3. Coordination of Care;
4. Continuity of Care;
5. Health Education; and
6. Emergency Services.

C. Performance Improvement Projects (PIPs)

In accordance with 42 CFR 438.358(b):

1. Validation of Performance Improvement Projects required by the State to comply with requirements set forth in 42 CFR 438.240(b); and
2. Projects that were under way during the preceding twelve (12) months.

3. Quality of care studies are an integral and critical component of the health care quality improvement system. The Vendor will be required annually to conduct and report on a minimum of two PIPs.
4. The purpose of a PIP is to assess and improve processes, thus enhancing the outcomes of care. The PIPs are designed to target and improve the quality of care or services received by managed care enrolled recipients. The Vendor will utilize, as a resource, the Centers for Medicare & Medicaid Services (CMS) guidelines as outlined in the most recent version of the CMS publication *Conducting Performance Improvement Projects, A Protocol for Use in Conducting Medicaid External Quality Review Activities, Final Protocol*.
5. A PIP will be required to decrease inappropriate utilization of emergency department visits.
6. The Vendor must conduct PIPs that focus on utilization of ambulatory care:
7. This measurement of quality indicators; the Vendors must implement a system of interventions to achieve improvement in quality; evaluate effectiveness of the interventions; and institute planning and initiation of activities for increasing or sustaining improvement.
8. The Vendor must have its own evaluation of the impact and effectiveness of its quality assessment and IQAP.
9. At its discretion and/or as required or directed by DHCFP, the Vendor's IQAP also monitors and evaluates other important aspects of care and service.

4.8.6.3 Use of Quality Indicators

Quality indicators are measurable variables relating to a specified clinical or health services delivery area, which are reviewed over a period of time to monitor the process or outcomes of care delivered in that area.

The Vendor is required to:

- A. Identify and use quality indicators that are objective, measurable, and based on current knowledge and clinical experience;

- B. Monitor and evaluate quality of care through studies which include, but are not limited to, the quality indicators also specified by the CMS Center for Medicaid and CHIP Services, with respect to the priority areas selected by the State;
- C. Ensure methods and frequency of data collection are effective and sufficient to detect the need for program change; and
- D. Have mechanisms to detect under and over utilization.

4.8.6.4 Use of Clinical Care Standards/Practice Guidelines

- A. The IQAP studies and other activities monitor quality of care against clinical care or health service delivery standards or practice guidelines specified for each area identified in Sections 4.8.5.3.A and 4.8.5.3.B above;
- B. The standards/guidelines are based on reasonable scientific evidence and developed or reviewed by Vendor providers;
- C. The standards/guidelines focus on the process and outcomes of health care delivery, as well as access to care;
- D. A mechanism is in place for continuously updating the standards/guidelines;
- E. The standards/guidelines are included in provider manuals developed for use by Vendor providers, or otherwise disseminated, including but not limited to, dissemination on the provider website, to all affected providers as they are adopted and to all members and potential members upon request;
- F. The standard/guidelines address preventive health services;
- G. The standards/guidelines are developed for the full spectrum of populations enrolled in the plan; and
- H. The IQAP shall use these standards/guidelines to evaluate the quality of care provided by the Vendor's providers, whether the providers are organized in groups, as individuals, or in combinations thereof.

4.8.6.5 Analysis of Clinical Care and Related Services

- A. Qualified clinicians monitor and evaluate quality through the review of individual cases where there are questions about care, and through studies analyzing patterns of clinical care

and related service. For issues identified in the IQAPs targeted clinical areas, the analysis includes the identified quality indicators and uses clinical care standards or practice guidelines.

- B. Multi-disciplinary teams are required, when available and appropriate, to analyze and address systems issues. The Vendor must have in effect mechanisms to assess quality and appropriateness of care furnished to members with special health care needs.
- C. From 4.8.6.3.A and 4.8.6.3.B above, clinical and related service areas requiring improvement are identified.
- D. The Vendor will work collaboratively with DHCFP to determine member race and ethnicity. The Vendor will organize interventions specifically designed to reduce or eliminate disparities in health care.
- E. The Vendor shall allow access to clinical studies, when available and appropriate.

4.8.6.6 Implementation of Corrective Actions

The IQAP includes written procedures for taking corrective action whenever, as determined under the IQAP, inappropriate or substandard services are furnished, or services that should have been furnished were not.

These written corrective action procedures include:

- A. Specification of the types of problems requiring corrective action;
- B. Specification of the person(s) or body responsible for making the final determinations regarding quality problems;
- C. Specific actions to be taken; provision of feedback to appropriate health professionals, providers and staff;
- D. The schedule and accountability for implementing corrective actions;
- E. The approach to modifying the corrective action if improvements do not occur; and
- F. Procedures for terminating the affiliation with the physician, or other health professional or provider.

- 4.8.6.7 Assessment of Effectiveness of Plans of Correction (POC)
- A. As actions are taken to improve care, there is monitoring and evaluation of the Plan of Correction (POC) to assure required changes have been made. In addition, changes in practice patterns are monitored.
 - B. The Vendor assures follow-up on identified issues to ensure actions for improvement have been effective.

- 4.8.6.8 Evaluation of Continuity and Effectiveness of the IQAP
- A. The Vendor conducts a regular and periodic examination of the scope and content of the IQAP to ensure that it covers all types of services in all settings, as specified in RFP Section 4.8.5.
 - B. At the end of each year, a written report on the IQAP is prepared which addresses: quality assurance studies and other activities completed; trending of clinical and service indicators and other performance data; demonstrated improvements in quality; areas of deficiency and recommendations for corrective action; and an evaluation of the overall effectiveness of the IQAP.
 - C. There is evidence that quality assurance activities have contributed to significant improvements in the care delivered to recipients.

4.8.7 Standard III: Accountability to the Governing Body

The Governing Body of the Vendor is the Board of Directors or, where the Board's participation with quality improvement issues is not direct, a designated committee of the senior management of the Vendor that is responsible for the Vendor IQAP review. Responsibilities of the Governing Body for monitoring, evaluating and making improvements to care include:

4.8.7.1 Oversight of IQAP

There is documentation that the Governing Body has approved the overall IQAP and an annual IQAP.

4.8.7.2 Oversight Entity

The Governing Body has formally designated an entity or entities within the Vendor to provide oversight of the IQAP and is accountable to the Governing Body, or has formally decided to provide such oversight as a committee of the whole.

4.8.7.3 IQAP Progress Reports

The Governing Body routinely receives written reports from the IQAP describing actions taken, progress in meeting quality assurance objectives, and improvements made.

4.8.7.4 Annual IQAP Review

The Governing Body formally reviews on a periodic basis, but no less frequently than annually, a written report on the IQAP. This annual quality program evaluation report shall be submitted to DHCFP annually in the second calendar quarter and at minimum include:

- A. Studies undertaken;
- B. Results;
- C. Subsequent actions and aggregate data on utilization and quality of services rendered; and
- D. An assessment of the IQAPs continuity, effectiveness and current acceptability.

4.8.7.5 Program Modification

Upon receipt of regular written reports delineating actions taken and improvements made, the Governing Body takes action when appropriate, and directs that the operational IQAP be modified on an ongoing basis to accommodate review findings and issues of concern with the Vendor. This activity is documented in the minutes of the meetings of the Governing Board in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to quality assurance.

4.8.8 Standard IV: Active QA Committee

The IQAP delineates an identifiable structure responsible for performing quality assurance functions within the Vendor. This committee or other structure has:

4.8.8.1 Regular Meetings

The structure/committee meets on a regular basis with specified frequency to oversee IQAP activities. This frequency is sufficient to demonstrate that the structure/committee is following up on all findings and required actions, but in no case are such meetings less frequent than quarterly.

4.8.8.2 Established Parameters for Operating

The role, structure and function of the structure/committee are specified.

4.8.8.3 Documentation

There are records documenting the structures/committee's activities, findings, recommendations and actions.

4.8.8.4 Accountability

IQAP subcommittees are accountable to the Governing Body and they report to it (or its designee) on a scheduled basis on activities, findings, recommendations and actions.

4.8.8.5 Membership

There is active participation in the IQAP committee from Vendor providers, who are representative of the composition of the Vendor's providers.

4.8.9 Standard V: IQAP Supervision

There is a designated senior executive who is responsible for IQAP implementation. The Vendor's Medical Director has involvement in quality assurance activities.

4.8.10 Standard VI: Adequate Resources

The IQAP has sufficient material resources and staff with the necessary education, experience, or training to effectively carry out its specified activities. (Refer to Section 4.7.2)

4.8.11 Standard VII: Provider Participation in IQAP

4.8.11.1 Participating physicians and other providers are kept informed about the written IQAP through provider newsletters and updates to the provider manual.

4.8.11.2 The Vendor includes in its provider contracts and employment agreements, for physician and non-physician providers, a requirement securing cooperation with the IQAP.

4.8.11.3 Contracts specify that hospitals and other Vendors will allow the Vendor access to the medical records of its recipients.

4.8.12 Standard VIII: Delegation of IQAP Activities

The Vendor remains accountable for all IQAP functions, even if certain functions are delegated to other entities. If the Vendor delegates any quality assurance activities to Vendors, it must:

- 4.8.12.1 Have a written description of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the Vendor;
- 4.8.12.2 Have written procedures for monitoring and evaluating the implementation of the delegated functions, and for verifying the actual quality of care being provided; and
- 4.8.12.3 Provide evidence of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans and regular specified reports.

4.8.13 Standard IX: Credentialing and Recredentialing

The IQAP contains provisions to determine whether physicians and other health care professionals, who are licensed by the State and who are under contract to the Vendor, are qualified to perform their services. These provisions are:

4.8.13.1 Written Policies and Procedures

The Vendor has written policies and procedures for the credentialing process, which include the Vendor's initial credentialing of practitioners, as well as its subsequent recredentialing, recertifying and/or reappointment of practitioners. The Vendor will comply with NAC 679B.0405 which requires the use of Form NDOI-901 for use in credentialing providers.

DHCFP reserves the right to request and inspect the credentialing process and supporting documentation. The Vendor agrees to allow DHCFP and/or its contracted EQRO to inspect its credentialing process and supporting documentation.

4.8.13.2 Oversight by Governing Body

The Governing Body, or the group or individual to which the Governing Body has formally delegated the credentialing function, has reviewed and approved the credentialing policies and procedures.

4.8.13.3 Credentialing Entity

The Vendor designates a credentialing committee, or other peer review body, which makes recommendations regarding credentialing decisions.

4.8.13.4 Scope

The Vendor identifies those practitioners who fall under its scope of authority and action. This shall include, at a minimum, all physicians and other licensed independent practitioners included in the Vendor's literature for recipients, as an indication of those practitioners whose service to recipients is contracted or anticipated.

4.8.13.5 Process

The initial credentialing process obtains and reviews primary source verification of the following information, at a minimum:

- A. The practitioner holds a current valid license to practice in Nevada or a current valid license to practice in the state where the practitioner practices.
- B. Valid Drug Enforcement Administration (DEA) certificate for all practitioners authorized by the scope of their license to prescribe drugs, with the exception of all participating dentists.
- C. Graduation from medical school and completion of a residency, or other post-graduate training, as applicable.
- D. Work history.
- E. Professional liability claims history.
- F. The practitioner holds current, adequate malpractice insurance according to the Vendor's policy.
- G. Any revocation or suspension of a State license or DEA number.
- H. Any curtailment or suspension of medical staff privileges (other than for incomplete medical records).
- I. Any sanctions imposed by the OIG or the DHCFF.
- J. Any censure by any state or county Medical Association, Dental Board or any other applicable licensing or credentialing entity.

- K. The Vendor obtains information from the National Practitioner Data Bank, the Nevada Board of Medical Examiners, the State Board of Osteopathic Medicine, the Nevada Dental Board, any equivalent licensing boards for out-of-state providers, and any other applicable licensing entities for all other practitioners in the plan.
- L. The application process includes a statement by the applicant regarding:
 - 1. Any physical or mental health problems that may affect current ability to provide health care;
 - 2. Any history of chemical dependency/ substance abuse;
 - 3. History of loss of license and/or felony convictions;
 - 4. History of loss or limitation of privileges or disciplinary activity; and,
 - 5. An attestation to correctness/ completeness of the application.

This information should be used to evaluate the practitioner's current ability to practice.

- M. There is an initial visit to each potential primary care practitioner's office, including documentation of a structured review of the site and medical record keeping practices to ensure conformance with the Vendor's standards. If the Vendor's credentialing process complies with the current NCQA standards, it is not required to conduct initial site visits.
- N. The Vendor's provider credentialing must comply with 42 CFR §1002.3.
- O. If the Vendor has denied credentialing or enrollment to a provider where the denial is due to Vendor concerns about provider fraud, integrity, or quality the Vendor is required to report this to the State within 15 calendar days.
- P. If the Vendor decredentials, terminates, or disenrolls a provider, the Vendor must inform the State, within 15 calendar days. If the decredentialing, termination or disenrollment of a provider is due to suspected criminal actions, or disciplinary actions relate to fraud or abuse the State will notify HHS-OIG.

4.8.13.6 Recredentialing

A process for the periodic re-verification of clinical credentials (recredentialing, reappointment, or recertification) is described in the Vendor's policies and procedures, including:

- A. Evidence that the procedure is implemented at least every 36 months;
- B. The Vendor conducts periodic review of information from the National Practitioner Data Bank and all other applicable licensing entities, along with performance data, on all practitioners, to decide whether to renew the participating practitioner agreement. At a minimum, the recredentialing, recertification or reappointment process is organized to verify current standing on items listed in Section 4.8.13.5.A through 4.8.13.5.M and
- C. The recredentialing, recertification or reappointment process also includes review of data from:
 1. Recipient grievances and appeals;
 2. Results of quality reviews;
 3. Utilization management;
 4. Recipient satisfaction surveys; and
 5. Re-verification of hospital privileges and current licensure, if applicable.
 6. The Vendor's provider recredentialing must comply with 42 CFR §1003.3

If the Vendor has denied recredentialing or enrollment to a provider where the denial is due to the Vendor concerns about provider fraud, integrity or quality the Vendor is required to report this to the DHCFP, with 15 calendar days.

If the Vendor decredentials, terminates or disenrolls a provider the Vendor must inform the State within 15 calendar days. If the decredentialing, termination or disenrollment of a provider is due to suspected criminal actions, or disciplinary actions relate to fraud or abuse the DHCFP will notify HHS-OIG.

4.8.13.7 Delegation of Credentialing Activities

If the Vendor delegates credentialing and recredentialing, recertification, or reappointment activities, there is a written description of the delegated activities, and the delegate's accountability for these activities. There is also evidence that the delegate accomplished the credentialing activities. The Vendor monitors the effectiveness of the delegate's credentialing and reappointment or recertification process.

4.8.13.8 Retention of Credentialing Authority

The Vendor retains the right to approve new practitioners and sites, and to terminate or suspend individual practitioners. The Vendor has policies and procedures for the suspension, reduction or termination of practitioner privileges.

4.8.13.9 Reporting Requirement

There is a mechanism for, and evidence of implementation of, the reporting of serious quality deficiencies resulting in suspension or termination of a practitioner, to the appropriate authorities.

4.8.13.10 Provider Dispute Process

There is a provider dispute process for instances wherein the Vendor chooses to deny, reduce, suspend or terminate a practitioner's privileges with the Vendor.

4.8.14 Standard X: Recipient Rights and Responsibilities

The Vendor demonstrates a commitment to treating recipients in a manner that acknowledges their rights and responsibilities.

4.8.14.1 Written Policy on Recipient Rights

The Vendor has a written policy that recognizes the following rights of recipients:

- A. To be treated with respect, and recognition of their dignity and need for privacy;
- B. To be provided with information about the Vendor, its services, the practitioners providing care, and recipients' rights and responsibilities;
- C. To be able to choose primary care practitioners, including specialists as their PCP if the member has a chronic condition, within the limits of the plan network, including the right to refuse care from specific practitioners;

- D. To participate in decision-making regarding their health care, including the right to refuse treatment;
- E. To pursue resolution of grievances and appeals about the Vendor or care provided;
- F. To formulate advance directives;
- G. To have access to his/her medical records in accordance with applicable federal and state laws and to request that they be amended or corrected as specified in 45 CFR Part 164;
- H. To guarantee the member's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; and
- I. To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.

4.8.14.2 Written Policy on Recipient Responsibilities

The Vendor has a written policy that addresses members' responsibility for cooperating with those providing health care services. This written policy addresses members' responsibility for:

- A. Providing, to the extent possible, information needed by professional staff in caring for the recipient; and
- B. Following instructions and guidelines given by those providing health care services.

The Vendor may include additional recipient responsibilities in their member communications (such as, the recipient is responsible for being on time for scheduled appointments and canceling appointments in a timely manner, the recipient is responsible for reporting fraud and/or abuse, etc.).

4.8.14.3 Communication of Policies to Providers

A copy of the Vendor's policies on recipients' rights and responsibilities is provided to all participating providers.

4.8.14.4 Communication of Policies to Recipients

Upon enrollment, recipients are provided a written statement that includes information on their rights and responsibilities.

4.8.14.5 Recipient Grievance and Appeals Procedures

The Vendor has a system(s) linked to the IQAP for addressing recipients' grievances and providing recipient appeals. This system includes:

- A. Procedures for registering and responding to grievances and appeals within 30 days. Vendors must establish and monitor standards for timeliness;
- B. Documentation of the substance of grievances, appeals, and actions taken;
- C. Procedures ensuring a resolution of the grievance and providing the recipient access to the State Fair Hearing process for appeals;
- D. Aggregation and analysis of grievance and appeal data and use of the data for quality improvement;
- E. Compliance with DHCFP due process and fair hearing policies and procedures specific to Nevada Medicaid and Nevada Check Up recipients; and
- F. Compliance with 42 CFR 438 Subpart F Grievance and Appeals.

4.8.14.6 Recipient Suggestions

Opportunity is provided for recipients to offer suggestions for changes in policies and procedures.

4.8.14.7 Steps to Assure Accessibility of Services

The Vendor takes steps to promote accessibility of services offered to recipients. These steps include:

- A. The points of access to primary care, specialty care and hospital services are identified for recipients; and
- B. At a minimum, recipients are given information about:
 - 1. How to obtain services during regular hours of operations;
 - 2. How to obtain emergency and after-hour care;
 - 3. How to obtain emergency out-of-service area care; and

4. How to obtain the names, qualifications and titles of the professionals who provide and/or are responsible for their care.

4.8.14.8 Information Requirements

- A. Recipient information (for example, subscriber brochures, announcements, and handbooks) in prose, written at an eighth (8th) grade level, that is readable and easily understood.
- B. Written information is available in the prevalent languages of the population groups served.

4.8.14.9 Confidentiality of Patient Information

The Vendor acts to ensure that the confidentiality of specified patient information and records is protected. The Vendor:

- A. Has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records;
- B. Ensures patient care offices/sites have implemented mechanisms to guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the Vendor;
- C. Shall hold confidential all information obtained by its personnel about recipients related to their examination, care and treatment and shall not divulge it without the recipient's authorization, unless:
 1. It is required by law, or pursuant to a hearing request on the recipient's behalf;
 2. It is necessary to coordinate the recipient's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; or
 3. It is necessary in compelling circumstances to protect the health or safety of an individual.
- D. Must report any release of information in response to a court order to the recipient in a timely manner; and
- E. May disclose recipient records whether or not authorized by the recipient, to qualified personnel, defined as persons or agency representatives who are subject to standards of

confidentiality that are comparable to those of the State agency.

4.8.14.10 Treatment of Minors

The Vendor has written policies regarding the treatment of minors.

4.8.14.11 Assessment of Recipient Satisfaction

The Vendor conducts periodic survey(s) of recipient satisfaction with its services:

- A. The survey(s) include content on perceived problems in the quality, availability and accessibility of care.
- B. The survey(s) assess at least a sample of:
 - 1. All recipients;
 - 2. Recipient requests to change practitioners and/or facilities; and
 - 3. Disenrollment by recipients.
- C. As a result of the survey(s), the Vendor:
 - 1. Identifies and investigates sources of dissatisfaction;
 - 2. Outlines action steps to follow up on the findings; and
 - 3. Informs practitioners and providers of assessment Results.
- D. The Vendor re-evaluates the effects of the above activities.

4.8.15 Standard XI: Standards for Availability and Accessibility

The Vendor has established standards for access (e.g., to routine, urgent and emergency care; telephone appointments; advice; and recipient service lines) and complies with Section 4.5.5 of this RFP. Performance on these dimensions of access is assessed against the standards.

4.8.16 Standard XII: Medical Record Standards

4.8.16.1 Accessibility and Availability of Medical Records

- A. The Vendor shall include provisions in all provider contracts for HIPAA compliance with regard to access to medical records for purposes of quality reviews conducted by the

Secretary of the United States Department of Health and Human Services (the Secretary), DHCFP, or agents thereof.

- B. Records are available to health care practitioners at each encounter.

4.8.16.2 Record Keeping

Medical records may be on paper or electronic. The Vendor takes steps to promote maintenance of medical records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review. Medical records must be maintained as follows:

- A. Medical Record Standards – The Vendor sets standards for medical records. The records reflect all aspects of patient care, including ancillary services. These standards shall, at a minimum, include requirements for:
 - 1. Patient Identification Information – Each page on electronic file in record contains the patient’s name or patient ID number;
 - 2. Personal/Demographic Data – Personal/biographical data includes: age, sex, race, address, employer, home and work telephone numbers, and marital status;
 - 3. Entry Date – All entries are dated;
 - 4. Provider Identification – All entries are identified as to author;
 - 5. Legibility – The record is legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer;
 - 6. Allergies – Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies – NKA) is noted in an easily recognizable location;
 - 7. Past Medical History [for patients seen three (3) or more times] – Past medical history is easily identified including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth;

8. Immunizations for Pediatric Records [ages twenty (20) and under] – There is a completed immunization record or a notation that immunizations are up to date with documentation of specific vaccines administered and those received previously (by history);
9. Diagnostic information;
10. Medication information;
11. Identification of Current Problems – Significant illnesses, medical conditions and health maintenance concerns are identified in the medical record;
12. Smoking, Alcohol or Substance Abuse – Notation concerning cigarettes, alcohol and substance abuse is present for patients twelve (12) years and over and seen three (3) or more times;
13. Consultations, Referrals, and Specialist Reports – Notes from any consultations are in the record. Consultation, lab, and x-ray reports filed in the chart have the ordering physician's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans;
14. Emergency care;
15. Hospital Discharge Summaries – Discharge summaries are included as part of the medical record for: 1) all hospital admissions that occur while the patient is enrolled with the Vendor; and 2) prior admissions as necessary; and
16. Advance Directive – For medical records of adults, the medical record documents whether or not the individual has executed an advance directive and documents the receipt of information about advance directives by the recipient and confirms acknowledgment of the option to execute an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.

B. Patient Visit Data – Documentation of individual encounters must provide adequate evidence of, at a minimum:

1. History and Physical Examination – Comprehensive subjective and objective information is obtained for the presenting complaints;
2. Plan of treatment;
3. Diagnostic tests;
4. Therapies and other prescribed regimens;
5. Follow-up – Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months, or PRN (as needed). Unresolved problems from previous visits are addressed in subsequent visits;
6. Referrals and results thereof; and
7. All other aspects of patient care, including ancillary services.

4.8.16.3 Record Review Process

- A. The Vendor has a system (record review process) to assess the content of medical records for legibility, organization, completion and conformance to its standards; and
- B. The record assessment system addresses documentation of some or all of the items listed in Section 4.8.14.2, above.

4.8.17 Standard XIII: Utilization Review

4.8.17.1 Written Program Description

The Vendor has a written utilization review management program description, which includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services.

4.8.17.2 Scope

The program has mechanisms to detect under-utilization as well as over-utilization.

4.8.17.3 Pre-Authorization and Concurrent Review Requirements

For Vendors with pre-authorization or concurrent review programs:

- A. Pre-authorization and concurrent review decisions are supervised by qualified medical professionals;
- B. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician, as necessary;
- C. The reasons for decisions are clearly documented and available to the recipient;
- D. The Vendor's prior authorization policies and procedures must be consistent with provision of covered medically necessary medical and dental care in accordance with community standards of practice;
- E. There are well-publicized and readily available mechanisms for recipient appeals and grievances as well as provider disputes. Providers may pursue an appeal on the recipient's behalf with the recipient's written authorization. The Notice of Action must include a description of how to file an appeal;
- F. Appeal and grievance decisions are made in a timely manner as warranted by the health of the enrolled recipient;
- G. There are mechanisms to evaluate the effects of the program using data on recipient satisfaction, provider satisfaction or other measures;
- H. Consistent with 42 CFR 438.6(h) and 42 CFR 423.208, Vendors must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member; and
- I. If the Vendor delegates responsibility for utilization management, it has mechanisms to ensure that the delegate meets these standards.

4.8.18 Standard XIV: Continuity of Care System

The Vendor has put a basic system in place, which promotes continuity of care and case management. The Vendor must take a comprehensive and collaborative approach to coordinate care for the eligible population and conditions as specified by DHCFP through an effective case management program, partnerships with primary care physicians and specialists, provider and recipient participation, recipient/family outreach and education, and the ability to holistically address member's health care needs. Care coordination must include not only the specific diagnosis, but also the complexities of multiple co-morbid conditions, including behavioral health, and related issues such as the lack of social or family support.

4.8.18.1 Vendor must offer and provide case management services which coordinate and monitor the care of members with specific diagnosis and/or who require high-cost or extensive services. The Vendor's case management program must include, at a minimum, the following:

- A. Identification of members who potentially meet the criteria for case management; through health risk assessment and tailoring care management programs to the recipients need, respecting the role of the recipient to be a decision maker in the care planning process.
- B. Assessment of the health condition for members with a positive screen.
- C. Notification to the members PCP of the member's enrollment in the Vendor's case management program;
- D. Development and implementation of a care treatment plan for members in case management based on the assessment which includes:
 - 1. Member and PCP participation in both development and implementation phases of the care treatment plan;
 - 2. Coordination of care and communication between the member, PCP, and other service providers and case managers; and
 - 3. Coordination with State and county agencies, as appropriate, [e.g., the Aging and Disability Services Division; Division of Child & Family Services; Governor's Office of Consumer Health Assistance (CHA); Office of Disability Services; Health Division; Mental Health and Developmental Services Division (MHDS); Division of Welfare and Supportive Services; and Substance Abuse Prevention and Treatment Agency (SAPTA)], as well as other public assistance programs, such as the Women, Infant, Children (WIC) program; teen pregnancy programs; parenting programs; and, Child Welfare programs.

4.8.18.2 The following components should be incorporated into the Vendor case management program:

- A. Identification

Vendor must have mechanisms in place to identify members potentially eligible for case management services. These mechanisms must include an administrative data review (e.g. diagnosis, cost threshold, and/or service utilization) and may also include telephone interviews; mail surveys; provider/self referrals; or home visits.

B. Assessment

The Vendor must arrange for or conduct an initial comprehensive assessment of new members, to confirm the results of a positive identification and to determine the need for case management services within 90 days of enrollment. Face-to-face assessments shall be conducted, as necessary. The goals of the assessment are to identify the member's existing and/or potential health care needs and assess the member's need of case management services.

The comprehensive assessment must evaluate the member's physical health, behavioral health, co-morbid conditions, and psycho-social, environmental, and community support needs. The assessment must be completed by a physician, physician assistant, RN, LPN, licensed social worker, or a graduate of a two- or four-year allied health program. If the assessment is completed by another medical professional, there should be oversight and monitoring by either a registered nurse or physician.

Furthermore, the Vendor must provide information to the members and their PCPs that they have been identified as meeting the criteria for case management, including their enrollment into case management services.

C. Prioritize Care Needs of the Member

The Vendor must develop methods to synthesize assessment information to prioritize care needs and develop treatment plans. Once the members care needs have been identified, the Vendor must, at a minimum:

1. Develop a care treatment plan (as described below);
2. Implement member - level interventions;
3. Continuously monitor the progress of the patient;
4. Identify gaps between care recommended and actual care provided, and propose and implement interventions to address the gaps; and

5. Re-evaluate the member's care needs and adjust the level of case management services accordingly.

D. Care Treatment Plan

Based on the assessment, the Vendor must assure and coordinate the placement of the member into case management and development of a care treatment plan within 90 days of membership. The care treatment plan as defined by DHCFP is the one developed by the Vendor. The member and the member's PCP must be actively involved in the development of the care treatment plan. The designated PCP is the physician who will manage and coordinate the overall care for the member. Ongoing communication regarding the status of the care treatment plan may be accomplished between the Vendor and the PCP's designee (i.e. qualified health professional). Revisions to the clinical portion of the care treatment plan should be completed in consultation with the PCP.

The Vendor must arrange or provide for professional care management services that are performed collaboratively by a team of professionals (which may include physicians, physician assistants, nurses, specialists, pediatricians, pharmacists, behavior health specialists, and/or social workers) appropriate for the member's condition and health care needs.

The care treatment plan should reflect the member's primary medical diagnosis and health condition, any co-morbidity, and the member's psychological and community support needs. At a minimum, the Vendor's physical health case manager must attempt to coordinate care with the member's case manager from other health systems, including behavioral health. The care treatment plan must also include specific provisions for periodic reviews of the member's condition and appropriate updates to the plan.

Vendor must honor ongoing care treatment plans, as medically necessary, for members transferred into the Vendor's plan from another Medicaid Vendor, a State-designated HIX plan or any other existing care treatment plans.

E. Designation of PCP

For members with case management needs, the designated PCP is the physician who will manage and coordinate the overall care for the member. See Section 4.2.1.8 for other PCP designation requirements. In addition, the Vendor will

facilitate the coordination of the members care and ensure communications between the member, PCP, and other service providers and case managers.

4.8.18.3 Case Management Program Staffing

The Vendor must identify the staff that will be involved in the operations of the case management program, including but not limited to: case manager supervisors, case managers, and administrative support staff. The Vendor must identify the role/functions of each case management staff member as well as the required educational requirements, clinical licensure standards, certification and relevant experience with case management standards and/or activities. Furthermore, the Vendor must provide case manager staff/member ratios based on the member risk stratification and different levels of care being provided to members.

4.8.18.4 Case Management Conditions

The Vendor must, at a minimum, provide case management to members with the following clinical and behavioral health conditions:

- A. Congestive Heart Failure (CHF);
- B. Coronary Arterial Disease (CAD);
- C. Hypertension (excluding Mild Hypertension);
- D. Diabetes;
- E. Chronic Obstructive Pulmonary Disease (COPD);
- F. Asthma;
- G. Severe Mental Illness;
- H. High-Risk or High-Cost Substance Abuse Disorders;
- I. Severe Cognitive and/or Developmental Limitation;
- J. Members in Supportive Housing; and
- K. Members with Complex Conditions.

However, Vendor' should focus on all members whose health conditions warrant case management services and should not limit these services only to members with these conditions (e.g., cystic fibrosis, cerebral palsy, sickle cell anemia, etc.).

4.8.18.5 Case Management Strategies

The Vendor must follow best-practice and/or evidence-based clinical guidelines when devising a member's treatment plan and coordinating the case management needs. Should a Vendor employ a disease management methodology (e.g., grouper, predictive modeling, proprietary screening algorithms) to identify and/or stratify members in need of various levels of health coaching and care intervention, the methods must be validated by scientific research and/or nationally accepted and recognized in the health care industry.

The Vendor must develop and implement mechanisms to educate and equip physicians with evidence-based clinical guidelines or best practice approaches to assist in providing a high level of quality care to Vendor members.

The Vendor will work collaboratively with DHCFP to determine member race and ethnicity. The Vendor will organize interventions specifically designed to reduce or eliminate disparities in health care.

4.8.18.6 Information Technology System for Case Management:

The Vendor's information technology system for its case management program must maximize the opportunity for communication between the Vendor, PCP, the patient, other service providers and case managers. The Vendor must have an integrated database that allows Vendor staff that may be contacted by a member in case management to have immediate access to and review of the most recent information within the Vendor's information systems relevant to the case. The integrated database may include the following: administrative data, call center communications, service authorizations, care treatment plans, patient assessments and case management notes. For example, Vendor member services staff must have access to a member's case management notes and recent inpatient or emergency department utilization if contacted by that member. The information technology system must also have the capability to share relevant information (i.e. utilization reports, care treatment plans, etc.) with the member, the PCP, and other service providers and case managers.

4.8.19 Standard XV: IQAP Documentation

4.8.19.1 Scope

The Vendor shall document that it is monitoring the quality of care across all services and all treatment modalities, according to its written QAP. (This review of the entire range of care is expected to be carried out over multiple review periods and not on a concurrent basis.)

4.8.19.2 Maintenance and Availability of Documentation

The Vendor must maintain and make available to the DHCFP, and upon request to the Secretary, studies, reports, protocols, standards, worksheets, minutes, or such other documentation as requested concerning its quality assurance activities and corrective actions.

4.8.20 Standard XVI: Coordination of Quality Assurance (QA) Activity with Other Management Activity

The findings, conclusions, recommendations, actions taken and results of the actions taken as a result of QA activity, are documented and reported within the Vendor's organization and through the established QA channels.

4.8.20.1 Quality assurance information is used in recertification, reconstructing and/or annual performance evaluations.

4.8.20.2 Quality assurance activities are coordinated with other performance monitoring activities, including utilization management, risk management and resolution and monitoring of recipient grievances and appeals.

4.8.20.3 There is a linkage between quality assurance and the other management functions of the Vendor such as:

- A. Network changes;
- B. Benefits redesign;
- C. Medical management systems (e.g., pre-certification);
- D. Practice feedback to practitioners;
- E. Patient education; and
- F. Recipient services.

4.8.21 Standard XVII: Data Collection

The Vendor must provide DHCFP with uniform utilization, cost, quality assurance, and recipient satisfaction/complaint data on a regular basis, in accordance with Section 4.7, Quality Assurance Standards. The Vendor will submit information to DHCFP in accordance with the contract, performance measures and reports. Data for measures of quality, utilization, recipient satisfaction and access will be reported for the contract population.

4.8.21.1 Specific areas of study required will be stated in the contract with each individual Vendor.

4.8.21.2 Data or studies required by the contract must be submitted timely, and be accurate and complete.

4.8.21.3 Monitoring and tracking of grievance/appeal information, childhood immunization, and prenatal and obstetrical care are required annually.

4.8.22 Standard XVIII: Dispute Resolution

The Vendor must staff a provider services unit to handle provider questions and disputes.

- 4.8.22.1 The Vendor must resolve ninety percent (90%) of written, telephone or personal contacts within thirty (30) calendar days of the date of receipt.
- 4.8.22.2 A written record in the form of a file or log is to be maintained by the Vendor for each provider inquiry or dispute to include the nature of it, the date filed, dates and nature of actions taken, and final resolution.

4.9 STATE QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY

The State’s Quality Assessment and Performance Improvement Strategy has two basic purposes:

To ensure compliance with federal and state statutory and regulatory requirements on quality, and

To go beyond compliance with the minimum statutory and regulatory requirements by implementing multiple methods for “continuous quality improvement” in order to raise the quality of care provided to, and received by, Medicaid beneficiaries in the state.

- 4.9.1 The DHCFP developed a Medicaid and Nevada Check Up Managed Care Quality Assessment and Performance Improvement Strategy (henceforth, referred to as the Strategy), pursuant to 42 CFR 438.200. The purpose of this quality strategy is to:

CFR 438.202 – State Responsibilities

- 4.9.1.1 Have a written strategy for assessing and improving the quality of managed care services offered by all managed care organizations (Vendors);
- 4.9.1.2 Obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it to final;
- 4.9.1.3 Ensure that the Vendors comply with standards established by the DHCFP;
- 4.9.1.4 Conduct periodic reviews to evaluate the effectiveness of the strategy, and update the strategy periodically, as needed; and,
- 4.9.1.5 Submit to CMS one (1) copy of the initial strategy, and a copy of the revised strategy whenever significant changes are made, and two (2) regular reports on the implementation and effectiveness of the strategy.

The DHCFP will approve the Strategy and maintain ultimate authority for overseeing its management and direction. The Vendor is also required to

participate in quality initiatives that align with the goals and objectives identified in the DHCFP's Performance Measures, as defined in the DHCFP budget. The Strategy is in two parts: an overriding conceptual program and an annual Work Plan.

CFR 438.204 – Elements of State Quality Strategies

4.9.2 The Strategy incorporates procedures that:

4.9.2.1 Assess the quality and appropriateness of care and services furnished to all DHCFP medical assistance program recipients enrolled in managed care under the Vendor contract, as well as to enrolled recipients who have special health care needs;

4.9.2.2 The Vendor will develop a cultural competency plan that will include methods to encourage culturally-competent contact between recipients and providers, staff recruitment, staff training, translation services, and the development of appropriate health education materials. The Vendor is responsible for promoting the delivery of services in a culturally competent manner, solely determined by DHCFP, to all members including those with limited English proficiency (LEP) and diverse cultural and ethnic background. The Vendor will develop methods to collect report and identify the race, ethnicity and primary language spoken of each enrolled recipient. The Vendor will track primary language information in the health plans' customer services systems. DHCFP will provide race and ethnicity and primary language spoken data for the Medicaid population to the Vendor(s) through a monthly interface. The Vendors may alert DHCFP, as part of the demographic update interface with DWSS NOMADS system, of any known discrepancies in the race and ethnicity or primary language data they receive from DHCFP. This data will be utilized to gather baseline data and will lead to the development of a Performance Improvement Projects (PIP) or quality improvement project. Such a project will incorporate data from the State enrollment file according to the race and ethnicity categories as defined by CMS. The data will be used to generate stratified reports as recommended by the Centers for Medicare and Medicaid Services (CMS) and compliant with the Health Insurance Portability and Accountability Act (HIPAA) for race and ethnicity categories to identify disparities. The Vendor's will organize interventions specifically designed to reduce or eliminate disparities in health care;

4.9.2.3 Monitor regularly and evaluate the contracted Vendors' compliance with the standards and a description of how the DHCFP will regularly monitor and evaluate Vendor compliance with the DHCFP established standards for access to care, structure and operations, and quality measurement and improvement. This may include, for example, a description of the types of reviews the DHCFP will

perform, how often it will monitor these standards, and how the results of the DHCFP's efforts will be reported;

- 4.9.2.4 Arrangements for external quality reviews including a description of the DHCFP's arrangements for an annual, independent external quality review of the timeliness, outcomes, and accessibility of the services covered under each Vendor contract. This section should include a broad description of the scope of the contract (e.g., calculating HEDIS measures or designing performance improvement projects, etc.) including the term of the contract;
- 4.9.2.5 For Vendors, the performance measures and levels developed by CMS in consultation with States and other relevant stakeholders;
- 4.9.2.6 An information system that supports initial and ongoing operation and review of the DHCFP's quality strategy;
- 4.9.2.7 For Vendors only, a description of how the DHCFP uses intermediate sanctions in support of its quality strategy. These sanctions must, at a minimum, meet the requirements specified in 42 CFR 438 Subpart I. The DHCFP's description specifies its methodology for using sanctions as a vehicle for addressing identified quality of care problems; and
- 4.9.2.8 Standards, at least as stringent as those in 42 CFR Part 438 for access to care, structure and operations, and quality measurement and improvement.

4.10 FISCAL REQUIREMENTS

4.10.1 Vendor Fiscal Standards

The State of Nevada Division of Insurance (DOI) regulates the financial stability of all certified Vendors. The Vendor must comply with all DOI standards in addition to the managed care program standards described in this section.

4.10.2 Performance Security Deposit

The Vendor is required to provide a performance security deposit in the form of a bond furnished by a surety company authorized to do business in the State of Nevada to DHCFP in order to guarantee payment of the Vendor's obligations under this contract. The performance security deposit may be utilized by DHCFP to remedy any breach of contract or sanctions imposed on the Vendor and shall meet the following criteria:

- 4.10.2.1 The amount of the performance security deposit shall be equal to one hundred and ten percent (110%) of highest month's total capitation amount in the first quarter or fifteen million dollars (\$15 million), whichever is greater. This must be deposited with the State Treasurer within fifteen (15) calendar days after the end of the first

quarter of the contract. The total capitation amount is the sum of all capitation payments for all members for the month; and

- 4.10.2.2 After the initial year of the contract DHCFP will require the Vendor to increase the performance security deposit amount to reflect an amount equal to one hundred and ten percent (110%) of the preceding year's highest month's total capitation payment or fifteen million dollars (\$15 million), whichever is greater.
- 4.10.2.3 Vendors submitting performance security to the State of Nevada in the form a surety bond must utilize a company that meets the below listed requirements:
 - A. A.M. Best A-VII rated insurance company
 - B. Certified by the Department of Treasury, Financial Management Services for Nevada
 - C. Licensed by the Nevada Department of Business and Industry, Insurance Division
- 4.10.2.4 The Vendor must maintain the performance security deposit after the contract term for a length of time to be determined by DHCFP in order to cover all outstanding liabilities.

4.10.3 Vendor Liability

The Vendor must ensure that its members are not held liable for any of the following:

- 4.10.3.1 The Vendor's debts, in the event of the Vendor's insolvency;
- 4.10.3.2 For services provided to the member in the event of the organization failing to receive payment from the State for such services;
- 4.10.3.3 For services provided to a member in the event a health care provider with a contractual, referral, or other arrangement with the Vendor fails to receive payment from the state or the organization for such services; or
- 4.10.3.4 For payments to a provider who furnishes covered services under a contractual, referral, or other arrangement with the Vendor in excess of the amount that would be owed by the recipient if the Vendor had directly provided the services.
- 4.10.3.5 To ensure continuation of services to members during insolvency pursuant to State Medicaid Manual (SMM) 2086.6.B.

- 4.10.4 The requirements set forth in Section 4.10.3 above shall be included in all subcontracts.
- 4.10.5 Timely Payment of Claims
- 4.10.5.1 The Vendor shall be responsible for paying all claims for properly accessed and, if necessary, authorized covered services provided to enrolled recipients on dates of service when they were eligible for coverage unless the services are excluded under the DHCFP managed care contract or the Nevada Medicaid State Plan. The Vendor will adjudicate and pay all claims in accordance with state and federal statutes and regulations.
- 4.10.5.2 The Vendor must have a claims processing system and Management Information System (MIS) sufficient to support the provider payment and data reporting requirements specified in the contract.
- 4.10.5.3 The Vendor shall have written policies and procedures for processing claims submitted for payment from any source and shall monitor its compliance with these procedures.
- 4.10.5.4 The Vendor shall allow network and non-network providers to submit an initial claim for covered services. The Vendor shall allow all network providers to submit claims for reimbursement up to ninety (90) days from the last date of service and non-network providers one hundred and eighty (180) days from the last date of service unless a shorter time period is negotiated. Vendor shall allow providers of emergency transportation 180 days from the last date of service to submit claims for reimbursement. The Vendor's claims payment system shall use standard claim forms wherever possible. In addition, the Vendor shall have the capability to electronically accept and adjudicate claims
- 4.10.5.5 The Vendor's claims processing system shall ensure that duplicate claims are denied. In addition, this system must include edits for unbundling and edits for certain provider types where DHCFP's payment responsibility is for federal share only.
- 4.10.5.6 The Vendor must meet the requirements for timely claims payment in 42 CFR 447.45d (2) and (d) (3) and abide by the specifications of 447.45(d) (5) and (d) (6). The Vendor agrees for valuable consideration that NRS §695C.185 and NRS§695C.128 shall apply to the terms of any contract entered into as a result of this RFP. The Vendor and its providers may, by mutual agreement, establish an alternative payment schedule but such a schedule must be stipulated in the provider's network contract.
- 4.10.5.7 The Vendor shall verify that reimbursed services were actually provided to enrolled recipients by providers and subcontractors.

4.10.5.8 The Vendor shall provide DHCFP with information prior to implementation of any changes to the software system to be used to support the claims processing function as described in the Vendor's proposal and incorporated by reference in the contract.

4.10.5.9 A medical review of claims will be conducted when the appropriateness of service, procedure, or payment is in question. Medical reviews must be conducted by a licensed medical clinician(s).

4.10.6 Financial Solvency

The Vendor must demonstrate that it has adequate financial reserves and administrative ability to carry out its contractual obligations. The Vendor must maintain financial records and provide DHCFP with various financial statements upon request and as outlined in the contract and ***Attachment I, Forms and Reporting Guide***, including any revisions or additions to the document.

4.10.6.1 The Vendor will submit a copy of its annual Independent Audit Report to DHCFP, as submitted to the Division of Insurance.

4.10.6.2 The Vendor will submit its quarterly and annual financial reports to DHCFP.

4.10.7 Third-Party Liability and Subrogation

Third-party liability (TPL) refers to any individual, entity (e.g., insurance company) or program (e.g., Medicare), including group health plans, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974 [29 USC and 1167 (1)] service benefits plans and Section 6035 of the Deficit Reduction Act of 2005. TPL also includes the Coordination of Benefits (COB) cost avoidance and COB recovery. Under Section 1902(a) (25) of the Social Security Act, DHCFP and its providers are required to take all reasonable measures to identify legally liable third parties and treat verified TPL as a resource of the Medicaid and CHIP recipient.

Subrogation is the principle under which an insurer that has paid a loss under an insurance policy is entitled to all the rights and remedies belonging to the insured against a third party with respect to any loss covered by the policy.

The DHCFP contracted managed care organization, as the Division's vendor, shall act as the State's authorized agent for the limited purpose of TPL collection, within the limitation of the Fair Debt Collection Practices Act, 15 USC § 1692, of all third-party liability (TPL) pursuant to 42 CFR § 433.135 et seq and 42 CFR 433.147. The managed care organization's capitated payments include an offset in the rates for these collections. The contracted managed care organization shall vigorously pursue billing prior resources as these amounts are considered part of their risk based capitation payment. The managed care organization is required to secure signed acknowledgements from enrolled Medicaid recipients or their

authorized representative confirming any prior resources (e.g., Medicare, worker's compensation, private insurance, etc.).

The contracted managed care organization must pursue third-party liability in accordance with 42 CFR 433.139 and Sections 103.6 and 3603.20 of the Nevada Medicaid Services Manual.

The Vendor must also determine if casualty claims are filed and recover costs through subrogation on behalf of both Medicaid and CHIP recipients. The managed care organization may utilize the EVS eligibility system to assist in accomplishing this objective.

The managed care organization is responsible not only for pursuing third-party resources that it identifies but also for pursuing third-party resources identified and communicated to the managed care organization by DHCFP.

All information on the third party, including collections and collection attempts, are to be reported to DHCFP (including circumstances under which the third party refuses to pay) on the Third Party Quarterly Report located in the Forms and Reporting Guide. TPL and subrogation collections may also be reported to DHCFP through encounter data and other required reports. The DHCFP will monitor and evaluate the managed care organization's TPL and subrogation collection reports to validate collection activities and results. The managed care organization will then be expected to meet or exceed baseline target collections as determined by DHCFP and its actuaries. The baseline target amount will be built into future rates. If the managed care organization does not meet or exceed baseline TPL and subrogation collections, DHCFP will conduct a review to determine if there is a legitimate reason. If there is no legitimate reason as determined by the Division, the difference between baseline and actual collections will be deducted from the managed care organization's costs before the data is used to set future rates. DHCFP will prospectively adjust capitation rates to account for expected TPL collections.

4.10.8 Reserving

As part of its accounting and budgeting function, the Vendor will be required to establish an actuarially sound process for estimating and tracking incurred but not reported claims (IBNRs). The Vendor must provide documentation of the IBNRs review and certification by an actuary. The Vendor must reserve funds by major categories of service (e.g., hospital inpatient, hospital outpatient, physician, and pharmacy) to cover both IBNRs and reported but unpaid claims (RBUCs). As part of its reserving methodology, the Vendor must conduct annual reviews to assess the actuarial validity of its reserving methodology, and make adjustments as necessary.

4.10.9 Prohibition on Payments to Institutions or Entities Located Outside of the United States

Pursuant to Section 6505 of the ACA, which amends Section 1902(a) of the Social Security Act (the Act), the Vendor shall not provide any payments for

items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States (U.S.).

Payments for items or services provided under the State Plan to financial institutions or entities such as provider bank accounts or business agents located outside of the United States are prohibited by this provision. Further, this Section prohibits payments to telemedicine providers located outside of the U.S. Additionally; payments to pharmacies located outside of the U.S. are not permitted.

Any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the U.S. may be recovered by the State from the Vendor.

For purposes of implementing this provision, section 1101(a) (2) of the Act defines the term “United States” when used in a geographical sense, to mean the “States.” Section 1101(a)(1) of the Act defines the term “State” to include the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, when used under Title XIX.

The phrase, “items or services provided under the State Plan or under a waiver” refers to medical assistance for which the State claims Federal funding under section 1903(a) of the Act. Tasks that support the administration of the Medicaid State Plan that may require payments to financial institutions or entities located outside of the U.S. are not prohibited under this statute. For example, payments for outsourcing information processing related to Plan administration or outsourcing call centers related to enrollment or claims adjudication are not prohibited under this statute.

4.11 GRIEVANCES, APPEALS AND FAIR HEARINGS

The Vendor shall establish a system for members, which includes a grievance process, an appeal process, and access to the State Fair Hearing system. The Vendor shall establish a similar system to resolve disputes with providers. The Vendor must provide information about these systems to members at the time of enrollment and to providers and subcontractors at the time they enter into a contract. As described in Section 4.7.2 of this RFP, the Vendor must submit to DHCFP quarterly reports that document the grievance and appeal activities listed on the templates located in the Forms and Reporting Guide.

4.11.1 Enrollee Grievances and Appeals

The authority for the following provisions concerning Enrollee Grievances and Appeals is found in 42 CFR 438 Subpart F (Subsections 400-424). Additional and cross-referenced regulations include 42 CFR 431.206(b) (3), 431.210(c) and (d), 431.213, 431.214, 431.230(b), 438.10(c) and (d) and (g) (1), 438.210(c), and 483.23(a) (5) (ii). NRS695G.090 exempts Medicaid from the provisions of NRS 695G.200- 695G 230 that regard grievances and appeals.

The Vendor’s enrollee grievance and appeal system must be in writing and submitted to DHCFP for review and approval at the time the Vendor’s Policies

and Procedures are submitted, and at anytime thereafter when the Vendor's enrollee grievances and appeals policies and procedures have been revised or updated (not including grammatical or readability revisions or updates). The Vendor may not implement any policies and procedures concerning its enrollee grievance and appeal system without first obtaining the written approval of the DHCFP.

An enrollee or an enrollee's representative (including a provider on behalf of an enrollee) may file a grievance or submit an appeal directly with the DHCFP. However, such grievances and appeals will be referred to the Vendor for resolution. In the event a provider files an appeal on the enrollee's behalf, the provider must first obtain the enrollee's written permission with the exception of an expedited appeal (Refer to RFP Section 4.11.4.3).

In the case of appeals, the enrollee must first exhaust the Vendor's appeal process, but if not satisfied with the outcome, may request a State Fair Hearing from the DHCFP. The Vendor is required to provide access to and information about the State Fair Hearing process in the event an enrollee's appeal is not resolved in favor of the enrollee. Grievances are not eligible for referral to the State Fair Hearing process.

An enrollee may file an appeal or grievance either orally or in writing. Unless the enrollee has requested an expedited resolution, an oral appeal may be followed by a written, signed appeal. If a grievance or appeal is filed orally, the Vendor is required to document the contact for tracking purposes and to establish the earliest date of receipt. There is no requirement to track routine telephone inquiries.

For tracking purposes, an oral appeal or grievance is differentiated from a routine telephone inquiry by the content of the inquiry. An appeal is a specific request for review of one of the following actions:

- 4.11.1.1 The denial or limited authorization of a requested service;
- 4.11.1.2 The reduction, suspension or termination of a previously authorized service;
- 4.11.1.3 The denial, in whole or in part, of payment for a service;
- 4.11.1.4 The failure to provide services in a timely manner; or
- 4.11.1.5 The failure of a Vendor to act within the required timeframes for resolution and notification of appeals and grievances.

A grievance is an expression of dissatisfaction about any matter other than one of the actions listed above. Possible issues for grievances include, but are not limited to, access to care, quality of services, interpersonal relationships between Vendor staff and enrollees, and failure to respect an enrollee's rights.

4.11.2 Authorization and Notice Timeliness Requirements

The Vendor must provide standard authorization decisions as expeditiously as the enrollee's health requires and within the State's established timelines that may not exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days if the enrollee or provider requests the extension; or, the Vendor justifies (to the DHCFP upon request) a need for additional information and how the extension is in the enrollee's interests.

For cases in which a provider indicates or the Vendor determines that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Vendor must make an expedited authorization decision and provide a Notice of Action as expeditiously as the enrollee's health condition warrants and no later than three (3) working days after receipt of the request for service. The Vendor may extend the three (3) working days time period by up to fourteen (14) calendar days if the enrollee requests an extension or if the Vendor justifies (to the State upon request) a need for additional information and how the extension is in the enrollee's interest.

4.11.3 Notice of Action

The Vendor must provide a written notice of action to the enrollee when the Vendor takes action or makes an adverse determination affecting the enrollee. If a provider has made a request on an enrollee's behalf and the Vendor makes an adverse determination, the provider must be notified but this notification need not be in writing.

To ensure ease of understanding by non-English speaking or visually impaired enrollees, or enrollees with limited reading proficiency, the written notice to the enrollee must meet the language and format requirements of 42 CFR 438.10(c) and (d).

A written notice of action to the enrollee must meet the following requirements and must explain:

- 4.11.3.1 The action the Vendor or its subcontractor has taken or intends to take;
- 4.11.3.2 The reasons for the action;
- 4.11.3.3 The enrollee's or the provider's right to file an appeal;
- 4.11.3.4 The enrollee's right to request a State Fair Hearing after the enrollee has exhausted the Vendor's internal appeal procedures;
- 4.11.3.5 The procedures for exercising the enrollee's rights to appeal;

- 4.11.3.6 The circumstances under which expedited resolution is available and how to request it;
- 4.11.3.7 The enrollee's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services;
- 4.11.3.8 That the enrollee may represent himself or use legal counsel, a relative, a friend, or other spokesman;
- 4.11.3.9 The specific regulations that support, or the change in federal or State law that requires the action; and
- 4.11.3.10 The enrollee's right to request an evidentiary hearing if one is available or a state agency hearing, or in cases of action based on change in law, the circumstances under which a hearing will be granted.

The Vendor must give notice at least ten (10) days before the date of action when the action is a termination, suspension, or reduction of previously authorized covered services. This timeframe may be shortened to five (5) days if probable enrollee fraud has been verified.

The Vendor must give notice by the date of the action for the following circumstances:

- 4.11.3.11 In the death of the enrollee;
- 4.11.3.12 A signed written enrollee statement requesting termination or giving information requiring termination or reduction of services (where the enrollee understands that this must be the result of supplying that information);
- 4.11.3.13 The enrollee's admission to an institution where he is ineligible for further services;
- 4.11.3.14 The enrollee's address is unknown and mail directed to him has no forwarding address;
- 4.11.3.15 The enrollee has been accepted for Medicaid services by another local jurisdiction;
- 4.11.3.16 The enrollee's physician prescribes the change in level of medical care;
- 4.11.3.17 An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989; or

- 4.11.3.18 The safety or health of individuals in a facility would be endangered; the residents health improves sufficiently to allow a more immediate transfer or discharge; an immediate transfer or discharge is required by the resident's urgent medical needs; or the resident has not resided in a nursing facility for thirty (30) days (applies only to adverse action for nursing facility transfers).
- 4.11.3.19 The Vendor must give a Notice of Action on the date of action when the action is a denial of payment.
- 4.11.3.20 The Vendor must give notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions.
- 4.11.3.21 Notice of Actions must include:
 - A. The enrollee's right to file a grievance if he or she disagrees with that decision; and
 - B. The enrollee's right to receive written resolution notice. In addition, reasonable efforts shall be made to provide oral resolution notice.

4.11.4 Handling of Grievances and Vendor Appeals

The Vendor is required to dispose of each grievance and resolve each appeal and to provide notice as expeditiously as the enrollee's health condition requires within the State's established time frames specified as follows:

- 4.11.4.1 Standard disposition of grievances: The Vendor is allowed no more than ninety (90) days from the date of receipt of the grievance.
- 4.11.4.2 Standard resolution of appeals: The Vendor is allowed no more than thirty (30) days from the date of receipt of the appeal.
- 4.11.4.3 Expedited resolution of appeals: The Vendor is allowed up to three (3) working days from the date of receipt of the appeal. The Vendor is required to establish and maintain an expedited review process for appeals when the Vendor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. The Vendor must ensure that punitive action is not taken against a provider who supports an expedited appeal. If the Vendor denies a request for an expedited resolution of an appeal, it must transfer the appeal to the standard resolution of appeals and make reasonable efforts to give the enrollee oral notice of the denial and follow up within two (2) calendar days with a written notice.

- 4.11.4.4 The vendor must inform the enrollee of the limited time available to present evidence and allegations of fact or law, in person or in writing, in the case of the expedited resolution.
- 4.11.4.5 These time frames may be extended up to fourteen (14) days if the enrollee requests such an extension or the Vendor demonstrates to the satisfaction of the DHCFP that there is a need for additional information and how the extension is in the enrollee's interests. If the State grants the Vendor's request for an extension, the Vendor must give the enrollee written notice of the reason for the delay.

In handling grievances and appeals, the Vendor must meet the following requirements:

- 4.11.4.6 The Vendor must provide enrollees any reasonable assistance in completing forms and taking other procedural steps, including assisting the enrollee and/or the enrollee's representative to arrange for non-emergency transportation services to attend and be available to present evidence at the appeal hearing. This also includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability;
- 4.11.4.7 Acknowledge receipt of each grievance and appeal;
- 4.11.4.8 Ensure that the individuals who make decisions on grievances and appeals were not involved in any previous level of review or decision-making; and
- 4.11.4.9 Ensure that the individuals who make decisions on grievances and appeals are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease if the grievance or appeal involves any of the following:
 - A. An appeal of a denial that is based on medical necessity;
 - B. A grievance regarding the denial of an expedited resolution of an appeal; or
 - C. A grievance or appeal that involves clinical issues.

The process for appeals also requires:

- 4.11.4.10 That oral inquiries seeking to appeal an action are treated as appeals (in order to establish the earliest possible filing date for the appeal) and must be confirmed in writing unless the enrollee requests expedited resolution;
- 4.11.4.11 That the enrollee is provided a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in

writing, and that the enrollee is informed by the Vendor of the limited time available for this in the case of expedited resolution;

- 4.11.4.12 That the enrollee and his/her representative is provided the opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other document and records considered during the appeals process; and
- 4.11.4.13 Include, as parties to the appeal, the enrollee and his/her representative or the legal representative of a deceased enrollee's estate.

The Vendor shall notify the enrollee of the disposition of grievances and appeals in written format. The written notice must include the results of the resolution process and the date it was completed. For appeals that are not wholly resolved in favor of the enrollee, the notice must also include:

- 4.11.4.14 The right of the enrollee to request a State Fair Hearing from the DHCFP and how to do so;
- 4.11.4.15 The right to request to receive benefits while the hearing is pending and how to make this request; and
- 4.11.4.16 That the enrollee may be held liable for the cost of those benefits if the State Fair Hearing Officer upholds the Vendor's action.

For expedited appeal resolution requests, the Vendor is required to make a good faith effort to provide an oral notice of the disposition in addition to the required written notice.

The Vendor is required to maintain records of grievances and appeals, which the State will review as part of the State's quality strategy.

4.11.5 State Fair Hearing Process

The State Fair Hearing process is described in Chapter 3100 of the MSM. An enrollee, enrollee's representative or the representative of a deceased enrollee's estate has the right to request a State Fair Hearing from the DHCFP when they have exhausted the Vendor's appeal system without receiving a wholly favorable resolution decision. The request for a State Fair Hearing must be submitted in writing within ninety (90) calendar days from the date of the Vendor's notice of resolution. The Vendor will participate in the State Fair Hearing process, at the Vendor's expense, in each circumstance in which an enrollee for whom the Vendor has made an adverse determination requests a State Fair Hearing. The Vendor is bound by the decision of the Fair Hearing Officer. (Please refer to the Chapter 3100 of the MSM for timeframes for standard and expedited State Fair Hearings.)

The Vendor is required to inform the enrollee of their right to a State Fair Hearing, how to obtain such a hearing, and representation rules must be explained

to the enrollee and provided by the vendor pursuant to 42 CFR 431.200(b); 42 CFR 431.220(5); 42 CFR 438.414; and 42 CFR 438.10(g)(1).

4.11.6 Continuation of Benefits While the Vendor's Appeal Process and the State Fair Hearing are Pending

The Vendor must continue the enrollee's benefits while the Vendor's internal appeals process is pending and while the State Fair Hearing is pending if all of the following conditions exist:

- 4.11.6.1 The appeal is submitted to the Vendor on or before the later of the following: within ten (10) days of the Vendor mailing the Notice of Action; or, the intended effective date of the Vendor's proposed action;
- 4.11.6.2 The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- 4.11.6.3 The services were ordered by an authorized provider;
- 4.11.6.4 The original periods covered by the original authorization have not expired; and
- 4.11.6.5 The enrollee requests an extension of benefits.

If, at the enrollee's request, the Vendor continues the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

- 4.11.6.6 The enrollee withdraws the appeal;
- 4.11.6.7 Ten (10) days pass after the Vendor mails the notice of action, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day timeframe has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached;
- 4.11.6.8 A State Fair Hearing Officer issues a hearing decision adverse to the enrollee; and
- 4.11.6.9 The time period of service limits of a previously authorized service has been met.

If the final resolution of the appeal is adverse to the enrollee, the Vendor may recover the cost of the services furnished to the enrollee while the appeal was pending, to the extent that they were furnished solely because of the requirements of this section and in accordance with policy set forth in 42 CFR 431.230(b).

If the Vendor or Fair Hearing Officer reverses an action to deny, limit, or delay services that were not furnished while the appeal was pending, the Vendor must

authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires. If the Vendor or State Fair Hearing Officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the Vendor or the State must pay for those services in accordance with State policy and regulations.

4.11.7 Provider Grievances and Appeals

The Vendor must establish a process to resolve any provider grievances and appeals that are separate from, and not a party to, grievances and appeals submitted by providers on behalf of enrollees. Written grievance and appeals procedures must be included, for review and approval, at the time the Vendor policies and procedures are submitted to the DHCFP and at anytime thereafter when the Vendor's provider grievance and appeals policies and procedures have been revised or updated. The Vendor may not implement any policies and procedures concerning its provider grievance and appeal system without first obtaining the written approval of the DHCFP.

The following provisions reflect minimum requirements and are not intended to limit the scope of the Vendor's grievance and appeals process for providers.

4.11.7.1 General Requirements

The Vendor must accept written or oral grievances and appeals that are submitted directly by the provider as well as those that are submitted from other sources, including the DHCFP. An oral appeal must be followed by a written, signed appeal; however, the oral appeal must count as the initial date of appeal. The Vendor must keep a written or electronic record of each provider grievance and appeal to include a description of the issue, the date filed, the dates and nature of actions taken, and the final resolution. The Vendor must issue a final decision, in writing, no later than:

- A. Ninety (90) days after a grievance is filed; and
- B. Thirty (30) days after an appeal is filed.

4.11.7.2 State Fair Hearings

Pursuant to Nevada Revised Statute 422.306, when a provider has exhausted the Vendor's internal appeals process, the provider has the right to submit a written request to the DHCFP for a State Fair Hearing. It is the Vendor's responsibility to notify the provider of this right at the time the provider enters into a contract with the Vendor and when the outcome of an appeal is not wholly in favor of the provider pursuant to 42 CFR 431.200(b); 42 CFR 431.220(5); 42 CFR 438.414; and 42 CFR 438.10(g)(1). Disputes eligible for the State Fair Hearing process include:

- A. Denial or limited authorization of a requested service;
- B. Reduction, suspension or termination of a previously authorized service;
- C. Denial, in whole or in part, of payment for a service;
- D. Demand for recoupment; or
- E. Failure of the Vendor to meet specified timeframes (e.g., authorization, claims processing, appeal resolution).

The DHCFP will not accept requests for State Fair Hearings that address provider enrollment, termination or other contract disputes between the Vendor and its providers and/or subcontractors. Likewise, grievances as defined in Section 4.11.1 are not eligible for State Fair Hearings. The Vendor is bound by the decision of the Fair Hearing Officer and must comply with any decision resulting from the Fair Hearing process

4.12 MANAGEMENT INFORMATION SYSTEM

- 4.12.1 The Vendor shall operate an MIS capable of maintaining, providing, documenting, and retaining information sufficient to substantiate and report Vendor's compliance with the contract requirements.
- 4.12.2 The Vendor shall have an MIS capable of documenting administrative and clinical procedures while maintaining the privacy and confidentiality requirements pursuant to HIPAA. The Vendor shall provide DHCFP with aggregate performance and outcome data, as well as its policies for transmission of data from network providers. The Vendor shall submit its work plan or readiness survey assessing its ability to comply with Health Insurance Portability and Accountability Act (HIPAA) mandates in preparation for the standards and regulations.
- 4.12.3 The Vendor shall have internal procedures to ensure that data reported to DHCFP are valid and to test validity and consistency on a regular basis.
- 4.12.4 Eligibility Data
 - 4.12.4.1 The Vendor enrollment system shall be capable of linking records for the same enrolled recipient that are associated with different Medicaid and/or Nevada Check Up identification numbers; e.g., recipients who are re-enrolled and assigned new numbers.
 - 4.12.4.2 At the time of service, the Vendor or its subcontractors shall verify every enrolled recipient's eligibility through the current electronic verification system.

4.12.4.3 The Vendor shall update its eligibility database whenever enrolled recipients change names, phone numbers, and/or addresses, and shall notify DHCFP of such changes.

4.12.4.4 The Vendor shall notify DHCFP if the addresses of recipients are not accurate. DHCFP will notify the caseworker at the DWSS either to correct the address or terminate the case if the recipient is no longer a resident of the State.

4.12.5 Encounter and Claims Records

4.12.5.1 The encounter data reporting system should be designed to assure aggregated, unduplicated service counts provided across service categories, provider types, and treatment facilities. The Vendor shall use a standardized methodology capable of supporting CMS reporting categories for collecting service event data and costs associated with each category of service.

4.12.5.2 The Vendor shall collect and submit service specific encounter data in the appropriate CMS 1500, UB 04, and the/or appropriate ADA Dental Claim format or an alternative format if prior approved by DHCFP. The data shall be submitted in accordance with the requirements set forth. The data shall include all services reimbursed by Medicaid.

4.12.6 EPSDT Tracking System

The Vendor shall operate a system that tracks EPSDT activities for each enrolled Medicaid eligible child by name and Medicaid identification number. The system shall allow the Vendor to report annually on the CMS reporting form. This system shall be enhanced, if needed, to meet any other reporting requirements instituted by CMS or DHCFP.

4.13 OPERATIONAL REQUIREMENTS

4.13.1 Medical Director's Office

The Vendor must designate a Medical Director to be responsible for the oversight of development, implementation and review of the Vendor's Internal Quality Assurance Program, including implementation of and adherence to any Plan of Correction. The Medical Director need not serve full time or be a salaried employee of the Vendor, but the Vendor must be prepared to demonstrate it is capable of meeting all requirements using a part-time or contracted non-employee director. The Vendor may also use assistant or associate Medical Directors to help perform the functions of this office. The Medical Director and the Vendor's Utilization Management and Internal Quality Assurance Plan Committee are accountable to the Vendor's governing body. The Medical Director must be licensed to practice medicine in the State of Nevada and be board-certified or board-eligible in his or her field of specialty.

The responsibilities of the Medical Director include the following:

- 4.13.1.1 Serves as co-chairman of the Vendor's Utilization Management and Quality Assurance Plan committee;
- 4.13.1.2 Directs the development and implementation of the Vendor's Internal Quality Assurance Plan (IQAP) and utilization management activities and monitoring the quality of care that Vendor enrollees receive;
- 4.13.1.3 Oversees the development and revision of the Vendor's clinical care standards and practice guidelines and protocols;
- 4.13.1.4 Reviews all potential quality of care problems, and oversees the development, and implementation of, as well as the adherence to, Plans of Correction;
- 4.13.1.5 Oversees the Vendor's referral process for specialty and out-of-network services. All services prescribed by a PCP or requested by an enrollee which are denied by the Vendor must be reviewed by a physician, physician assistant, or advanced nurse practitioner with the reason for the denial being documented and logged;
- 4.13.1.6 Oversees the Vendor's provider recruitment and credentialing activities;
- 4.13.1.7 Serves as a liaison between the Vendor and its providers, communicating regularly with the Vendor's providers, including oversight of provider education, in-service training and orientation;
- 4.13.1.8 Serves as the Vendor's consultant to medical staff with regard to referrals, denials, grievances and problems;
- 4.13.1.9 Ensures enrollee Individual Family Service Plans (IFSPs) and Individualized Education Programs (IEPs) are followed; and
- 4.13.1.10 Ensures coordination of out-of-network services.

The Vendor must also identify a liaison, which can be the Medical Director, to work with DHCFP regarding utilization review and quality assurance issues.

4.13.2 Vendor Operating Structure and Staffing

The Vendor must assure DHCFP that the organization is adequately staffed with experienced, qualified personnel. The Vendor shall provide such assurances as follows:

- 4.13.2.1 Provide DHCFP with an updated organizational chart, every six (6) months or whenever a significant change in the organization occurs.

The organizational chart must depict each functional unit of the organization, numbers and types of staff for each function identified, lines of authority governing the interaction of staff, and relationships with major subcontractors. The organizational chart must also identify key personnel and senior-level management staff and clearly delineate lines of authority over all functions of the Contract. The names of key personnel must be shown on the organizational chart.

4.13.2.2 The Vendor must have in place the organizational, management and administrative systems capable of fulfilling all contract requirements. At a minimum, the Vendor must have qualified staff in the following areas:

- A. Executive management, including a Nevada Medicaid/CHIP
- B. Operations Manager;
- C. Accounting and budgeting;
- D. Medical Director's office;
- E. Medical Management, including quality assurance/utilization review;
- F. Recipient services;
- G. Provider services;
- H. Grievances, appeals, and fair hearings;
- I. Claims processing; and
- J. Management information systems (MIS).

4.13.2.3 With the exception of the Nevada Medicaid/CHIP Operations Manager, who may not be assigned to any other responsibility and must be housed in the Vendor's Nevada administrative offices, key personnel may be responsible for more than one area. The Vendor shall ensure that all staff has appropriate training, education, and experience to fulfill the requirements of their positions, including the Nevada Medicaid/CHIP Operations Manager. The Vendor shall inform DHCFP in writing within seven (7) calendar days of any changes in the following key positions:

- A. Administrator;
- B. Chief Financial Officer;
- C. Medical Director;
- D. Recipient Services Manager;

- E. Provider Services Manager;
- F. Grievance and Appeals Coordinator;
- G. Claims Administrator; and
- H. Nevada Operations Manager.

4.13.3 Subcontractors

The Vendor must comply with the requirements in 42 CFR 438.214 regarding contracts with health care professionals.

The Vendor shall comply with the following:

- 4.13.3.1 All subcontracts must fulfill the requirements of 42 CFR 438.6 that are appropriate to the service or activity delegated under the subcontract;
- 4.13.3.2 The Vendor is responsible for oversight of all network subcontracts and is accountable for any responsibilities it delegates to any subcontracted provider (AKA, subcontractor). The Vendor must evaluate the prospective subcontractor's ability to perform the activities to be delegated;
- 4.13.3.3 All subcontracts for administrative services provided pursuant to this RFP, including, but not limited to, utilization review, quality assurance, recipient services, and claims processing, shall be prior-approved by DHCFP. Prior to the award of any subcontract or execution of an agreement with a delegated entity, the Vendor must provide written information to the DHCFP disclosing the Vendor's ownership interest of five percent (5%) or more in the subcontractor or delegated entity, if applicable. All subcontracts shall be submitted to DHCFP for approval prior to their effective date. Failure to obtain advance written approval of a subcontract from DHCFP will result in the application of a penalty of one (1) month's current capitation payment for an adult female TANF recipient for each day that the subcontractor was in effect without the DHCFP's approval;
- 4.13.3.4 By the service start date and whenever a change occurs, submit to DHCFP for review and approval the names of any material subcontractors the Vendor has hired to perform any of the requirements of the Contract and the names of their principals;
- 4.13.3.5 Maintain all agreements and subcontracts relating to the contract in writing. Provide copies of all agreements and subcontracts to DHCFP within five (5) days of receiving such request. All such agreements and subcontracts shall contain relevant provisions of the contract appropriate to the subcontracted service or activity, specifically including but not limited to the provisions related to confidentiality, HIPAA requirements, insurance requirements and record retention. The Vendor has the responsibility to assure that

subcontractors are adequately insured to current insurance industry standards;

- 4.13.3.6 Remain fully responsible for meeting all of the requirements of the Contract regardless of any subcontracts for the performance of any Contract responsibility. No subcontract will operate to relieve the Vendor of its legal responsibility under the Contract;
- 4.13.3.7 Must have a written agreement with the subcontractor that specifies the activities and report responsibilities delegated to the subcontractor and provides for revoking delegation or imposing sanctions if the subcontractor's performance is inadequate or substandard;
- 4.13.3.8 Must monitor the subcontractor's performance on an on-going basis and subject the subcontractor to formal review according to periodic schedules established by the State, consistent with industry standards and/or State laws and regulations. If the Vendor identifies deficiencies or areas for improvement, the Vendor and the subcontractor must take corrective action;
- 4.13.3.9 Notify DHCFP, in writing, immediately upon notifying any material subcontractor of the Vendor's intention to terminate any such subcontract; and
- 4.13.3.10 Within thirty (30) calendar days of the date of request, the Vendor must provide full and complete information about the ownership of any subcontractor with whom the Vendor has had business transactions totaling more than twenty-five thousand dollars (\$25,000.00) during the twelve-month (12-month) period ending on the date of request as required by 42 CFR 455.105. Failure to timely comply with the request will result in withholding of payment by the State to the Vendor. Payment for services will cease on the day following the date the information is due and begin again on the day after the date on which the information is received.
- 4.13.3.11 DHCFP retains the right to review contracts between the Vendor and providers. DHCFP agrees to protect the terms of Vendor-Provider contracts, if the Vendor clearly label individual documents as a "trade secret" or "confidential" as per Section 25 of **Attachment D, Contract Form** of contract.

In the event any network provider or subcontractor is determined not to meet federal requirements and results in a federal disallowance of federal funds, the Vendor will be financially responsible to refund the amount of the federal disallowance and the corresponding state share to DHCFP. If such disallowance is treated as a default or breach, or otherwise subject the Vendor to sanctions under Section 13 of **Attachment D Contract Form**, any such liquidated damages are not exclusive and are in addition to any other remedies available under this contract. All existing subcontracts, requiring amendments to meet the

requirements of this contract, shall be amended. All future subcontracts must meet the requirements of this contract and any amendments thereto.

4.13.4 Policies and Procedures

Written policies and procedures must be developed by the Vendor to provide a clear understanding of the program and its operations to Vendor staff, DHCFP, other DHCFP Vendors and the providers (network and non-network).

Policies and procedures must be developed, in accordance with the DHCFP managed care contract, amendments, attachments, and MSMs, for each of the Vendor functions. The Vendor's policies and procedures must be kept in a clear and up-to-date manual. The Policy and Procedure Manual will be used as a training tool, and subsequently as a reference when performing contract related activities. The Policy and Procedure Manual must be reviewed at least annually for accuracy and updated as needed.

DHCFP must be provided with at least three (3) hard copies and an electronic copy of the Vendor Policy and Procedure Manual, including any exhibits, attachments or other documentation included as part of the Vendor Policy and Procedure Manual. DHCFP reserves the right to review and reject any policies or procedures believed to be in violation of federal or state law.

4.13.5 Implementation

4.13.5.1 Vendor Plan

The Vendor shall:

- A. Develop and submit to DHCFP for approval, no later than one (1) month after notification that DHCFP has selected it for Contract negotiations, a detailed work plan and timeline for performing the obligations set forth in the Contract for the first contract year.
- B. Provide DHCFP with updates to the initial work plan and timeline, identifying adjustments that have been made to either, and describing the Vendor's current state of readiness to perform all Contract obligations. Until the service start date, the Vendor shall provide biweekly written updates to the work plan and timeline, and thereafter as often as DHCFP determines necessary.
- C. Unless otherwise agreed to by DHCFP, submit to DHCFP within a minimum of ten (10) working days of the service start date, all deliverables to permit any DHCFP identified modifications.
- D. Beginning no later than thirty (30) calendar days prior to the service start date, the Vendor shall implement procedures

necessary to obtain executed subcontracts and Medicaid provider agreements with a sufficient number of providers to ensure satisfactory coverage of initial enrollments. The DHCFP reserves the right to require an access report at any time after the service start date when barriers to access or network inadequacies are identified or are questionable.

- E. Ensure that all workplace requirements DHCFP deems necessary, including but not limited to office space, post office boxes, telephones and equipment, are in place and operative as of the service start date.
- F. Ensure that there is no interruption of covered services to enrolled recipients and work cooperatively with DHCFP to meet these requirements.
- G. Ensure that a toll-free telephone number is in operation at the Vendor's office as of 8:00 a.m. (Pacific Time) on the first day of the open enrollment period and remains in operation for the duration of the contract, unless otherwise directed or agreed to by DHCFP. A single telephone number may be utilized as long as there is a menu option to channel different caller categories, e.g. recipients, providers, etc.
- H. Ensure that a toll-free hotline telephone number is in operation for recipient access at the Vendor's office as of 8:00 a.m. (Pacific Time) on the first day of the open enrollment period and remains in operation for the duration of the contract, unless otherwise directed or agreed to by DHCFP.
- I. Establish and implement enrollment procedures and maintain applicable enrolled recipient data.
- J. Establish its Provider Network and maintain existing Provider Agreements with such Providers, all in accordance with the provisions set forth in **Section 4.5**.

4.13.5.2 Pre-Implementation Readiness Review

DHCFP may conduct Operational and Financial Readiness Reviews on all awarded Vendors and will, subject to the availability of DHCFP resources, provide technical assistance as appropriate. The purpose of the readiness reviews is to assess the Vendor's readiness and ability to provide services to enrolled recipients. The areas that may be reviewed include, but are not limited to: financial operations; administration and organization; enrollee services; provider network; quality improvement; and, management information systems, including claims processing and reporting systems. The Vendor shall provide necessary documentation

specified by DHCFP and cooperate with DHCFP or its designees in conducting the review. DHCFP shall determine when the Vendor may begin marketing and providing program services. Provision of services as set forth in the contract is also subject to review and prior approval of CMS.

4.13.6 Presentation of Findings

The Vendor must obtain DHCFP's approval prior to publishing or making formal public presentations of statistical or analytical material that includes information about enrolled recipients. This material must protect specific individual recipient privacy and confidentiality to the extent required by both federal and state law and regulation.

4.13.7 Vendor Marketing Materials

The Vendor may develop marketing materials for distribution during any open enrollment period. The Vendor must request and obtain permission from DHCFP to distribute materials during an open enrollment period as well as in other locations or to implement an advertising campaign. Marketing materials must be submitted to the DHCFP for review and approval a minimum of sixty (60) days prior to the scheduled Medical Care Advisory Committee (MCAC) meeting for approval. The MCAC Schedule is subject to change. Please refer to the DHCFP website, <http://dhcfp.nv.gov> for revisions. Notwithstanding the requirement that the MCAC must review all Vendor marketing materials, the DHCFP has the sole authority to approve or disapprove materials (including updates to existing materials), distribution and advertising campaigns. The Vendor, or any provider, organization, or agency that contracts with the Vendor, is not permitted to market directly to potential enrollees. Vendors are also prohibited from providing materials that contain false or misleading information, and from initiating cold calls to potential enrollees.

The Vendor may not distribute, in any manner, marketing materials related to the managed care program without the prior written approval of DHCFP. This includes any updates to previously approved materials. Although federal regulations require the MCAC to review Vendor marketing materials pursuant to Section 4707 (a) of the Balanced Budget Act of 1997, the DHCFP has the sole authority to approve the Vendor's marketing materials. If DHCFP approval is granted, the Vendor must distribute the materials to its entire service area, as indicated in the contract and must comply with the requirements in Section 4.4.1 to ensure that, before enrolling, the potential enrollee receives the accurate oral and written information that he/she needs to make an informed decision regarding whether to enroll with the Vendor. The Vendor may not seek use of approved marketing materials to influence enrollment in conjunction with the sale or offering of any private insurance. The Vendor may not, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities.

The Vendor must provide the methods by which it intends to assure the DHCFP that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud enrollees or potential enrollees or the DHCFP. Statements

that will be considered inaccurate, false, or misleading include but are not limited to any assertion or statement that:

4.13.7.1 The recipient must enroll with the Vendor in order to obtain benefits or in order not to lose benefits; or

4.13.7.2 The Vendor is endorsed by CMS, the federal or state government, or similar entity.

4.13.8 Fraud and Abuse

Vendors must comply with all applicable program integrity requirements, including those specified in 42 CFR 455 and 42 CFR 438 Subpart H. Vendor or any subcontractor that receives or makes annual payments under the State Plan of at least \$5,000,000, as a condition of receiving such payments, shall:

4.13.8.1 Fraud and Abuse Program:

Vendors must have a program that includes administrative and management arrangements or procedures, including a mandatory compliance plan to guard against fraud and abuse. The Vendor's compliance plan must designate staff responsibility for administering the plan and include clear goals, milestones or objectives, measurements, key dates for achieving identified outcomes, and explain how the Vendor will determine the compliance plan's effectiveness.

The Vendor's compliance program which safeguards against fraud and abuse must, at a minimum, specifically address the following:

A. Employee education about false claims recovery:

In order to comply with Section 6032 of the Deficit Reduction Act of 2005 Vendors must, as a condition of receiving Medicaid payment, do the following:

1. Establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of Title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of Title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in

Federal health care programs (as defined in section 1128B(f) of the Social Security Act of 1932;

2. Educate employees and contractors on the Vendor's policies and procedures for detecting and preventing fraud, waste, and abuse;
3. Educate employees and contractors on the laws governing the rights of employees to be protected as whistleblowers; and
4. Include in any employee handbook the required written policies regarding false claims recovery.

4.13.8.2 Disseminate the required written policies to all contractors and agents, who must abide by those written policies. Include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

4.13.8.3 Include in any employee handbook for the entity, a specific discussion of the laws described in Section 4.13.8.1, the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

4.13.8.4 Monitoring for fraud and abuse

The Vendor's program which safeguards against fraud and abuse must specifically address the Vendor's prevention, detection, investigation, and reporting strategies in at least the following areas:

- A. Embezzlement and theft – Vendors must monitor activities on an ongoing basis to prevent and detect activities involving embezzlement and theft (e.g., by staff, providers, contractors, etc.) and respond promptly to such violations.
- B. Underutilization of services – Vendors must monitor for the potential under-utilization of services by their members in order to assure that all Medicaid-covered services are being provided, as required. If any under-utilized services are identified, the Vendor must immediately investigate and, if indicated, correct the problem(s) which resulted in such under-utilization of services.
- C. The Vendor's monitoring efforts must, at a minimum, include the following activities: a) an annual review of their prior authorization procedures to determine that they do not unreasonably limit a member's access to Medicaid-covered services; b) an annual review of the procedures providers are

to follow in appealing the Vendor's denial of a prior authorization request to determine that the process does not unreasonably limit a member's access to Medicaid-covered services; and c) ongoing monitoring of Vendor service denials and utilization in order to identify services which may be underutilize.

- D. Claims submission and billing – On an ongoing basis, Vendors must identify and correct claims submission and billing activities which are potentially fraudulent including, at a minimum, double-billing and improper coding, such as up coding and bundling.

4.13.8.5 Reporting fraud and abuse

When an Vendor investigation reveals that an incident of suspected fraud and/or abuse by a member or provider may have occurred, the Vendors is required to report the instances of suspected fraud and/or abuse to the Surveillance and Utilization Review Section (SURS) at the DHCFP no later than ten (10) business days after the completion of an investigation. At a minimum the Vendor's investigation must provide the following information:

- A. Provider's name and Medicaid provider number or Provider Reporting Number (PRN);
- B. Member's name and Medicaid number;
- C. Source of complaint;
- D. Type of provider;
- E. Nature of complaint;
- F. Approximate range of dollars involved, if applicable;
- G. Results of Vendor's investigation and actions taken;
- H. Name(s) of other agencies/entities (e.g., medical board, law enforcement) notified by Vendor; and
- I. Officials to whom the case has been referred.

4.13.8.6 Monitoring for Prohibited Affiliations

The Vendor's policies and procedures for ensuring that, pursuant to 42 CFR 438.610, the Vendor will not knowingly have a relationship with individuals debarred by Federal Agencies.

4.13.8.7 Data Certification

Pursuant to 42 CFR 438.604 and 42 CFR 438.606, Vendors are required to provide certification as to the accuracy, completeness, and truthfulness of data and documents submitted to DHCFP, which may affect Vendor payment.

A. Vendor Submissions

Vendors must submit the appropriate DHCFP certification as to the accuracy, completeness, and truthfulness of all data and documents submitted to DHCFP which may affect Vendor payment.

B. Source of Certification

The above Vendor data submissions must be certified by one of the following:

1. The Vendor's Chief Executive Officer;
2. The Vendor's Chief Financial Officer; or
3. An individual who has delegated authority to sign for, or who reports directly to, the Vendor's Chief Executive Officer or Chief Financial Officer.

4.13.8.8 Vendor shall

- A. Adhere to federal and state regulations, and the provider agreement, to establish written policy for dissemination to their staff;
- B. Ensure policies are adopted by any contractor or agent acting on their behalf; Educate staff on the regulations.
- C. Educate staff on the regulations;
- D. Disseminate this information to new staff within 30 days from the date of hire;
- E. Provide signed Certification Form, signed provider agreement, copies of written policy and employee handbook;
- F. Maintain documentation that staff has been educated, within the required timeframes;

- G. Maintain documentation on the education of staff, and make it readily available for review by state or federal officials; and
 - H. Provide requested re-certification within required timeframes to ensure ongoing compliance.
- 4.13.8.9 The vendor shall include terms in its subcontracts requiring its subcontractors to comply with Section 4.13.8.10.
- 4.13.8.10 Vendor agrees to furnish to DHCFP or to the Secretary on request, the information below:
- A. Information that must be submitted.
 - B. Vendor must submit, within 35 days of the date on a request by the Secretary or the DHCFP, full and complete information regarding:
 - 1. The ownership of any subcontractor with whom the Vendor has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
 - 2. Any significant business transactions between the Vendor and any wholly owned supplier, or between the Vendor and any subcontractor, during the 5-year period ending on the date of the request.
 - C. Denial of Federal Financial Participation (FFP)
 - 1. FFP is not available in expenditures for services furnished by Vendors who fail to comply with a request made by the Secretary or the DHCFP under Section 4.13.8.10 or under Section 42 CFR420.205.
 - 2. FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the DHCFP and ending on the day before the date on which the information was supplied.

4.14 REPORTING

Adequate data reporting capabilities are critical to the ability of CMS and DHCFP to effectively evaluate the DHCFP's managed care programs. The success of the managed care program is based on the belief that recipients will have better access to care, including preventive services, and will experience improved health status, outcomes, and satisfaction within the managed health care delivery system. To measure the program's

accomplishments in each of these areas, the Vendor must provide DHCFP and/or its contractors with uniform utilization, cost, quality assurance, and recipient satisfaction and grievance/appeal data on a regular basis. It must also cooperate with DHCFP in carrying out data validation steps.

The Vendor must meet all reporting requirements and timeframes as required in ***Attachment I, Forms and Reporting Guide***, and this RFP unless otherwise agreed to in writing by both parties. Failure to meet all reporting requirements and timeframes as required by this RFP and all attachments thereto may be considered to be in default or breach of the contract.

Unless it is clearly labeled as “confidential” or “trade secret,” pursuant to NRS 239.010, information or documents received from Vendor may be open to public disclosure and copying. The State will have the duty to disclose, unless a particular record is made confidential by law or a common law balancing of interests. This includes compensation arrangements, profit levels, consumer satisfaction levels, audits and findings, pertinent litigation, and outcomes/HEDIS data.

Vendor may clearly label individual documents as a "trade secret" or "confidential" provided that Vendor agrees to indemnify and defend the State for honoring such a designation. The failure to so label any document that is released by the State shall constitute a complete waiver of any and all claims for damages caused by any release of the records. If a public records request for a labeled document is received by the State, the State will notify the Vendor of the request and delay access to the material until seven (7) working days after notification to the Vendor. Within that time delay, it will be the duty of Vendor to act in protection of its labeled record. Failure to so act shall constitute a complete waiver.

4.14.1 Encounter Reporting

Vendors must submit encounter data in accordance with the requirements in this contract, to include any revisions or additions which contain information regarding encounter data, including DHCFP’s media and file format requirements, liquidated damages and submittal timeframes. The Vendor must assist DHCFP in its validation of encounter data. Compliance with reporting requirements is described in this RFP.

The Vendor is required to submit encounter data for the Nevada Check Up program in the same manner as the Medicaid program. Nevada Check Up recipients must be separately identified from Medicaid recipients, but the information can be combined for submission.

The Vendor may not submit encounter data for amounts expended for providers excluded by Medicare, Medicaid, or CHIP, except for emergency services pursuant to 42 CFR 431.55(h) and 42 CFR 438.808.

All encounters must be submitted for proper and accurate reporting and must be submitted in a within ninety (90) days of receipt of encounter.

4.14.2 Summary Utilization Reporting

The Vendor shall produce reports using HEDIS, as specified in Section 4.7.2. The Vendor must submit these reports to DHCFP in a timely manner pursuant to Section 3.6 in addition to the other reports required by this contract.

4.14.3 Dispute Resolution Reporting

The Vendor must provide DHCFP with quarterly reports documenting the number and types of provider disputes, recipient grievances, appeals and fair hearing requests received by the Vendor and its subcontractors. Reports must be submitted within forty-five (45) business days after close of the quarter to which they apply.

These reports are to include, but not be limited to, the total number of recipient grievances, the total number of notices provided to recipients, the total number of recipient and appeals requests, and provider disputes filed, including reporting of all subcontractor's recipient grievances, notices, appeals and provider disputes. The reports must identify the recipient grievance or appeal issue or provider dispute received; and verify the resolution timeframe for recipient grievances and appeals and provider disputes.

Comprehensive recipient grievance, notice, and appeal information, fair hearing requests, and provider dispute information, including, but not limited to, specific outcomes, shall be retained for each occurrence for review by the DHCFP.

4.14.4 Quality Assurance Reporting

Performance Improvement Projects (PIPs) will be performed by the Vendors pursuant to guidelines established jointly by the Vendors, DHCFP, and the External Quality Review Organization (EQRO), as well as those identified in this RFP. In addition, the Vendor must provide outcome-based clinical reports and Management Reports as may be requested by DHCFP. Should the Vendor fail to provide such reports in a timely manner, the DHCFP will require the Vendor to submit a POC to address contractual requirements regarding timely reporting submissions.

4.14.5 Recipient Satisfaction Reporting

Each Vendor must collect and submit to DHCFP a child and adult Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measuring recipient satisfaction prior to the third quarter of each contract year, unless the requirement is waived by DHCFP due to an EQRO performed survey. This may be done in conjunction with the Vendor's own satisfaction survey. DHCFP requires data stratified to indicate the satisfaction level of parents or guardians of Nevada Check Up participants. Vendors are required to report results from the CAHPS Child Medicaid Survey and the Supplemental Items for the Child Questionnaires on dental care, access to specialist care, and coordination of care from other health providers DHCFP may request a specific sample, and/or survey

tool. Survey results must be disclosed to the State, and, upon State's or enrollee's request, disclosed to enrollees.

4.14.6 Financial Reporting

The Vendor must meet the financial reporting requirements set forth in the Forms and Reporting Guide, including any revisions or additions to the document.

4.14.7 Fraud and Abuse Reporting

The Vendor must provide DHCFP with monthly reports documenting the number and types of disciplinary actions, sanctions, and suspected or confirmed cases of fraud and abuse received by the Vendor and its subcontractors. Reports are monthly but may be submitted on a quarterly basis. Reports must be submitted within Forty-five (45) business days after close of the quarter to which they apply. Major or significant instances of fraud or abuse must be reported to the DHCFP within 10 business days after the completion of the investigation. This report is added to ***Attachment I, Section 3 of the Forms and Reporting Guide.***

The Vendor and its subcontractors must provide immediate notification to DHCFP regarding all suspected recipient and provider fraud and abuse pursuant to 42 CFR 455.15.

Upon the Vendor's awareness of any disciplinary action, sanction taken against a network provider, or any suspected fraud or abuse, the Vendor shall immediately inform DHCFP.

The Vendor and/or its subcontractors are responsible for informing DHCFP of any suspected recipient fraud or abuse.

These reporting requirements shall be included in all Vendor subcontracts.

4.14.8 Network Adequacy

The Vendor and its subcontractors must provide DHCFP with quarterly reports documenting the access and availability of its network. Reports must be submitted within forty five (45) business days after close of the quarter to which they apply. This report is added to Section 6 of ***Attachment I, Forms and Reporting Guide.***

4.14.9 Hospital Adequacy

The Vendor must provide DHCFP with a quarterly report on the adequacy of contracted hospitals to the assigned recipient caseload. The report shall document the number and types of specialties covered by contracted hospitals. Reports must be submitted within forty five (45) business days after close of the quarter to which they apply. This report is added to Section 6 of ***Attachment I, Forms and Reporting Guide.***

4.14.10 Out-of-State Services

The Vendor and its subcontractors must provide DHCFP with quarterly reports documenting the number and types of services provided to Nevada Medicaid recipients outside of the state of Nevada or its catchments. The report shall document the reasons the services were provided out of state. Reports must be submitted within forty five (45) business days after close of the quarter to which they apply. This report is added to Section 6 ***Attachment I, Forms and Reporting Guide***.

4.14.11 Other Reporting

The Vendor shall be required to comply with additional reporting requirements upon the request of DHCFP. Additional reporting requirements may be imposed on the Vendor if DHCFP identifies any area of concern with regard to a particular aspect of the Vendor's performance under this contract. Such reporting would provide DHCFP with the information necessary to better assess the Vendor's performance.

4.15 INFORMATION SYSTEMS AND TECHNICAL REQUIREMENTS

4.15.1 Data Requirements

The Vendor will be required to provide compatible data in a DHCFP prescribed format for the following functions:

- 4.15.1.1 Enrollment;
- 4.15.1.2 Eligibility;
- 4.15.1.3 Provider Network Data;
- 4.15.1.4 PCP Assignment;
- 4.15.1.5 Claims Payment; and
- 4.15.1.6 Encounter Data.

4.15.2 Interfaces

The Vendor will work closely with the DHCFP staff and the DHCFP's fiscal agent to establish schedules for each interface. The DHCFP's Medicaid Management Information System (MMIS) will interface with the Vendor's system in the following areas, although not necessarily limited to these areas:

- 4.15.2.1 Health Plan - Encounter Data (encounter data reflects all services provided to clients for whom the health plan pays.)
- 4.15.2.2 Health Plan - Weekly Stop Loss File
- 4.15.2.3 Health Plan - Weekly Supplemental Omnibus Budget Reconciliation Act (SOBRA) File
- 4.15.2.4 Health Plan - Network Data File

- 4.15.2.5 Health Plan - Client Update File
- 4.15.2.6 MMIS - Encounter Data Error File (HIPAA X12 837 and NCPDP)
- 4.15.2.7 MMIS - Encounter Data informational Errors File
- 4.15.2.8 MMIS - SOBRA Error File
- 4.15.2.9 MMIS - Stop Loss Error File
- 4.15.2.10 MMIS - Stop Loss Rejection File
- 4.15.2.11 MMIS - Health Plan Error File
- 4.15.2.12 MMIS - Third Party Liability Update File
- 4.15.2.13 MMIS - Client Demographic Data
- 4.15.2.14 MMIS - Newborn Data
- 4.15.2.15 MMIS - Daily Health Plan Enrollee File
- 4.15.2.16 MMIS - Health Plan Enrollee File
- 4.15.2.17 MMIS - Network Data Exception File
- 4.15.2.18 MMIS - Network Primary Care Provider (PCP) Updates
- 4.15.2.19 MMIS - Client PCP changes
- 4.15.2.20 MMIS - Client Enrollment Updates
- 4.15.2.21 MMIS - Health Plan Notification
- 4.15.2.22 Health Division Immunization Registry
- 4.15.2.23 Vital Statistics Birth Records

All transactions must be in a HIPAA-compliant format. In addition to complying with the requirements of the National EDI Transaction Set Implementation Guide, Vendors will find EDI Companion Guides at the following website: http://www.healthlink.com/edi_companion_guide.asp. These companion guides contain HIPAA-compliant technical specifications.

The Vendor shall be responsible for any new and/or modified interfaces that may be required by CMS, including but not limited to, HIPAA regulations, and at the vendor's own expense.

Vendors may access additional information regarding the MMIS system and associated interfaces by requesting review of the redacted version of the First Health Services Contract and attachments.

4.15.3 Data Report Files

Upon request from DHCFP, the Vendor must provide encounter data report files in prescribed data fields to DHCFP's encounter data processing agent on a monthly basis. DHCFP will provide the required data fields and data transfer instructions upon at the time of the request, and will allow a time frame mutually agreeable to DHCFP and the Vendor from the delivery of this information for the Vendor to comply with this requirement.

Encounters must:

- 4.15.3.1 Successfully pass through the HIPAA compliance editors used by the State's fiscal agent. The DHCFP will not entertain any requests for other compliance checkers to be used for the convenience of proposers.
- 4.15.3.2 Successfully pass all claims edits in the MMIS. In developing the encounter data interface, the Vendor will be provided with a list of edits and descriptions of the edits. A written list of technical rules will not be made available; however, the Vendor will have adequate access to fiscal agent staff that will assist in the development of the interface.
- 4.15.3.3 A minimum of ninety-five percent (95%) of the data must successfully pass all encounter edits within the first six (6) months of submission, with ninety seven percent (97%) passing all thereafter. In the event the Vendor fails to demonstrate affirmative, good faith efforts to achieve these requirements, progressive sanctions, including monetary penalties, may be applied until data submissions meet the required standards. The Vendor will not be held liable for encounters that do not successfully pass all encounter edits if the Vendor is not solely responsible for the failure.

4.15.4 HIPAA Transaction Requirements

All electronic transactions must be accepted/transmitted in a HIPAA-compliant format. These include, but are not limited to:

- 4.15.4.1 Premium payments (X12F 820)
- 4.15.4.2 Enrollment and disenrollment into a health plan (X12N 834)
- 4.15.4.3 Eligibility inquiry and response (X12N 270-inquiry and 271-response and approval of authorization)

- 4.15.4.4 Referrals and prior authorizations (X12N 278-both request and approval of authorization)
- 4.15.4.5 Claims encounter data (X12N 837 and NCPDP)
- 4.15.4.6 Claims status Inquiry and response (X12N 276-inquiry and 277-response)
- 4.15.4.7 Payment and remittance advice (X12N 835-remittance advice)

In addition to complying with the requirements of the National EDI Transaction Set Implementation Guide, proposers will find EDI Companion Guides at the following website: http://www.healthlink.com/edi_companion_guide.asp. These companion guides contain HIPAA compliant technical specifications for each transaction.

4.15.5 NPI/API Transaction Requirements

The Vendor must provide DHCFP with an National Provider Identifier, (NPI), including any taxonomy code(s), with their proposal, unless it is determined that they are neither a covered nor an eligible entity, in which case Atypical Provider Identifier (API) will be assigned by the State's fiscal agent. The Vendors must electronically transmit and receive fully HIPAA compliant transactions. This applies to all HIPAA regulations currently effective and those in draft form. Throughout the duration of the initial contract and any extensions, the State will not bear any of the cost for any enhancements or modifications to the Vendors information system(s) or the systems of any of the Vendors subcontractors or Vendors, to make it compliant with any HIPAA regulations. This includes those HIPAA requirements currently in effect or future regulations as they become effective.

All encounters must be submitted electronically as fully HIPAA compliant 'shadow claims.' This includes but is not limited to, providing DHCFP, through its fiscal agent, the NPI on all providers.

Without exception, all providers contracting through the Vendor must be registered with DHCFP as a Medicaid provider. This includes any providers who are required to have NPI and those who are not required by CMS, but are eligible to receive an NPI. If an eligible provider submits their claims on paper, they must still use an NPI, and the shadow claim of that paper encounter must be submitted from the Vendor to the State's fiscal agent electronically and it must include the provider's NPI. This applies for any providers who have obtained a taxonomy code in addition to their NPI. The taxonomy code must be provided to the State's fiscal agent, and that taxonomy code must be used appropriately on all encounters submitted to the State's fiscal agent on behalf of DHCFP. The same NPI and taxonomy codes must be used for any third party insurance, including but not limited to private insurance and Medicare, for which the Vendor rebills. Without exception, all encounters from sub-capitated providers must be captured by the Vendor and transmitted to the State's fiscal agent following the guidelines outlined above. These must be fully detailed encounters following HIPAA

requirements and using HIPAA compliant transactions, including but not limited to the use of NPI and taxonomy.

For those providers who are defined as "Atypical" by federal regulation, a similar state devised numbering system will be used. The State calls this an Atypical Provider Identifier (API). This API is issued by the State's fiscal agent on behalf of the State. The Vendors must be capable of accepting and transmitting this API. All encounters from atypical providers must be captured by the Vendors and submitted to the State's fiscal agent using the API. The Vendors must ensure that every atypical provider contracted with them has obtained this API from the State's fiscal agent before any payment can be made by the Vendor to that provider.

4.16 DHCFP RESPONSIBILITIES

DHCFP will be responsible for the following:

4.16.1 External Quality Review

DHCFP will contract, to the extent required by federal law, with an External Quality Review Organization (EQRO) to conduct independent, external reviews of the quality of services provided by the Vendor. These reviews will be conducted at least annually.

4.16.2 Due Process

4.16.2.1 The DWSS is responsible for all appeals pertaining to eligibility for Medicaid. The DHCFP is responsible for all appeals pertaining to eligibility for the Children's Health Insurance Program (CHIP), the appeals process for disenrollment from managed care programs, and for providing a State Fair Hearing to all recipients who request such a hearing for all actions taken on medical assistance program benefits.

4.16.2.2 DHCFP will receive all recipient requests for state fair hearings, arrange for the fair hearings and provide the fair hearings officer. Upon receipt of the fair hearing request, DHCFP will forward a copy to the Vendor.

4.16.3 DHCFP On-Site Audits

The DHCFP may schedule on-site audits at the Vendor's primary place of business. The purpose of these audits is to confirm contract compliance and to more effectively manage DHCFP contract monitoring and oversight responsibilities of the Vendor. These audits will be scheduled in advance and will focus on contract sections prior identified by the DHCFP. The Vendor will be informed of the scheduling, focus of the audit and the expectations regarding Vendor's participation no less than thirty (30) days in advance of the on-site visit. The vendor will have all prior requested data and information available at the time the audit begins.

4.16.4 Actuarial Services

The DHCFP will contract to the extent required by federal and state law with an actuarial contractor to establish rates using a methodology that is certified as actuarially sound and in compliance with state and federal law. Rate reviews will be conducted at least annually.

4.16.5 Encounter Data Processing

The DHCFP will contract with an encounter data processing agent to accept, edit, process, and review encounter data submitted by contracted Vendors. It is DHCFP's sole responsibility to determine the format in which the data is to be submitted.

4.16.6 Data Interface:

The Vendor will work closely with the State staff and the State's fiscal agent to establish schedules for each data interface. The Vendor's data system will interface with the DHCFP's MMIS data system in the following areas, although not necessarily limited to these areas:

- 4.16.6.1 Health Plan - Encounter Data (encounter data reflects all services provided to clients for which the health plan pays);
- 4.16.6.2 Health Plan - Weekly Stop Loss File;
- 4.16.6.3 Health Plan - Weekly Supplemental Omnibus Budget Reconciliation Act (SOBRA) File;
- 4.16.6.4 Health Plan - Network Data File;
- 4.16.6.5 Health Plan - Client Update File;
- 4.16.6.6 MMIS - Encounter Data Error File (HIPAA X12 837 and NCPDP);
- 4.16.6.7 MMIS - Encounter Data informational Errors File;
- 4.16.6.8 MMIS - SOBRA Error File;
- 4.16.6.9 MMIS - Stop Loss Error File; MMIS - Stop Loss Rejection File;
- 4.16.6.10 MIS - Health Plan Error File; MMIS - Third Party Liability Update File;
- 4.16.6.11 MIS - Client Demographic Data; MMIS - Newborn Data;
- 4.16.6.12 MIS - Daily Health Plan Enrollee File;

- 4.16.6.13 MIS - Health Plan Enrollee File;
- 4.16.6.14 MIS - Network Data Exception File;
- 4.16.6.15 MIS - Network Primary Care Provider (PCP) Updates;
- 4.16.6.16 MIS - Client PCP changes;
- 4.16.6.17 MIS - Client Enrollment Updates; and
- 4.16.6.18 MIS - Health Plan Notification.

All transactions must be in a HIPAA-compliant format. In addition to complying with the requirements of the National EDI Transaction Set Implementation Guide, EDI Companion Guides can be found at the following website: http://www.healthlink.com/edi_companion_guide.asp. These companion guides contain HIPAA compliant technical specifications.

Further information regarding managed care interfaces, inputs, processing and outputs is available through a soft copy of the fiscal agent's REDATED proposal in the DHCFP Information Technology library.

4.16.7 Website Access

The DHCFP will maintain an Internet link on its official website at which the Vendor's website can be accessed.

4.17 COST CONTAINMENT AND/OR COST AVOIDANCE INITIATIVES

The Vendor shall develop policies and procedures that ensure cost containment and avoidance initiatives that positively impact health outcomes and result in cost savings to the State. Cost containment and avoidance initiatives must be provided to the DHCFP for review and approval prior to implementation.

The Vendor will also propose a shared savings model focusing on reductions in behavioral and mental health related lengths of stay, re-admissions, and ER utilization in general hospitals. Disincentives shall be created to reduce the over-utilization of referrals from general hospitals to State IMD hospitals.

The Vendor will also demonstrate its ability to operate an effective claims processing system that minimizes payment errors and, through the effective use of system edits and audits, prevents loss of public funds to fraud, abuse, and/or waste.

5. COMPANY BACKGROUND AND REFERENCES

5.1 VENDOR INFORMATION

5.1.1 Vendors must provide a company profile in the table format below.

Question	Response
Company name:	
Ownership (sole proprietor, partnership, etc.):	
State of incorporation:	
Date of incorporation:	
# of years in business:	
List of top officers:	
Location of company headquarters:	
Location(s) of the company offices:	
Location(s) of the office that will provide the services described in this RFP:	
Number of employees locally with the expertise to support the requirements identified in this RFP:	
Number of employees nationally with the expertise to support the requirements in this RFP:	
Location(s) from which employees will be assigned for this project:	

5.1.2 **Please be advised**, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state must register with the State of Nevada, Secretary of State’s Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.

5.1.3 The selected vendor, prior to doing business in the State of Nevada, must be appropriately licensed by the State of Nevada, Secretary of State’s Office pursuant to NRS76. Information regarding the Nevada Business License can be located at <http://sos.state.nv.us>.

Question	Response
Nevada Business License Number:	
Legal Entity Name:	

Is “Legal Entity Name” the same name as vendor is doing business as?

Yes		No	
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If “No”, provide explanation.

5.1.4 Vendors are cautioned that some services may contain licensing requirement(s). Vendors shall be proactive in verification of these requirements prior to proposal submittal. Proposals that do not contain the requisite licensure may be deemed non-responsive.

5.1.5 Has the vendor ever been engaged under contract by any State of Nevada agency?

Yes		No	
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If “Yes”, complete the following table for each State agency for whom the work was performed. Table can be duplicated for each contract being identified.

Question	Response
Name of State agency:	
State agency contact name:	
Dates when services were performed:	
Type of duties performed:	
Total dollar value of the contract:	

- 5.1.6 Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

Yes		No	
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If “Yes”, please explain when the employee is planning to render services, while on annual leave, compensatory time, or on their own time?

If you employ (a) any person who is a current employee of an agency of the State of Nevada, or (b) any person who has been an employee of an agency of the State of Nevada within the past two (2) years, and if such person will be performing or producing the services which you will be contracted to provide under this contract, you must disclose the identity of each such person in your response to this RFP, and specify the services that each person will be expected to perform.

- 5.1.7 Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor’s ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP must also be disclosed.

Does any of the above apply to your company?

Yes		No	
-----	--	----	--

If “Yes”, please provide the following information. Table can be duplicated for each issue being identified.

Question	Response
Date of alleged contract failure or breach:	
Parties involved:	
Description of the contract	

Question	Response	
failure, contract breach, or litigation, including the products or services involved:		
Amount in controversy:		
Resolution or current status of the dispute:		
If the matter has resulted in a court case:	Court	Case Number
Status of the litigation:		

5.1.8 Vendors must review the insurance requirements specified in *Attachment E, Insurance Schedule for RFP 1988*. Does your organization currently have or will your organization be able to provide the insurance requirements as specified in *Attachment E*.

Yes		No	
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Any exceptions to the insurance requirements *must* be identified on *Attachment B, Technical Proposal Certification of Compliance with Terms and Conditions of RFP*. In order for any exceptions to the insurance requirements to be considered they must be documented in detail in *Attachment B*. The State will not accept additional exceptions and/or assumptions if submitted after the proposal submission.

Upon contract award, the successful vendor *must* provide the Certificate of Insurance identifying the coverages as specified in *Attachment E, Insurance Schedule for RFP 1988*.

5.1.9 Company background/history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.

5.1.9.1 Corporate Background

- A. Provide a general description of the primary business of your organization and its client base. Include the length of time vendor has been providing services described in this RFP to the **public and/or private sector**.
- B. Provide a brief history and current company ownership including the ultimate parent organization and major shareholders/principals.
- C. Is your firm a resident of Nevada or a resident of another state? If so, please list the state of residence. Does your resident state apply a preference, which is not afforded to bidders or vendors who are residents in the state of Nevada? This information may be utilized in determining whether an

inverse preference applies pursuant to Nevada Revised Statutes.

- D. The location of disaster recovery back-up site.
- E. The name, address and telephone number of the Vendor's point of contact for a contract resulting from this RFP.
- F. The size of organization in assets, revenue and people.
- G. The organizational chart of your senior management by function including key personnel.
- H. The areas of specialization.
- I. The company's main product/service lines and annual revenues for each product/service line in 2004 and 2005.
- J. The corporate philosophy and mission statement.
- K. A description of any plans for future growth and development of your organization.
- L. Please identify any recent market expansion and/or business line addition by your organization. Describe the implementation approach and methodology you employed for the market expansion and/or additional business line identified. For example, what kind of planning and project management techniques, what resources and organization, etc.?

5.1.10 Length of time vendor has been providing services described in this RFP to the public and/or private sector. Please provide a brief description.

5.1.10.1 Experience

- A. Explain in detail the experience your organization has in providing the services requested in this RFP, including specific experience with the following:
 - 1. Managing a network of Medicaid Providers;
 - 2. Managed care programs for Medicaid recipients;
 - 3. Administering Medicaid utilization and case management programs;
 - 4. Medicaid claims processing and adjudication

5. Project management; and
 6. Qualifications of key personnel.
- B. Describe your experience with performance incentives based on targeted health outcome standards. In addition, identify specific performance measures that would provide the most meaningful measure of health care service delivery performance.
- C. Describe where you have invested in the improvement of services, treatment protocols, and development of best practices.
- D. Describe the experience your organization has had working with state government and/or experience in specifically related services.
- E. Provide the names, résumés, and any additional pertinent information regarding key personnel responsible for performance of any contract resulting from this RFP. In addition, specify the specific responsibilities of each of these individuals in relation to the requirements set forth herein. This information must be included in vendor's technical response to the RFP.
- F. Provide the names of any additional full-time staff and project supervisors with contract responsibilities in the following area:
1. Information Systems
 2. Utilization/Case Management
 3. Claims Payment
 4. Quality Improvement and Reporting (e.g., HEDIS, CMS 416)
 5. Health Education
 6. Data Coding
 7. Contract Negotiation Specialists/Network Recruiters
 8. Encounter Data
 9. Other staff as needed for project

- G. Provide copies of any current licenses or certifications, including your license to operate as an HMO in Nevada.
- H. List any bilingual staff, the area to which they are assigned and the languages spoken.
- I. List any associations or organizations to which the organization belongs.

5.1.11 Plan of Operation

The following are items that will facilitate the evaluation of the Vendor's ability to provide the different components required for the operation of a DHCFP contracted HMO. In each response, a comprehensive description detailing how the requirement will be implemented and maintained must be provided. In addition, descriptions of services which the Vendor believes may be beneficial in implementing and/or maintaining this program shall be included.

5.1.11.1 Medical Services

- A. Describe how you will determine the need to provide services beyond those required in ***Section 4.2.2, Vendor Covered Services***.
- B. Describe the guidelines and procedures you will use to determine the medical necessity of service authorization requests. Include your process for medical review of claims.
- C. Do you have a process for monitoring and evaluating these guidelines and procedures? If so, please explain.
- D. Describe your procedure for providing, monitoring and coordinating out-of-network services to enrolled recipients.
- E. Describe the roll and responsibilities of your case managers.
- F. Describe your plan to coordinate and communicate with DHCFP's DO care coordination staff on behalf of high risk pregnant women.
- G. Describe the policies and procedures you have in place to assess enrollees identified as Children with Special Health Care Needs (CSHCN). How will a treatment plan for CSHCN be developed?
- H. Describe the network you have in place to provide mental health and rehabilitative services to Severely Emotionally Disturbed (SED) children and Seriously Mentally Ill (SMI) adults.

- I. Provide your policies and procedures for emergency and post stabilization services.

5.1.11.2 Enrollment

Provide your policy and procedure for transitioning a recipient from or to FFS or another Vendor's plan.

5.1.11.3 Recipient Services

- A. Provide a sample copy of your current or proposed enrollee handbook and identification card you may issue to enrolled recipients.
- B. Describe your process for assignment or auto assignment of enrolled recipients to a PCP or PCS, including your process for changing a PCP or PCS.

5.1.11.4 Network

- A. What steps will you take to develop and maintain a network that ensures the ability to provide the managed care benefits required in this RFP to enrolled recipients in the required service areas of urban Clark and Washoe counties?
- B. Provide a sample of all base network provider contracts.
- C. What is your plan to involve essential community providers, such as the Federally Qualified Health Centers, in your network?
- D. How will you monitor and evaluate performance and correct deficiencies relative to **Section 4.5.5.1 through 4.5.5.9, Access and Availability?**
- E. How will you monitor contracted network provider's activities to ensure they comply with your requirements and those set forth in **Section 4.5.3, Network Management?** Describe your plan of action to ensure positive provider relations. Include in your response information regarding contracting; compensation; policy and procedures; disputes; and, communications.
- F. Do you anticipate offering any physician incentive plan(s)? If so, provide a summary of the plan(s) you anticipate offering. If you currently have a physician incentive plan, so indicate and provide a summary.
- G. Do you currently have or intend to have sole source subcontracts for any of the benefits services? If so, please

identify the services and the sole source subcontracts you currently have or intend to have.

- H. The National Provider Identifier (NPI) is the standard unique health identifier for health care providers. Health plans must use the NPIs of any health care provider or subpart to identify the health care provider or subpart in standard transactions by the 5/23/07 compliance date. How will your health plan prepare for use of NPIs to identify providers on standard transactions in order to be in compliance by the deadline of 5/23/07?

5.1.11.5 Quality Assurance

- A. Provide a description of your Internal Quality Assurance Plan and how you will comply with quality standards in **Section 4.8** of this RFP.
- B. In adherence with the State's Quality Assessment and Performance Improvement Strategy and Work Plan in RFP **Section 4.9**, how will you monitor and measure quality improvement of the care delivered to enrolled recipients?
- C. In relation to HEDIS Measure Diversity of Medicaid Membership, will the vendor please describe their systems capability to collect and report race, ethnicity, and language over and above what is given to them by the DHCFP?

5.1.11.6 Fiscal Requirements

- A. How will you ensure timely payment of claims in accordance with state and federal statutes and regulations?
- B. Describe your claims payment performance using the most recent available annual period as the time frame of reference. What is your payment aging profile for clean and non-clean claims? What is your percent of claims pending? What is your denial rate? What is your rate of claims resubmission?
 - 1. Provide a recent set of unedited month-end management reports from your claims system. At a minimum, samples should include aging report, clean claim payment rate, denial rate and pending.

If you are not currently a Nevada Medicaid HMO, redacted sample reports will be accepted.
- C. Describe your plan to identify and report suspected provider and recipient fraud.

- D. Describe and submit your policies and procedures for determining and collecting patient liability.

5.1.11.7 Grievances, Appeals and Fair Hearings

- A. Explain your process for ensuring the due process rights of enrolled recipients with regard to grievances, appeals and access to state fair hearings are followed.
- B. Do you have performance standards for the frequency of enrolled recipient grievances and appeals and provider disputes? If so, what are your standards and what have been your performance outcomes?

5.1.11.8 Operational Requirements

Provide an organizational chart depicting each functional unit of your organization associated with the proposed contract, numbers and types of staff for each function identified, lines of authority governing the interaction of staff, and relationships with major subcontractors. Identify key personnel and senior-level management staff and clearly delineate lines of authority over all functions of the proposed contract and lines of authority within the corporate structure.

5.1.11.9 Implementation

- A. If you currently do not have an established network, what time frame and approach will you use to build a network?
- B. Provide a Gantt Chart detailing the implementation process and proposed timeline for all program requirements.

5.1.11.10 Reporting

The Vendor has been requested throughout the RFP to provide various reports. All reporting requirements can be found in this RFP and in ***Attachment I Forms and Reporting Guide***. Review these reporting requirements and acknowledge

5.1.11.11 Information Systems and Technical Requirements

Based upon the information provided in this RFP and available in the Vendors' library, provide your acknowledgement of your ability to provide compatible interfaces with existing and proposed information systems.

5.1.11.12 HIPAA Compliance

- A. Describe your status, resources, and approach to HIPAA compliance.
- B. Describe your experience in processing HIPAA-compliant provider claims and in submitting HIPAA-compliant encounters to States.

5.1.12 Financial information and documentation to be included in Part III, Confidential Financial of vendor’s response in accordance with **Section 10.5, Part III – Confidential Financial**.

- 5.1.12.1 Dun and Bradstreet Number
- 5.1.12.2 Federal Tax Identification Number
- 5.1.12.3 The last two (2) years and current year interim:
 - A. Profit and Loss Statement
 - B. Balance Statement

5.2 SUBCONTRACTOR INFORMATION

5.2.1 Does this proposal include the use of subcontractors? Check the appropriate response in the table below.

Yes		No	
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If “Yes”, vendor must:

- 5.2.1.1 Identify specific subcontractors and the specific requirements of this RFP for which each proposed subcontractor will perform services.
- 5.2.1.2 If any tasks are to be completed by subcontractor(s), vendors must:
 - A. Describe the relevant contractual arrangements;
 - B. Describe how the work of any subcontractor(s) will be supervised, channels of communication will be maintained and compliance with contract terms assured; and
 - C. Describe your previous experience with subcontractor(s).
- 5.2.1.3 Vendors must describe the methodology, processes and tools utilized for:
 - A. Selecting and qualifying appropriate subcontractors for the project/contract;

- B. Ensuring subcontractor compliance with the overall performance objectives for the project;
- C. Ensuring that subcontractor deliverables meet the quality objectives of the project/contract; and
- D. Providing proof of payment to any subcontractor(s) used for this project/contract, if requested by the State. Proposal should include a plan by which, at the State’s request, the State will be notified of such payments.

- 5.2.1.4 Provide the same information for any proposed subcontractors as requested in *Section 5.1, Vendor Information*.
- 5.2.1.5 Business references as specified in *Section 5.3, Business References* must be provided for any proposed subcontractors.
- 5.2.1.6 Vendor shall not allow any subcontractor to commence work until all insurance required of the subcontractor is provided to the vendor.
- 5.2.1.7 Vendor must notify the using agency of the intended use of any subcontractors not identified within their original proposal and provide the information originally requested in the RFP in *Section 5.2, Subcontractor Information*. The vendor must receive agency approval prior to subcontractor commencing work.

5.3 BUSINESS REFERENCES

- 5.3.1 Vendors should provide a minimum of three (3) business references from similar projects performed for private, state and/or large local government clients within the last three (3) years.
- 5.3.2 Vendors must provide the following information for every business reference provided by the vendor and/or subcontractor:

The “Company Name” must be the name of the proposing vendor or the vendor’s proposed subcontractor.

Reference #:			
Company Name:			
<i>Identify role company will have for this RFP project (Check appropriate role below):</i>			
	VENDOR		SUBCONTRACTOR
Project Name:			
Primary Contact Information			
Name:			
Street Address:			
City, State, Zip			

Phone, including area code:	
Facsimile, including area code:	
Email address:	
Alternate Contact Information	
Name:	
Street Address:	
City, State, Zip	
Phone, including area code:	
Facsimile, including area code:	
Email address:	
Project Information	
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	
Original Project/Contract Start Date:	
Original Project/Contract End Date:	
Original Project/Contract Value:	
Final Project/Contract Date:	
Was project/contract completed in time originally allotted, and if not, why not?	
Was project/contract completed within or under the original budget/cost proposal, and if not, why not?	

- 5.3.3 Vendors must also submit **Attachment F, Reference Questionnaire** to the business references that are identified in **Section 5.3.2**.
- 5.3.4 The company identified as the business references must submit the Reference Questionnaire directly to the Purchasing Division.
- 5.3.5 It is the vendor's responsibility to ensure that completed forms are received by the Purchasing Division on or before the deadline as specified in **Section 9, RFP Timeline** for inclusion in the evaluation process. Reference Questionnaires not received, or not complete, may adversely affect the vendor's score in the evaluation process.
- 5.3.6 The State reserves the right to contact and verify any and all references listed regarding the quality and degree of satisfaction for such performance.

5.4 VENDOR STAFF RESUMES

A resume must be completed for each proposed individual on the State format provided in **Attachment G Proposed Staff Resume**, for key personnel to be responsible for performance of any contract resulting from this RFP.

6. COST

Note: All Cost Proposals shall be submitted to the State as a separate, sealed package and clearly marked: “*Part II - Cost Proposal in Response to RFP No. 1988*”, please refer to *Section 10 Proposal Submission Requirements, Format and Content* for further instruction.

6.1 ADMINISTRATIVE COSTS

There are two separate cost components in administrative costs:

6.1.1 Non-Medical Administrative Costs

Those costs (both direct and indirect) necessary to administer the Medicaid managed care program.

6.1.1.1 Direct Expenses: Those expenses that can be charged directly as a part of the overall administrative costs; and

6.1.1.2 Indirect Expenses: Those elements of costs necessary in the performance of administering the program that are of such a nature that the amount applicable to the program cannot be determined accurately or readily (i.e., rent, heat, electrical power, salaries and benefits of management personnel which are allocated to different programs, etc.).

6.1.2 Medical Administrative Costs

Costs, either direct or indirect, related to recipient medical care management (i.e., development of physician protocols for disease management, utilization review activities, case management costs, and medical information management systems).

DHCFP will review Medical Administrative Costs for reasonability and in the context of the benefit received by the client and DHCFP (i.e., is the cost of developing physician protocols for disease management less than or equal to the fiscal and health outcome benefit received).

6.2 NON-MEDICAL COSTS

The following are not considered administrative costs. They are, however, included in the overall percentage of non-medical costs, and will be reviewed for reasonableness by DHCFP:

6.2.1 Profit: The percentage of profit which the Contractor anticipates receiving after expenses (net income, revenues less expenses, divided by total revenues received from DHCFP); and

- 6.2.2 Risk and contingencies: That amount which the Contractor anticipates setting aside (as a percentage of the revenues received) for potential unknown risks and contingencies.

Vendors must provide detailed fixed prices for all costs associated with the responsibilities and related services. Clearly specify the nature of all expenses anticipated (refer to ***Attachment O, Cost Proposal***).

7. FINANCIAL

7.1 PAYMENT

Consideration shall be paid on a risk-based capitated rate basis. The methodology used to determine the rates has been certified to be actuarially sound.

DHCFP will review and revise the rates, using a certified actuarially sound capitation rate method.

The Vendor will receive from the DHCFP Rates Unit, a compact disc containing the updated Fee For Service rate at the end of each quarter. The Vendor will be notified by letter from DHCFP of changes to the capitated rates or to the benefit package as they occur. Rates will be actuarially determined prior to any subsequent contract renewal period.

7.1.1 Vendor Administrative Rate Bid

An actuarially sound rate will be developed by DHCFP's actuary and certified by CMS. In addition to a capitated rate to cover the costs of required medical services, an Administrative rate is paid to cover organizational costs. This cost is a percentage of the Managed Care Blended Capitated Rate.

This Section shall be included in ***Attachment O, Cost Proposal***. Each Vendor is required to submit a not-to-exceed Administrative rate bid for calendar year 2013 relative to the rates effective November 1, 2012. The DHCFP reserves the right to further negotiate this Administrative Rate prior to contract signing. Note that this process may result in the two participating health plans having different rates.

7.1.2 Managed Care Capitated Rates

Attachment J, Managed Care Capitated Rates of this RFP contains monthly medical and dental capitation rates and SOBRA delivery kick payments. These rates are effective from November 1, 2011, through December 31, 2012. DHCFP intends to publish rates for the 2013 calendar year near the end of November 2012.

DHCFP agrees to pay the Vendor the agreed upon capitated rate for all Medicaid and Nevada Check Up recipients who enroll with the Vendor with the exception that payments provided for under the contract will be denied for new enrollees when, and for as long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e). The Vendor will be capitated for all services in the Vendor

benefit package described in Section 3, Scope of Work. **Payments will be made in the following manner in accordance with Attachment J, Managed Care Capitated Rates.**

7.1.2.1 For each Medicaid and Nevada Check Up recipient enrolled with the Vendor, DHCFP shall make a prepaid, per-recipient, per-month payment as payment in full for any and all medically necessary covered services provided to the recipient, including dental and pharmacy services. All capitation payments will be paid monthly. In the event the Vendor does not receive a monthly capitation payment for an eligible recipient, the Vendor shall have one hundred eighty (180) days to submit a request for a retroactive capitation payment to the DHCFP. The DHCFP shall process requests for retroactive capitation payments within sixty (60) days of receipt. Payments will be sent to the Vendor by the fiscal agent, by either electronic funds transfer or overnight mail. The Vendor shall be responsible for direct payment of any and all overnight mail charges. The Vendor must meet the requirements of 42 CFR 438.606 regarding certification of data used for billing purposes.

7.1.2.2 The DHCFP reserves the right to recover pro-rated capitation whenever the Vendor's responsibility to pay medical claims ends in mid-month. Situations where a mid-month capitation recovery may occur includes, but is not limited to:

- A. Enrollee is placed in an out-of-home placement;
- B. Enrollee enters an Intermediate Care Facility/Mental Retardation;
- C. Enrollee enters a Home and Community Based Waiver program; and
- D. Death of the enrollee.

7.1.2.3 The DHCFP will assume partial risk for recipient inpatient hospital medical costs that exceed one hundred thousand dollars (\$100,000.00) during a State Fiscal Year (SFY). The DHCFP will reimburse the Vendor at seventy-five percent (75%) of the Vendor's paid amount for a recipient's inpatient hospital medical costs above one hundred thousand dollars (\$100,000.00) threshold, inclusive of a thirty-day (30-day) period prior to the commencement of the SFY. The Vendor will be responsible for the remaining twenty-five percent (25%) of the costs and shall continue to care for the recipient under the terms of the contract. Requests for reimbursement must be accompanied by all required documentation. Complete and correct Stop Loss requests must be submitted within two hundred seventy (270) days of the last date of service on a submission within a contract period. The DHCFP shall process

complete requests for reimbursement within sixty (60) days of receipt of a complete and correct request for reimbursement.

The managed care organization is responsible for providing DHCFP with a “Member High-Cost Report” that identifies individual recipients that have incurred inpatient medical costs of at least \$50,000.00 during the contract year. See the Forms and Reporting Guide for the “Member High-Cost Report” with instructions for completion and submittal. The Vendor is also responsible for applying intensive case management principles for all members identified on the Member High-Cost Report or who are at risk of reaching the \$100,000.00 Stop Loss threshold. The Forms and Reporting Guide contains the case management criteria that are expected to be implemented by the Vendor and instructions for completion of the review. If the Vendor utilizes an alternative Stop Loss Review form or documented process it may request DHCFP to consider it as an equivalent tracking reporting tool. These Case Management Stop Loss Review documents will be evaluated by DHCFP when determining the Vendor’s adherence to effective case management of high cost members. DHCFP and/or the EQRO may conduct on-site reviews as needed to validate the Vendor’s coordination and assess medical management of high-cost recipients. Insufficient documentation of adequate case management shall be subject to review/audit and may result in the reduction and/or disallowance of stop loss payments.

- 7.1.2.4 For Medicaid and CHIP enrollees who give birth during a given month, and who are enrolled with the Vendor on the date and time of the birth, and there is an accompanying provider claim for the delivery, DHCFP shall make a one-time (1-time) maternity payment to the Vendor performing the delivery to cover the cost of maternity care for Medicaid and CHIP enrollees. The maternity payment will be paid in the first month following the month of DHCFP’s receipt of an electronic submission of the record of the child's delivery. The electronic submission must be received within 180 days of the date of birth. The payment is a “maternity kick payment/ SOBRA” to offset most of the costs to the Vendor for costs associated specifically with the covered delivery of a child, including prenatal and postpartum maternity expenses. Ante partum care for the prospective mother and all infant care are covered by their respective capitation rates. The Vendor will also receive a full-month capitated payment for the birth mother and the child for the month of birth if the child is eligible from the date of birth.

It is not the intent of the DHCFP to pay a SOBRA payment in a situation where there is no accompanying provider claim for the delivery.

- 7.1.2.5 For Medicaid newborns, the Vendor shall receive a capitation payment for the month of birth and for all subsequent months the child remains program eligible and enrolled with the Vendor.
- 7.1.2.6 For those Medicaid enrolled recipients exempt from mandatory enrollment for the reasons specified below, payments will be made as follows:
- A. For Medicaid recipients enrolled with the Vendor on a voluntary basis due to the identification as “Children with Special Health Care Needs” (CSHCN), DHCFP will make a prepaid, per recipient, per month payment as payment in full for any and all covered services provided to the recipient. The prepaid, per-recipient, per-month payment includes the cost of the initial assessment from the Nevada Early Intervention Program. The payment will be determined in the same manner as it is for other recipients: by cohort in the rate schedule.
 - B. For Medicaid recipients enrolled with the Vendor on a voluntary basis due to identification of a serious emotional disturbance (SED) or a serious mental illness (SMI), DHCFP will make a prepaid, per recipient, per month payment as payment in full for any and all medically necessary covered services provided to the recipient. This payment includes the cost of the initial assessment for determining SED or SMI as well as on-going patient care all covered medically necessary mental health services. The payment will be determined in the same manner as it is for other recipients: by cohort in the rate schedule (*Attachment J- Managed Care Capitated Rate*).
 - C. Medicaid-eligible Native Americans can enroll with a Vendor on a voluntary basis and DHCFP will make a prepaid, per-recipient, per- month payment as payment in full for any and all covered services provided to the recipient. The payment will be determined in the same manner as it is for other recipients: by cohort in the rate schedule (Attachment J). Native American recipients can access services at Indian Health Service facilities (IHS) and Tribal Clinics while enrolled with the Vendor. The Vendor is not responsible for payment of any service received by an enrolled recipient at an IHS facility or Tribal Clinic. The IHS facility or Tribal Clinic will submit their claims directly to DHCFP’s Fiscal Agent and will be paid by DHCFP through the Medicaid FFS fee schedule. The Vendor must adhere to the requirements set forth in *RFP Sections 4.2.3.1* for voluntary Native American recipients assessed as CSHCN, SED or SMI.

- 7.1.2.7 The aforementioned payments are the total payments to the plan.
- 7.1.2.8 For each month the DHCFP pays a capitated payment to the Vendor on behalf of a recipient, the Vendor is responsible for providing all covered medically necessary services for that recipient.
- 7.1.2.9 The Vendor must not accept compensation for work performed under the contract from any other department of the State of Nevada, from either Medicaid or Nevada Check Up recipients, or from any other source including the federal government or other clients except for the collection of third-party liability (TPL) as described in *Section 4.10.7* of this RFP.

7.1.3 Disputed Capitation and Requests for Retroactive Capitation

Any notice of disputed capitation and requests for retroactive capitation payments must be made by the Vendor in writing in required format (refer to the Forms and Reporting Guide) within one hundred eighty (180) calendar days from the date of receipt of a particular month's capitation. The notice must include the recipients Medicaid ID number and month of enrollment; if the recipient is a child, the notice must additionally include the mother's Medicaid ID number and month of enrollment. Failure to notify DHCFP within one hundred eighty (180) days waives the right of the Vendor to seek an adjustment. No payment shall be made unless such changes or adjustments and the amount therefore have been authorized in writing by DHCFP. DHCFP shall make its determination within sixty (60) working days from receipt of a dispute. The Vendor may appeal any DHCFP decision concerning capitation disputes, adjustment decisions or retroactive capitation payments.

7.1.4 Capitation Recovery

The DHCFP reserves the right to adjust capitation payments or to bill the Vendor to recover improperly paid capitation.

7.2 BILLING

- 7.2.1 The State does not issue payment prior to receipt of goods or services.
- 7.2.2 The vendor must bill the State as outlined in the approved contract and/or payment schedule.
- 7.2.3 Vendors may propose an alternative payment option. Alternative payment options must be listed on *Attachment P, Cost Proposal Certification of Compliance with Terms and Conditions of the RFP*. Alternative payment options will be considered if deemed in the best interest of the State, project or service solicited herein.

8. WRITTEN QUESTIONS AND ANSWERS

In lieu of a pre-proposal conference, the Purchasing Division will accept questions and/or comments in writing, received by email regarding this RFP.

8.1 FIRST SET OF QUESTIONS AND ANSWERS

8.1.1 The RFP Question Submittal Form is located on the Services RFP/RFQ Opportunities webpage at <http://purchasing.state.nv.us/services/sdocs.htm>. Select this RFP number and the “Question” link.

8.1.2 The deadline for submitting questions is as specified in *Section 9, RFP Timeline*.

8.1.3 All questions and/or comments will be addressed in writing and responses emailed or faxed to prospective vendors on or about the date specified in *Section 9, RFP Timeline*.

8.2 SECOND SET OF QUESTIONS AND ANSWERS

8.2.1 Additional questions may be submitted via email by the date specified in *Section 9, RFP Timeline* and according to the process identified in *Section 10.1.1 through Section 10.1.3*.

9. RFP TIMELINE

The following represents the proposed timeline for this project. All times stated are Pacific Time (PT). These dates represent a tentative schedule of events. The State reserves the right to modify these dates at any time. . The State also reserves the right to forego vendor presentations and select vendor(s) based on the written proposals submitted.

Task	Date/Time
Deadline for submitting first set of questions	09/26/2012@ 2:00 PM
Answers posted to website	On or about 10/04/2012
Deadline for submitting second set of questions	10/15/2012@ 2:00 PM
Answers posted to website	On or about 10/24/2012
Deadline for submittal of Reference Questionnaires	<u>No later than 4:30 PM on 11/14/2012</u>
<u>Deadline for submission and opening of proposals</u>	<u>No later than 2:00 PM on 11/15/2012</u>
Evaluation period (approximate time frame)	11/16/2012-12/18/2012
Selection of vendor	On or about 12/19/2012
Anticipated BOE approval	03/12/2013
Contract start date (contingent upon BOE approval)	07/01/2013

10. PROPOSAL SUBMISSION REQUIREMENTS, FORMAT AND CONTENT

10.1 GENERAL SUBMISSION REQUIREMENTS

Vendors' proposals must be packaged and submitted in counterparts; therefore, vendors must pay close attention to the submission requirements. Proposals will have a technical response, which may be composed of two (2) parts in the event a vendor determines that a portion of their technical response qualifies as "confidential" as defined within *Section 3, Acronyms/Definitions*.

If complete responses cannot be provided without referencing confidential information, such confidential information must be provided in accordance with *Section 10.3, Part I B – Confidential Technical and Section 10.5, Part III Confidential Financial*. Specific references made to the tab, page, section and/or paragraph where the confidential information can be located must be identified on *Attachment A, Confidentiality and Certification of Indemnification* and comply with the requirements stated in *Section 10.6, Confidentiality of Proposals*.

The remaining section is the Cost Proposal. Vendors may submit their proposal broken out into the three (3) sections required, or four (4) sections if confidential technical information is included, in a single box or package for shipping purposes.

The required CDs must contain information as specified in *Section 10.6.4*.

Detailed instructions on proposal submission and packaging follows and vendors must submit their proposals as identified in the following sections. Proposals and CDs that do not comply with the following requirements may be deemed non-responsive and rejected at the State's discretion.

- 10.1.1 All information is to be completed as requested.
- 10.1.2 Each section within the technical proposal and cost proposal must be separated by clearly marked tabs with the appropriate section number and title as specified in the following sections.
- 10.1.3 Although it is a public opening, only the names of the vendors submitting proposals will be announced per NRS 333.335(6). Technical and cost details about proposals submitted will not be disclosed. Assistance for handicapped, blind or hearing-impaired persons who wish to attend the RFP opening is available. If special arrangements are necessary, please notify the Purchasing Division designee as soon as possible and at least two (2) days in advance of the opening.
- 10.1.4 If discrepancies are found between two (2) or more copies of the proposal, the master copy will provide the basis for resolving such discrepancies. If one (1) copy of the proposal is not clearly marked "MASTER," the State may reject the proposal. However, the State may at its sole option, select one (1) copy to be used as the master.

- 10.1.5 For ease of evaluation, the proposal must be presented in a format that corresponds to and references sections outlined within this RFP and must be presented in the same order. Written responses must be in ***bold/italics*** and placed immediately following the applicable RFP question, statement and/or section. Exceptions/assumptions to this may be considered during the evaluation process.
- 10.1.6 Proposals are to be prepared in such a way as to provide a straightforward, concise delineation of capabilities to satisfy the requirements of this RFP. Expensive bindings, colored displays, promotional materials, etc., are not necessary or desired. Emphasis should be concentrated on conformance to the RFP instructions, responsiveness to the RFP requirements, and on completeness and clarity of content.

Unnecessarily elaborate responses beyond what is sufficient to present a complete and effective response to this RFP are not desired and may be construed as an indication of the proposer's lack of environmental and cost consciousness. Unless specifically requested in this RFP, elaborate artwork, corporate brochures, lengthy narratives, expensive paper, specialized binding, and other extraneous presentation materials are neither necessary nor desired.

The State of Nevada, in its continuing efforts to reduce solid waste and to further recycling efforts requests that proposals, to the extent possible and practical:

- 10.1.6.1 Be submitted on recycled paper;
 - 10.1.6.2 Not include pages of unnecessary advertising;
 - 10.1.6.3 Be printed on both sides of each sheet of paper; and
 - 10.1.6.4 Be contained in re-usable binders rather than with spiral or glued bindings.
- 10.1.7 For purposes of addressing questions concerning this RFP, the sole contact will be the Purchasing Division as specified on Page 1 of this RFP. Upon issuance of this RFP, other employees and representatives of the agencies identified in the RFP will not answer questions or otherwise discuss the contents of this RFP with any prospective vendors or their representatives. Failure to observe this restriction may result in disqualification of any subsequent proposal per NAC 333.155(3). This restriction does not preclude discussions between affected parties for the purpose of conducting business unrelated to this procurement.
- 10.1.8 Any vendor who believes proposal requirements or specifications are unnecessarily restrictive or limit competition may submit a request for administrative review, in writing, to the Purchasing Division. To be considered, a request for review must be received no later than the deadline for submission of questions.

The Purchasing Division shall promptly respond in writing to each written review request, and where appropriate, issue all revisions, substitutions or clarifications through a written amendment to the RFP.

Administrative review of technical or contractual requirements shall include the reason for the request, supported by factual information, and any proposed changes to the requirements.

- 10.1.9 If a vendor changes any material RFP language, vendor’s response may be deemed non-responsive per NRS 333.311.

10.2 PART I A – TECHNICAL PROPOSAL

10.2.1 Submission Requirements

10.2.1.1 Technical proposal must include:

- A. One (1) original marked “MASTER”; and
- B. Nine (9) identical copies.

10.2.1.2 The technical proposal ***must not include*** confidential technical information (refer to ***Section 10.3, Part I B, Confidential Technical***) or project costs. Cost and/or pricing information contained in the technical proposal may cause the proposal to be rejected.

10.2.2 Format and Content

10.2.2.1 Tab I – Title Page

The title page must include the following:

Part I A – Technical Proposal	
RFP Title:	Medicaid Managed Care Organization Services
RFP:	1988
Vendor Name:	
Address:	
Proposal Opening Date:	November 15, 2012
Proposal Opening Time:	2:00 PM

10.2.2.2 Tab II – Table of Contents

An accurate and updated table of contents must be provided.

10.2.2.3 Tab III – Vendor Information Sheet

The vendor information sheet completed with an original signature by an individual authorized to bind the organization must be included in this tab.

10.2.2.4 Tab IV – State Documents

The State documents tab must include the following:

- A. The signature page from all amendments with an original signature by an individual authorized to bind the organization.
- B. Attachment A – Confidentiality and Certification of Indemnification with an original signature by an individual authorized to bind the organization.
- C. Attachment C – Vendor Certifications with an original signature by an individual authorized to bind the organization.
- D. Attachment Q – Certification regarding lobbying with an original signature by an individual authorized to bind the organization.
- E. Copies of any vendor licensing agreements and/or hardware and software maintenance agreements.
- F. Copies of applicable certifications and/or licenses.

10.2.2.5 Tab V - Attachment B

The Technical Proposal Certification of Compliance with Terms and Conditions of RFP with an original signature by an individual authorized to bind the organization must be included in this tab.

In order for any technical exceptions and/or assumptions to be considered they **MUST** be documented in detail in the tables in ***Attachment B - Technical Proposal Certification of Compliance***. Only technical exceptions and/or assumptions should be identified on this attachment. The State will not accept additional exceptions and/or assumptions if submitted after the proposal submission deadline. Vendors must be specific. Nonspecific exceptions or assumptions may not be considered. If the exception or assumption requires a change in the terms or wording of the contract, the scope of work, or any incorporated documents, vendors must provide the specific language that is being proposed in ***Attachment B Technical Proposal Certification of Compliance***. .

10.2.2.6 Tab VI – Section 3 – Scope of Work

Vendors must place their written response(s) in ***bold/italics*** immediately following the applicable RFP question, statement and/or section.

10.2.2.7 Tab VII– Section 4 – Company Background and References

Vendors must place their written response(s) in ***bold/italics*** immediately following the applicable RFP question, statement and/or section. This section must also include the requested information in ***Section 5.2, Subcontractor Information***, if applicable.

10.2.2.8 Tab VIII – Attachment G – Proposed Staff Resume(s)

Vendors must include all proposed staff resumes per ***Section 5.4, Vendor Staff Resumes*** in this section. This section should also include any subcontractor proposed staff resumes, if applicable.

10.2.2.9 Tab IX – Other Informational Material

Vendors must include any other applicable reference material in this section clearly cross referenced with the proposal.

10.3 PART I B – CONFIDENTIAL TECHNICAL

Vendors only need to submit Part I B if the proposal includes any confidential technical information (***Refer to Attachment A, Confidentiality and Certification of Indemnification***).

10.3.1 Submission Requirements, if confidential technical information is being submitted.

10.3.1.1 Confidential technical information must include:

- A. One (1) original marked “MASTER”; and
- B. Nine (9) identical copies.

10.3.2 Format and Content

10.3.2.1 Tab I – Title Page

The title page must include the following:

Part I B – Confidential Technical Proposal	
RFP Title:	Medicaid Managed Care Organization Services
RFP:	1988
Vendor Name:	
Address:	
Proposal Opening Date:	November 15, 2012
Proposal Opening Time:	2:00 PM

10.3.2.2 Tabs – Confidential Technical

Vendors must have tabs in the confidential technical information that cross reference back to the technical proposal, as applicable.

10.4 PART II – COST PROPOSAL

10.4.1 Submission Requirements

10.4.1.1 Cost proposal must include:

- A. One (1) original marked “MASTER”; and
- B. Nine (9) identical copies.

10.4.1.2 The cost proposal must not be marked “confidential”. Only information that is deemed proprietary per NRS 333.020(5)(a) may be marked as “confidential”.

10.4.2 Format and Content

10.4.2.1 Tab I – Title Page

The title page must include the following:

Part II – Cost Proposal	
RFP Title:	Medicaid Managed Care Organization Services
RFP:	1988
Vendor Name:	
Address:	
Proposal Opening Date:	November 15, 2012
Proposal Opening Time:	2:00 PM

10.4.2.2 Tab II – Cost Proposal

Vendor’s response for the cost proposal must be included in this tab.

10.4.2.3 Tab III – Attachment P

The Cost Proposal Certification of Compliance with Terms and Conditions of RFP with an original signature by an individual authorized to bind the organization must be included in this tab.

In order for any cost exceptions and/or assumptions to be considered they **MUST** be documented in detail in the tables in **Attachment P**. Only cost exceptions and/or assumptions should be identified on this attachment, do not restate the technical exceptions and/or assumptions on this form. The State will not accept additional exceptions and/or assumptions if submitted after the proposal

submission deadline. Vendors must be specific. Nonspecific exceptions or assumptions may not be considered. If the exception or assumption requires a change in the terms or wording of the contract, the scope of work, or any incorporated documents, vendors must provide the specific language that is being proposed in *Attachment P*.

10.5 PART III – CONFIDENTIAL FINANCIAL

10.5.1 Submission Requirements

10.5.1.1 Confidential financial information must include:

- A. One (1) original marked “MASTER”; and
- B. Two (2) identical copy.

10.5.2 Format and Content

10.5.2.1 Tab I – Title Page

The title page must include the following:

Part III – Confidential Financial Proposal	
RFP Title:	Medicaid Managed Care Organization Services
RFP:	1988
Vendor Name:	
Address:	
Proposal Opening Date:	November 15, 2012
Proposal Opening Time:	2:00 PM

10.5.2.2 Tab II – Financial Information and Documentation

- A. Dun and Bradstreet Number
- B. The completed *Attachment H, State of Nevada Registration Substitute IRS Form W-9*
- C. The last two (2) years and current year interim:
 - 1. Profit and Loss Statement
 - 2. Balance Statement

10.6 CONFIDENTIALITY OF PROPOSALS

10.6.1 As a potential contractor of a public entity, vendors are advised that full disclosure is required by law.

10.6.2 Vendors are required to submit written documentation in accordance with **Attachment A, Confidentiality and Certification of Indemnification** demonstrating the material within the proposal marked “confidential” conforms to NRS §333.333, which states “Only specific parts of the proposal may be labeled a “trade secret” as defined in NRS §600A.030(5)”. Not conforming to these requirements will cause your proposal to be deemed non-compliant and will not be accepted by the State of Nevada.

10.6.3 Vendors acknowledge that material not marked as “confidential” will become public record upon contract award.

10.6.4 The required CDs must contain the following:

10.6.4.1 One (1) **“Master”** CD with an exact duplicate of the technical and cost proposal contents only. The electronic files must follow the format and content section for the technical and cost proposal. The CD must be packaged in a case and clearly labeled as follows:

Master CD	
RFP No:	1988
Vendor Name:	
Contents:	Part IA – Technical Proposal Part IB – Confidential Technical Part II – Cost Proposal

10.6.4.2 One (1) **“Public Records CD”** with the technical and cost proposal contents to be used for public records requests. This CD **must not** contain any confidential or proprietary information. The electronic files must follow the format and content section for the redacted versions of the technical and cost proposal. The CD must be packaged in a case and clearly labeled as follows:

Public Records CD	
RFP No:	1988
Vendor Name:	
Contents:	Part IA – Technical Proposal for Public Records Request Part II – Cost Proposal for Public Records Request

10.6.5 It is the vendor’s responsibility to act in protection of the labeled information and agree to defend and indemnify the State of Nevada for honoring such designation. Failure to label any information that is released by the State shall constitute a complete waiver of any and all claims for damages caused by release of said information.

10.7 PROPOSAL PACKAGING

10.7.1 If the separately sealed technical and cost proposals as well as confidential technical information and financial documentation, marked as required, are

enclosed in another container for mailing purposes, the outermost container must fully describe the contents of the package and be clearly marked as follows:

- 10.7.2 Vendors are encouraged to utilize the copy/paste feature of word processing software to replicate these labels for ease and accuracy of proposal packaging.

Gail Burchett, Purchasing Officer II State of Nevada, Purchasing Division 515 E. Musser Street, Suite 300 Carson City, NV 89701	
RFP:	1988
PROPOSAL OPENING DATE:	November 15, 2012
PROPOSAL OPENING TIME:	2:00 PM
FOR:	Medicaid Managed Care Organization Services
VENDOR'S NAME:	

- 10.7.3 Proposals **must be received at the address referenced below no later than the date and time specified in Section 9, RFP Timeline.** Proposals that do not arrive by proposal opening time and date WILL NOT BE ACCEPTED. Vendors may submit their proposal any time prior to the above stated deadline.

- 10.7.4 The State will not be held responsible for proposal envelopes mishandled as a result of the envelope not being properly prepared. Facsimile, e-mail or telephone proposals will NOT be considered; however, at the State's discretion, the proposal may be submitted all or in part on electronic media, as requested within the RFP document. Proposal may be modified by facsimile, e-mail or written notice provided such notice is received prior to the opening of the proposals.

- 10.7.5 The technical proposal shall be submitted to the State in a sealed package and be clearly marked as follows:

Gail Burchett, Purchasing Officer II State of Nevada, Purchasing Division 515 E. Musser Street, Suite 300 Carson City, NV 89701	
RFP:	1988
PROPOSAL COMPONENT:	PART I A - TECHNICAL
PROPOSAL OPENING DATE:	November 15, 2012
PROPOSAL OPENING TIME:	2:00 PM
FOR:	Medicaid Managed Care Organization Services
VENDOR'S NAME:	

- 10.7.6 If applicable, confidential technical information shall be submitted to the State in a sealed package and be clearly marked as follows:

Gail Burchett, Purchasing Officer II State of Nevada, Purchasing Division
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515 E. Musser Street, Suite 300 Carson City, NV 89701	
RFP:	1988
PROPOSAL COMPONENT:	PART I B – CONFIDENTIAL TECHNICAL
PROPOSAL OPENING DATE:	November 15, 2012
PROPOSAL OPENING TIME:	2:00 PM
FOR:	Medicaid Managed Care Organization Services
VENDOR’S NAME:	

10.7.7 The cost proposal shall be submitted to the State in a sealed package and be clearly marked as follows:

Gail Burchett, Purchasing Officer II State of Nevada, Purchasing Division 515 E. Musser Street, Suite 300 Carson City, NV 89701	
RFP:	1988
PROPOSAL COMPONENT:	PART II - COST
PROPOSAL OPENING DATE:	November 15, 2012
PROPOSAL OPENING TIME:	2:00 PM
FOR:	Medicaid Managed Care Organization Services
VENDOR’S NAME:	

10.7.8 Confidential financial information shall be submitted to the State in a sealed package and be clearly marked as follows:

Gail Burchett, Purchasing Officer II State of Nevada, Purchasing Division 515 E. Musser Street, Suite 300 Carson City, NV 89701	
RFP:	1988
PROPOSAL COMPONENT:	PART III - CONFIDENTIAL FINANCIAL INFORMATION
PROPOSAL OPENING DATE:	November 15, 2012
PROPOSAL OPENING TIME:	2:00 PM
FOR:	Medicaid Managed Care Organization Services
VENDOR’S NAME:	

10.7.9 The CDs shall be submitted to the State in a sealed package and be clearly marked as follows:

Gail Burchett, Purchasing Officer II State of Nevada, Purchasing Division 515 E. Musser Street, Suite 300 Carson City, NV 89701	
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RFP:	1988
PROPOSAL COMPONENT:	CDs
PROPOSAL OPENING DATE:	November 15, 2012
PROPOSAL OPENING TIME:	2:00 PM
FOR:	Medicaid Managed Care Organization Services
VENDOR'S NAME:	

11. PROPOSAL EVALUATION AND AWARD PROCESS

The information in this section does not need to be returned with the vendor's proposal.

11.1 Proposals shall be consistently evaluated and scored in accordance with NRS 333.335(3) based upon the following criteria:

- Demonstrated competence
- Experience in performance of comparable engagements
- Conformance with the terms of this RFP
- Expertise and availability of key personnel
- Cost

Note: Financial stability will be scored on a pass/fail basis.

Proposals shall be kept confidential until a contract is awarded.

11.2 The evaluation committee may also contact the references provided in response to the Section identified as Company Background and References; contact any vendor to clarify any response; contact any current users of a vendor's services; solicit information from any available source concerning any aspect of a proposal; and seek and review any other information deemed pertinent to the evaluation process. The evaluation committee shall not be obligated to accept the lowest priced proposal, but shall make an award in the best interests of the State of Nevada per NRS 333.335(5).

11.3 Each vendor must include in its proposal a complete disclosure of any alleged significant prior or ongoing contract failures, contract breaches, any civil or criminal litigation or investigations pending which involves the vendor or in which the vendor has been judged guilty or liable. Failure to comply with the terms of this provision may disqualify any proposal. The State reserves the right to reject any proposal based upon the vendor's prior history with the State or with any other party, which documents, without limitation, unsatisfactory performance, adversarial or contentious demeanor, significant failure(s) to meet contract milestones or other contractual failures. See generally, NRS 333.335.

11.4 Clarification discussions may, at the State's sole option, be conducted with vendors who submit proposals determined to be acceptable and competitive per NAC 333.165. Vendors shall be accorded fair and equal treatment with respect to any opportunity for discussion and/or written revisions of proposals. Such revisions may be permitted after submissions and prior to award for the purpose of obtaining best and final offers. In conducting discussions, there shall be no disclosure of any information derived from proposals submitted by competing vendors. Any modifications made to the original proposal during the best and final negotiations will be included as part of the contract.

- 11.5** A Notification of Intent to Award shall be issued in accordance with NAC 333.170. Any award is contingent upon the successful negotiation of final contract terms and upon approval of the Board of Examiners, when required. Negotiations shall be confidential and not subject to disclosure to competing vendors unless and until an agreement is reached. If contract negotiations cannot be concluded successfully, the State upon written notice to all vendors may negotiate a contract with the next highest scoring vendor or withdraw the RFP.
- 11.6** Any contract resulting from this RFP shall not be effective unless and until approved by the Nevada State Board of Examiners (NRS 284.173).

12. TERMS AND CONDITIONS

12.1 PROCUREMENT AND PROPOSAL TERMS AND CONDITIONS

*The information in this section does not need to be returned with the vendor's proposal. However, if vendors have any exceptions and/or assumptions to any of the terms and conditions in this section, they MUST identify in detail their exceptions and/or assumptions on **Attachment B, Technical Proposal Certification of Compliance**. In order for any exceptions and/or assumptions to be considered they MUST be documented in Attachment B. The State will not accept additional exceptions and/or assumptions if submitted after the proposal submission deadline.*

- 12.1.1 This procurement is being conducted in accordance with NRS Chapter 333 and NAC Chapter 333.
- 12.1.2 The State reserves the right to alter, amend, or modify any provisions of this RFP, or to withdraw this RFP, at any time prior to the award of a contract pursuant hereto, if it is in the best interest of the State to do so.
- 12.1.3 The State reserves the right to waive informalities and minor irregularities in proposals received.
- 12.1.4 For ease of responding to the RFP, vendors are encouraged to download the RFP from the Purchasing Division's website at <http://purchasing.state.nv.us>.
- 12.1.5 The failure to separately package and clearly mark **Part I B and Part III** – which contains confidential information, trade secrets and/or proprietary information, shall constitute a complete waiver of any and all claims for damages caused by release of the information by the State.
- 12.1.6 Proposals must include any and all proposed terms and conditions, including, without limitation, written warranties, maintenance/service agreements, license agreements and lease purchase agreements. The omission of these documents renders a proposal non-responsive.
- 12.1.7 The State reserves the right to reject any or all proposals received prior to contract award (NRS 333.350).

- 12.1.8 The State shall not be obligated to accept the lowest priced proposal, but will make an award in the best interests of the State of Nevada after all factors have been evaluated (NRS 333.335).
- 12.1.9 Any irregularities or lack of clarity in the RFP should be brought to the Purchasing Division designee's attention as soon as possible so that corrective addenda may be furnished to prospective vendors.
- 12.1.10 Descriptions on how any and all services and/or equipment will be used to meet the requirements of this RFP shall be given, in detail, along with any additional informational documents that are appropriately marked.
- 12.1.11 Alterations, modifications or variations to a proposal may not be considered unless authorized by the RFP or by addendum or amendment.
- 12.1.12 Proposals which appear unrealistic in the terms of technical commitments, lack of technical competence, or are indicative of failure to comprehend the complexity and risk of this contract, may be rejected.
- 12.1.13 Proposals from employees of the State of Nevada will be considered in as much as they do not conflict with the State Administrative Manual, NRS Chapter 281 and NRS Chapter 284.
- 12.1.14 Proposals may be withdrawn by written or facsimile notice received prior to the proposal opening time. Withdrawals received after the proposal opening time will not be considered except as authorized by NRS 333.350(3).
- 12.1.15 Prices offered by vendors in their proposals are an irrevocable offer for the term of the contract and any contract extensions. The awarded vendor agrees to provide the purchased services at the costs, rates and fees as set forth in their proposal in response to this RFP. No other costs, rates or fees shall be payable to the awarded vendor for implementation of their proposal.
- 12.1.16 The State is not liable for any costs incurred by vendors prior to entering into a formal contract. Costs of developing the proposal or any other such expenses incurred by the vendor in responding to the RFP, are entirely the responsibility of the vendor, and shall not be reimbursed in any manner by the State.
- 12.1.17 Proposals submitted per proposal submission requirements become the property of the State, selection or rejection does not affect this right; proposals will be returned only at the State's option and at the vendor's request and expense. The masters of the technical proposal, confidential technical proposal, cost proposal and confidential financial information of each response shall be retained for official files.
- 12.1.18 The Nevada Attorney General will not render any type of legal opinion regarding this transaction.

- 12.1.19 Any unsuccessful vendor may file an appeal in strict compliance with NRS 333.370 and Chapter 333 of the Nevada Administrative Code.

12.2 CONTRACT TERMS AND CONDITIONS

The information in this section does not need to be returned with the vendor's proposal. However, if vendors have any exceptions and/or assumptions to any of the terms and conditions in this section, they **MUST** identify in detail their exceptions and/or assumptions on **Attachment B, Technical Proposal Certification of Compliance**. In order for any exceptions and/or assumptions to be considered they **MUST** be documented in Attachment B. The State will not accept additional exceptions and/or assumptions if submitted after the proposal submission deadline.

- 12.2.1 The awarded vendor will be the sole point of contract responsibility. The State will look solely to the awarded vendor for the performance of all contractual obligations which may result from an award based on this RFP, and the awarded vendor shall not be relieved for the non-performance of any or all subcontractors.
- 12.2.2 The awarded vendor must maintain, for the duration of its contract, insurance coverages as set forth in the Insurance Schedule of the contract form appended to this RFP. Work on the contract shall not begin until after the awarded vendor has submitted acceptable evidence of the required insurance coverages. Failure to maintain any required insurance coverage or acceptable alternative method of insurance will be deemed a breach of contract.
- 12.2.3 Notwithstanding any other requirement of this section, the State reserves the right to consider reasonable alternative methods of insuring the contract in lieu of the insurance policies required by the attached Insurance Schedule. It will be the awarded vendor's responsibility to recommend to the State alternative methods of insuring the contract. Any alternatives proposed by a vendor should be accompanied by a detailed explanation regarding the vendor's inability to obtain insurance coverage as described within this RFP. The State shall be the sole and final judge as to the adequacy of any substitute form of insurance coverage.
- 12.2.4 The State will not be liable for Federal, State, or Local excise taxes per NRS 372.325.
- 12.2.5 **Attachment B and Attachment P** of this RFP shall constitute an agreement to all terms and conditions specified in the RFP, except such terms and conditions that the vendor expressly excludes. Exceptions and assumptions will be taken into consideration as part of the evaluation process; however, vendors must be specific. Nonspecific exceptions or assumptions may not be considered.
- 12.2.6 The State reserves the right to negotiate final contract terms with any vendor selected per NAC 333.170. The contract between the parties will consist of the RFP together with any modifications thereto, and the awarded vendor's proposal, together with any modifications and clarifications thereto that are submitted at the request of the State during the evaluation and negotiation process. In the event of any conflict or contradiction between or among these documents, the documents shall control in the following order of precedence: the final executed contract,

any modifications and clarifications to the awarded vendor's proposal, the RFP, and the awarded vendor's proposal. Specific exceptions to this general rule may be noted in the final executed contract.

- 12.2.7 Local governments (as defined in NRS 332.015) are intended third party beneficiaries of any contract resulting from this RFP and any local government may join or use any contract resulting from this RFP subject to all terms and conditions thereof pursuant to NRS 332.195. The State is not liable for the obligations of any local government which joins or uses any contract resulting from this RFP.
- 12.2.8 Any person who requests or receives a Federal contract, grant, loan or cooperative agreement shall file with the using agency a certification that the person making the declaration has not made, and will not make, any payment prohibited by subsection (a) of 31 U.S.C. 1352.
- 12.2.9 Pursuant to NRS Chapter 613 in connection with the performance of work under this contract, the contractor agrees not to unlawfully discriminate against any employee or applicant for employment because of race, creed, color, national origin, sex, sexual orientation or age, including, without limitation, with regard to employment, upgrading, demotion or transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including, without limitation apprenticeship.

The contractor further agrees to insert this provision in all subcontracts, hereunder, except subcontracts for standard commercial supplies or raw materials.

12.3 PROJECT TERMS AND CONDITIONS

The information in this section does not need to be returned with the vendor's proposal. However, if vendors have any exceptions and/or assumptions to any of the terms and conditions in this section, they **MUST** identify in detail their exceptions and/or assumptions on **Attachment B, Technical Proposal Certification of Compliance**. In order for any exceptions and/or assumptions to be considered they **MUST** be documented in Attachment B. The State will not accept additional exceptions and/or assumptions if submitted after the proposal submission deadline.

12.3.1 Award of Related Contracts

- 12.3.1.1 The State may undertake or award supplemental contracts for work related to this project or any portion thereof. The contractor shall be bound to cooperate fully with such other contractors and the State in all cases.
- 12.3.1.2 All subcontractors shall be required to abide by this provision as a condition of the contract between the subcontractor and the prime contractor.

12.3.2 State Owned Property

The awarded vendor shall be responsible for the proper custody and care of any State owned property furnished by the State for use in connection with the performance of the contract and will reimburse the State for any loss or damage.

12.3.3 Inspection/Acceptance of Work

12.3.3.1 It is expressly understood and agreed all work done by the contractor shall be subject to inspection and acceptance by the State.

12.3.4 Travel

The State is not responsible for travel expenses of any kind for this proposal and subsequent contract.

12.3.5 Right to Publish

12.3.5.1 All requests for the publication or release of any information pertaining to this RFP and any subsequent contract must be in writing and sent to the Director of Health and Human Resources or designee.

12.3.5.2 No announcement concerning the award of a contract as a result of this RFP can be made without prior written approval of the Director of Health and Human Resources or designee.

12.3.5.3 As a result of the selection of the contractor to supply the requested services, the State is neither endorsing nor suggesting the contractor is the best or only solution.

12.3.5.4 The contractor shall not use, in its external advertising, marketing programs, or other promotional efforts, any data, pictures or other representation of any State facility, except with the specific advance written authorization of the Director of Health and Human Resources or designee.

12.3.5.5 Throughout the term of the contract, the contractor must secure the written approval of the State per **Section 12.3.5.2** prior to the release of any information pertaining to work or activities covered by the contract.

13. SUBMISSION CHECKLIST

This checklist is provided for vendor’s convenience only and identifies documents that must be submitted with each package in order to be considered responsive. Any proposals received without these requisite documents may be deemed non-responsive and not considered for contract award.

Part I A– Technical Proposal Submission Requirements		Completed
Required number of Technical Proposals per submission requirements		
Tab I	Title Page	
Tab II	Table of Contents	
Tab III	Vendor Information Sheet	
Tab IV	State Documents	
Tab V	Attachment B – Technical Proposal Certification of Compliance with Terms and Conditions of RFP	
Tab VI	Section 3 – Scope of Work	
Tab VII	Section 4 – Company Background and References	
Tab VIII	Attachment G – Proposed Staff Resume(s)	
Tab IX	Other Information Material	
Part I B – Confidential Technical Submission Requirements		
Required number of Confidential Technical Proposals per submission requirements		
Tab I	Title Page	
Tabs	Appropriate tabs and information that cross reference back to the technical proposal	
Part II – Cost Proposal Submission Requirements		
Required number of Cost Proposals per submission requirements		
Tab I	Title Page	
Tab II	Cost Proposal	
Tab III	Attachment P - Cost Proposal Certification of Compliance with Terms and Conditions of RFP	
Part III – Confidential Financial Submission Requirements		
Required number of Confidential Financial Proposals per submission requirements		
Tab I	Title Page	
Tab II	Financial Information and Documentation	
CDs Required		
One (1)	Master CD with the technical and cost proposal contents only	
One (1)	Public Records CD with the technical and cost proposal contents only	
Reference Questionnaire Reminders		
Send out Reference Forms for Vendor (with Part A completed)		
Send out Reference Forms for proposed Subcontractors (with Part A completed, if applicable)		

ATTACHMENT A – CONFIDENTIALITY AND CERTIFICATION OF INDEMNIFICATION

Submitted proposals, which are marked “confidential” in their entirety, or those in which a significant portion of the submitted proposal is marked “confidential” **will not** be accepted by the State of Nevada. Pursuant to NRS 333.333, only specific parts of the proposal may be labeled a “trade secret” as defined in NRS 600A.030(5). All proposals are confidential until the contract is awarded; at which time, both successful and unsuccessful vendors’ technical and cost proposals become public information.

In accordance with the Submittal Instructions of this RFP, vendors are requested to submit confidential information in separate binders marked “**Part I B Confidential Technical**” and “**Part III Confidential Financial**”.

The State will not be responsible for any information contained within the proposal. Should vendors not comply with the labeling and packing requirements, proposals will be released as submitted. In the event a governing board acts as the final authority, there may be public discussion regarding the submitted proposals that will be in an open meeting format, the proposals will remain confidential.

By signing below, I understand it is my responsibility as the vendor to act in protection of the labeled information and agree to defend and indemnify the State of Nevada for honoring such designation. I duly realize failure to so act will constitute a complete waiver and all submitted information will become public information; additionally, failure to label any information that is released by the State shall constitute a complete waiver of any and all claims for damages caused by the release of the information.

This proposal contains Confidential Information, Trade Secrets and/or Proprietary information as defined in *Section 2 “ACRONYMS/DEFINITIONS.”*

Please initial the appropriate response in the boxes below and provide the justification for confidential status.

Part I B – Confidential Technical Information			
YES		NO	
Justification for Confidential Status			

A Public Records CD has been included for the Technical and Cost Proposal			
YES		NO	

Part III – Confidential Financial Information			
YES		NO	
Justification for Confidential Status			

Company Name

Signature

Print Name

Date

This document must be submitted in Tab IV of vendor’s technical proposal

**ATTACHMENT B – TECHNICAL PROPOSAL CERTIFICATION OF COMPLIANCE
WITH TERMS AND CONDITIONS OF RFP**

I have read, understand and agree to comply with the terms and conditions specified in this Request for Proposal.

YES _____ I agree to comply with the terms and conditions specified in this RFP.

NO _____ I do not agree to comply with the terms and conditions specified in this RFP.

In order for any exceptions and/or assumptions to be considered they **MUST** be documented in detail in the tables below. The State will not accept additional exceptions and/or assumptions if submitted after the proposal submission deadline. Vendors must be specific. Nonspecific exceptions or assumptions may not be considered. If the exception or assumption requires a change in the terms or wording of the contract, the scope of work, or any incorporated documents, vendors must provide the specific language that is being proposed in the tables below.

Company Name

Signature

Print Name

Date

Vendors MUST use the following format. Attach additional sheets if necessary.

EXCEPTION SUMMARY FORM

RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION (Complete detail regarding exceptions must be identified)

ASSUMPTION SUMMARY FORM

RFP SECTION NUMBER	RFP PAGE NUMBER	ASSUMPTION (Complete detail regarding assumptions must be identified)

This document must be submitted in Tab V of vendor’s technical proposal

ATTACHMENT C – VENDOR CERTIFICATIONS

Vendor agrees and will comply with the following:

- (1) Any and all prices that may be charged under the terms of the contract do not and will not violate any existing federal, State or municipal laws or regulations concerning discrimination and/or price fixing. The vendor agrees to indemnify, exonerate and hold the State harmless from liability for any such violation now and throughout the term of the contract.
- (2) All proposed capabilities can be demonstrated by the vendor.
- (3) The price(s) and amount of this proposal have been arrived at independently and without consultation, communication, agreement or disclosure with or to any other contractor, vendor or potential vendor.
- (4) All proposal terms, including prices, will remain in effect for a minimum of 180 days after the proposal due date. In the case of the awarded vendor, all proposal terms, including prices, will remain in effect throughout the contract negotiation process.
- (5) No attempt has been made at any time to induce any firm or person to refrain from proposing or to submit a proposal higher than this proposal, or to submit any intentionally high or noncompetitive proposal. All proposals must be made in good faith and without collusion.
- (6) All conditions and provisions of this RFP are deemed to be accepted by the vendor and incorporated by reference in the proposal, except such conditions and provisions that the vendor expressly excludes in the proposal. Any exclusion must be in writing and included in the proposal at the time of submission.
- (7) Each vendor must disclose any existing or potential conflict of interest relative to the performance of the contractual services resulting from this RFP. Any such relationship that might be perceived or represented as a conflict should be disclosed. By submitting a proposal in response to this RFP, vendors affirm that they have not given, nor intend to give at any time hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, in connection with this procurement. Any attempt to intentionally or unintentionally conceal or obfuscate a conflict of interest will automatically result in the disqualification of a vendor's proposal. An award will not be made where a conflict of interest exists. The State will determine whether a conflict of interest exists and whether it may reflect negatively on the State's selection of a vendor. The State reserves the right to disqualify any vendor on the grounds of actual or apparent conflict of interest.
- (8) All employees assigned to the project are authorized to work in this country.
- (9) The company has a written equal opportunity policy that does not discriminate in employment practices with regard to race, color, national origin, physical condition, creed, religion, age, sex, marital status, sexual orientation, developmental disability or handicap.
- (10) The company has a written policy regarding compliance for maintaining a drug-free workplace.
- (11) Vendor understands and acknowledges that the representations within their proposal are material and important, and will be relied on by the State in evaluation of the proposal. Any vendor misrepresentations shall be treated as fraudulent concealment from the State of the true facts relating to the proposal.
- (12) Vendor must certify that any and all subcontractors comply with Sections 7, 8, 9, and 10, above.
- (13) The proposal must be signed by the individual(s) legally authorized to bind the vendor per NRS 333.337.

Vendor Company Name

Vendor Signature

Print Name

Date

This document must be submitted in Tab IV of vendor's technical proposal

ATTACHMENT D – CONTRACT FORM

The following State Contract Form is provided as a courtesy to vendors interested in responding to this RFP. Please review the terms and conditions in this form, as this is the standard contract used by the State for all services of independent contractors. It is not necessary for vendors to complete the Contract Form with their proposal.

Please pay particular attention to the insurance requirements, as specified in Paragraph 16 of the attached contract and Attachment E, Insurance Schedule.



Contract Form -
10-31-11.doc

To open the document, double click on the icon.

*If you are unable to access the above inserted file
once you have doubled clicked on the icon,
please contact Nevada State Purchasing at
srvpurch@admin.nv.gov for an emailed copy.*

ATTACHMENT E – INSURANCE SCHEDULE FOR RFP 1988



Attachment E
INSURANCE SCHEDULE

To open the document, double click on the icon.

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ATTACHMENT F – REFERENCE QUESTIONNAIRE

The State of Nevada, as a part of the RFP process, requires proposing vendors to submit business references as required within this document. The purpose of these references is to document the experience relevant to the scope of work and provide assistance in the evaluation process.

INSTRUCTIONS TO PROPOSING VENDOR	
1.	Proposing vendor or vendor’s proposed subcontractor MUST complete Part A of the Reference Questionnaire.
2.	Proposing vendor MUST send the following Reference Questionnaire to EACH business reference listed for completion of Part B, Part C and Part D.
3.	<p>Business reference is requested to submit the completed Reference Questionnaire via email or facsimile to:</p> <p style="margin-left: 40px;">State of Nevada, Purchasing Division Subject: RFP 1988 Attention: Geoff Landry Email: rfpdocs@admin.nv.gov Fax: 775-684-0188</p> <p>Please reference the RFP number in the subject line of the email or on the fax.</p>
4.	The completed Reference Questionnaire MUST be received no later than 4:30 PM PT <u>November 14, 2012</u>
5.	Business references are NOT to return the Reference Questionnaire to the Proposer (Vendor).
6.	In addition to the Reference Questionnaire, the State may contact any and all business references by phone for further clarification, if necessary.
7.	Questions regarding the Reference Questionnaire or process should be directed to the individual identified on the RFP cover page.
8.	Reference Questionnaires not received, or not complete, may adversely affect the vendor’s score in the evaluation process.



Reference
Questionnaire.doc

To open the document, double click on the icon.

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ATTACHMENT G – PROPOSED STAFF RESUME

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff using the State format.



Proposed Staff
Resume.doc

To open the document, double click on the icon.

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ATTACHMENT H – STATE OF NEVADA REGISTRATION SUBSTITUTE IRS FORM W-9

The completed form must be included in Tab II, Financial Information and Documentation of the *Part III – Confidential Financial* proposal submittal.



KTLVEN-05
Registration.doc

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ATTACHMENT I – FORMS AND REPORTING GUIDE



Attachment I
Reporting Guide Secti



Attachment I Section
2 - Financial Reports.

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ATTACHMENT J – MANAGED CARE CAPITATED RATES



Attachment J
Managed Care Capita

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ATTACHMENT K – CASELOAD MANAGEMENT



Copy of Medicaid
SFY 14-15 Caseload F



Attachment K
Caseload Master Apri

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ATTACHMENT L – PROVIDER TYPES



Attachment L
PROVIDER TYPES.doc

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ATTACHMENT M – CHECK UP PROJECTIONS



Attachment M
Checkup Projections.:

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ATTACHMENT N – DATA BOOK



Attachment Data
Book.doc

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ATTACHMENT O – COST PROPOSAL



Cost Proposal
Form.doc

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srvpurch@admin.nv.gov for an emailed copy.*

**ATTACHMENT P – COST PROPOSAL CERTIFICATION OF COMPLIANCE
TERMS AND CONDITIONS OF RFP**

I have read, understand and agree to comply with the terms and conditions specified in this Request for Proposal.

YES _____ I agree to comply with the terms and conditions specified in this RFP.

NO _____ I do not agree to comply with the terms and conditions specified in this RFP.

In order for any exceptions and/or assumptions to be considered they **MUST** be documented in detail in the tables below. The State will not accept additional exceptions and/or assumptions if submitted after the proposal submission deadline. Vendors must be specific. Nonspecific exceptions or assumptions may not be considered. If the exception or assumption requires a change in the terms or wording of the contract, the scope of work, or any incorporated documents, vendors must provide the specific language that is being proposed in the tables below.

Company Name

Signature

Print Name

Date

Vendors MUST use the following format. Attach additional sheets if necessary.

EXCEPTION SUMMARY FORM

RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION (Complete detail regarding exceptions must be provided)

ASSUMPTION SUMMARY FORM

RFP SECTION NUMBER	RFP PAGE NUMBER	ASSUMPTION (Complete detail regarding assumptions must be provided)

**This document must be submitted in Tab III of vendor’s cost proposal.
This form MUST NOT be included in the technical proposal.**

ATTACHMENT R – FEDERAL LAWS AND AUTHORITIES

The information in this section does not need to be returned with the vendor's proposal. Following is a list of Federal Laws and Authorities with which the awarded vendor will be required to comply.

ENVIRONMENTAL:

1. Archeological and Historic Preservation Act of 1974, PL 93-291
2. Clean Air Act, 42 U.S.C. 7506(c)
3. Endangered Species Act 16 U.S.C. 1531, ET seq.
4. Executive Order 11593, Protection and Enhancement of the Cultural Environment.
5. Executive Order 11988, Floodplain Management
6. Executive Order 11990, Protection of Wetlands
7. Farmland Protection Policy Act, 7 U.S.C. 4201 ET seq.
8. Fish and Wildlife Coordination Act, PL 85-624, as amended
9. National Historic Preservation Act of 1966, PL 89-665, as amended
10. Safe Drinking Water Act, Section 1424(e), PL 92-523, as amended

ECONOMIC:

1. Demonstration Cities and Metropolitan Development Act of 1966, PL 89-754, as amended
2. Section 306 of the Clean Air Act and Section 508 of the Clean Water Act, including Executive Order 11738, Administration of the Clean Air Act and the Federal Water Pollution Control Act with Respect to Federal Contracts, Grants or Loans

SOCIAL LEGISLATION

1. Age Discrimination Act, PL 94-135
2. Civil Rights Act of 1964, PL 88-352
3. Section 13 of PL 92-500; Prohibition against sex discrimination under the Federal Water Pollution Control Act
4. Executive Order 11246, Equal Employment Opportunity
5. Executive Orders 11625 and 12138, Women's and Minority Business Enterprise
6. Rehabilitation Act of 1973, PL 93, 112

MISCELLANEOUS AUTHORITY:

1. Uniform Relocation and Real Property Acquisition Policies Act of 1970, PL 91-646
2. Executive Order 12549 – Debarment and Suspension

ATTACHMENT S – DISENROLLMENT FORM



Disenrollment
Form.doc

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ATTACHMENT T – BUSINESS ASSOCIATE ADDENDUM



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