|  |  |  |
| --- | --- | --- |
| State of Nevada |  | Brian Sandoval |
| Department of Administration | *Governo*r |
|  |  |
| Purchasing Division | Patrick Cates |
|  | *Director* |
| 515 E. Musser Street, Suite 300  Carson City, NV 89701 |  |
| Jeffrey Haag |
| *Administrator* |

|  |
| --- |
| State of Nevada |
| Purchasing Division |
| **Request for Proposal: 3290** |
| For |
| **DENTAL BENEFITS ADMINISTRATOR** |

|  |
| --- |
| Release Date: November 7, 2016 |
| Deadline for Submission and Opening Date and Time: December 15, 2016 @ 2:00 PM |
| ***Refer to Section 8, RFP Timeline for the complete RFP schedule*** |

|  |
| --- |
| For additional information, please contact: |
| Ronda Miller, Purchasing Officer II |
| State of Nevada, Purchasing Division |
| 515 E. Musser Street, Suite 300 |
| Carson City, NV 89701 |
| Phone: 775-684-0182 |
| Email address: [rlmiller@admin.nv.gov](mailto:rlmiller@admin.nv.gov) |
| (TTY for Deaf and Hard of Hearing: 1-800-326-6868  Ask the relay agent to dial: 1-775-684-0182/V.) |

|  |
| --- |
| ***Refer to Section 9 for instructions on submitting proposals*** |

**VENDOR INFORMATION SHEET FOR RFP 3290**

**Vendor Must:**

1. 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;
2. Type or print responses; and
3. Include this Vendor Information Sheet in Tab III of the Technical Proposal.

|  |  |  |
| --- | --- | --- |
| V1 | Company Name |  |

|  |  |  |
| --- | --- | --- |
| V2 | Street Address |  |

|  |  |  |
| --- | --- | --- |
| V3 | City, State, ZIP |  |

|  |  |  |  |
| --- | --- | --- | --- |
| V4 | Telephone Number | | |
| Area Code: | Number: | Extension: |

|  |  |  |  |
| --- | --- | --- | --- |
| V5 | Facsimile Number | | |
| Area Code: | Number: | Extension: |

|  |  |  |  |
| --- | --- | --- | --- |
| V6 | Toll Free Number | | |
| Area Code: | Number: | Extension: |

|  |  |
| --- | --- |
| V7 | ***Contact Person for Questions / Contract Negotiations,***  ***including address if different than above*** |
| Name: |
| Title: |
| Address: |
| Email Address: |

|  |  |  |  |
| --- | --- | --- | --- |
| V8 | Telephone Number for Contact Person | | |
| Area Code: | Number: | Extension: |

|  |  |  |  |
| --- | --- | --- | --- |
| V9 | Facsimile Number for Contact Person | | |
| Area Code: | Number: | Extension: |

|  |  |  |
| --- | --- | --- |
| V10 | ***Name of Individual Authorized to Bind the Organization*** | |
| Name: | Title: |

|  |  |  |
| --- | --- | --- |
| V11 | Signature ***(Individual must be legally authorized to bind the vendor per NRS 333.337)*** | |
| Signature: | Date: |

**TABLE OF CONTENTS**

[1. PROJECT OVERVIEW 4](#_Toc465681817)

[2. ACRONYMS/DEFINITIONS 11](#_Toc465681818)

[3. SCOPE OF WORK 34](#_Toc465681819)

[4. COMPANY BACKGROUND AND REFERENCES 156](#_Toc465681820)

[5. COST 161](#_Toc465681821)

[6. FINANCIAL 161](#_Toc465681822)

[7. WRITTEN QUESTIONS AND ANSWERS 163](#_Toc465681823)

[8. RFP TIMELINE 164](#_Toc465681824)

[9. PROPOSAL SUBMISSION REQUIREMENTS, FORMAT AND CONTENT 164](#_Toc465681825)

[10. PROPOSAL EVALUATION AND AWARD PROCESS 173](#_Toc465681826)

[11. TERMS AND CONDITIONS 174](#_Toc465681827)

[12. SUBMISSION CHECKLIST 180](#_Toc465681828)

[ATTACHMENT A – CONFIDENTIALITY AND CERTIFICATION OF INDEMNIFICATION 181](#_Toc465681829)

[ATTACHMENT B – TECHNICAL PROPOSAL CERTIFICATION OF COMPLIANCE 182](#_Toc465681830)

[ATTACHMENT C – VENDOR CERTIFICATIONS 183](#_Toc465681831)

[ATTACHMENT D – CONTRACT FORM 184](#_Toc465681832)

[ATTACHMENT E – INSURANCE SCHEDULE FOR RFP 3290 185](#_Toc465681833)

[ATTACHMENT F – REFERENCE QUESTIONNAIRE 186](#_Toc465681834)

[ATTACHMENT G – PROPOSED STAFF RESUME 187](#_Toc465681835)

[ATTACHMENT H – COST SCHEDULE 188](#_Toc465681836)

[ATTACHMENT I – COST PROPOSAL CERTIFICATION OF COMPLIANCE 189](#_Toc465681837)

[ATTACHMENT J – CERTIFICATION REGARDING LOBBYING 190](#_Toc465681838)

[ATTACHMENT K – FEDERAL LAWS AND AUTHORITIES 191](#_Toc465681839)

[ATTACHMENT L – PROVIDER TYPES 192](#_Toc465681840)

[ATTACHMENT M– MANDATORY MCO ZIP CODES 193](#_Toc465681841)

[ATTACHMENT N– DISENROLLMENT FORM 194](#_Toc465681842)

[ATTACHMENT O– LIQUIDATED DAMAGES AND INTERMEDIATE SANCTIONS 195](#_Toc465681843)

[ATTACHMENT P– CY16 MC DENTAL RATES 196](#_Toc465681844)

[ATTACHMENT Q– PROGRAM INTEGRITY PROVIDER REFERRAL FORM 197](#_Toc465681845)

[ATTACHMENT R– PROGRAM INTEGRITY RECIPIENT REFERRAL FORM 198](#_Toc465681846)

[ATTACHMENT S– APPEALS AND GRIEVANCES 199](#_Toc465681847)

[ATTACHMENT T– FORMS AND REPORTING GUIDE 200](#_Toc465681848)

**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.nv.gov**](http://purchasing.state.nv.us)**).**

# PROJECT OVERVIEW

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 proposals from qualified firms for a Prepaid Ambulatory Health Plans (PAHP), Nevada Dental Benefits Administrator (DBA) 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.

DBAs must be licensed under the Nevada Insurance Code to provide dental services for this RFP. Contact the Nevada Division of Insurance for information on obtaining a Certificate of Authority which must be obtained upon contract award.

The DHCFP will contract with vendors to provide dental services to Medicaid and CHIP recipients in urban Clark and Washoe Counties ***(see Attachment M ~ Mandatory MCO Zip Codes)***. ***Coverage of dental benefits is subject to limitations set forth in the State Plan and Medicaid Services Manual Chapter 1000.***

## CONTRACT INFORMATION

### The contract will include the administration or delivery of the following services:

#### A Dental Services Program designed to administer and provide dental care under the supervision of a licensed provider. Dental services provided will maintain a high standard of quality and will be provided within the coverage and limitation guidelines outlined in the Title XIX and Title XX1 State Plan and amendments and the Medicaid Service Manual Chapter 1000;

#### Through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefits, individuals under the age of 21, receive comprehensive dental care such as periodic and routine dental services needed for restoration of teeth, prevention, and maintenance of dental health. The EPSDT program assures children receive the full range of necessary dental services;

#### Individuals age 21 and over who qualify for full Medicaid benefits receive emergency extractions, palliative care, and may also be eligible to receive prosthetic care (dentures/partials) under certain guidelines and limitations. Nevada Medicaid offers expanded dental services in addition to the adult dental services for Medicaid-eligible pregnant women;

#### Strengthening the Dental program in terms of enhanced network access to quality dental and specialty providers;

#### Monitoring and encouraging appropriate dental utilization; and

#### Effective program integrity activities.

### The vendor will demonstrate exceptional provider relations and network recruitment/retention abilities, including proven strategies to:

#### Establish and expand provider network access;

#### Maintain high provider satisfaction ratings;

#### Target recruitment of providers and specialists based upon program need;

#### Effectively credential for participation of quality service providers; and

#### Assist with the development of a quality improvement strategy.

### The vendor will be responsible for monitoring and encouraging appropriate dental utilization through dental disease prevention, outreach, and education activities.

#### The vendor must demonstrate effective utilization control and program integrity practices through activities including but not limited to: service authorization, prepayment claims review, etc.

#### The vendor will promote the dental program; conduct provider and enrollee outreach activities, including but not limited to enrollment outreach to newly Medicaid-eligible pregnant women; monitor network use including missed and cancelled appointments to provide outreach to enrollees and assist enrollees in finding a provider handle enrollee and provider services issues; interface with the Nevada Medicaid Management Information System (NVMMIS) and submit encounter data per established criteria outlined in this RFP.

#### Specific details about this procurement are in the enclosed Request for Proposal (RFP).

### The contract resulting from this RFP shall be effective from July 1, 2017, to June 30, 2021 with the possibility of two (2) one (1) year extensions if in the best interest of the State. The DHCFP intends to contract with vendors to provide services to Medicaid recipients determined categorically eligible under the Family Medical Categories (FMC):  Family Medical Coverage – Applications for medical assistance under the Modified Adjusted Gross Income (MAGI) medical eligibility group includes the following aid categories: AM, AM1, CH, CH1, CH5, TR, PM, NC CA; and the aged out of foster care coverage group AO.

The mandatory geographic service areas included in the contracts will be urban Clark and Washoe Counties.

### Expanded services, geographic areas and/or populations may be included in the dental benefits contract during the course of this contract and are to be considered as covered for this Request for Proposal (RFP). Should the DHCFP expand geographic areas, services or Medicaid populations, or carve services out, the DHCFP will, if necessary, adjust the capitation paid the DBA to an actuarial sound rate at the time of change.

### This is a risk based Prepaid Ambulatory Health Plan (PAHP) contract, rates will be established using a methodology that is certified as actuarially sound and in compliance with state and federal law ***(see Attachment P ~ CY16 MC Dental Rates)***.

### Actuarially sound capitation rates mean capitation rates that:

#### Have been developed in accordance with generally accepted actuarial principles and practices;

#### Are appropriate for the populations to be covered, and the services to be furnished under the contract; and

#### Have been certified, as meeting the requirements of this section, by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

## GOALS ~ MISSION STATEMENT

The mission of the DHCFP 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 dental health of Nevadans by:

#### Emphasizing preventive care, early intervention, appropriate utilization and quality care;

#### Enhancing continuity of care through integrated dental, medical, behavioral and social care;

#### Ensuring a dental home where each recipient can access high quality, comprehensive dental services within the recipient's service area;

#### Streamline and simplify the Medicaid and Nevada Check Up dental care program administration and encourage provider participation;

#### Provide and implement a process for continuous quality improvement.

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.

## DIVISION STRATEGIC PLAN AND OBJECTIVES

### Procure risk based capitated dental care delivery system to provide medical coverage to enrolled recipients to enable high quality health outcomes.

### The objectives of this procurement are to:

#### Improve recipient access to medically necessary covered services;

#### Provide recipients choices for managed dental care through a simplified process and meet standards for network adequacy for dental benefit plans;

#### Manage utilization of services to ensure healthy outcomes including prevention and early intervention through case management and effective outreach programs;

#### Reduce operational costs to include cost-containment and avoidance initiatives;

#### Incorporate managed care encounter data (shadow claims) into the existing Medicaid Management Information System (MMIS);

#### Streamline and simplify the Medicaid and Nevada Check Up health care program administration and encourage provider participation;

#### Enable continuity of care coordination between health care systems including but not limited to the State and/or Federal Health Insurance Exchange (HIX);

#### Provide and implement a process for continuous quality improvement; and

#### Provide integrated dental care to ensure optimal outcomes.

### 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.

## HOW MEDICAID AND NEVADA CHECK UP OPERATE IN NEVADA

### The DHCFP administers the Medicaid and Nevada Check Up Programs in accordance with the applicable Title XIX and Title XXI State Plans, all applicable United States Code, Code of Federal Regulations (CFR’s), Nevada Revised Statutes (NRS), Nevada Administrative Code (NAC), the Medicaid Services Manual (MSM) and the Medicaid Operations Manual (MOM). The DHCFP may adopt such regulations and policies as deemed necessary and may also amend the Title XIX or Title XXI State Plans.

### Nevada operates both a fee-for-service (FFS) system, managed care delivery system, and has procured a contract for Non-Emergency Transportation (NET).

### Enrollment in a DBA plan is mandatory.

### The vendor must permit recipients to choose a provider in the network or to obtain services from any other provider under any of the following circumstances:

#### The service or type of provider in terms of training, experience, and specialization is not available with the PAHP network.

#### The provider is not part of the network, but is the main source of a service to the beneficiary, provided that:

##### The provider is given the opportunity to become a participating provider under the same requirements for participation in the PAHP network as other network providers of that type.

##### If the provider chooses not to join the network, or does not meet the necessary qualification requirements to join, the recipient will be transitioned to a participating provider within thirty (30) calendar days (after being given the opportunity to select a provider who participates.

#### The only plan or provider available to the beneficiary does not, because of moral or religious objections, provide the service the recipient seeks.

#### The recipient’s primary dental provider or other provider determines that the recipient is in need of related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network.

#### The DHCFP determines that other circumstances warrant out of network treatment.

### The eligibility and enrollment functions for the Medicaid and Nevada Check Up programs are the responsibility of the DHCFP and the Division of Welfare and Supportive Services (DWSS).

### The DHCFP currently contracts with a fiscal agent for 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, NET services, and other clinical and administrative services.

### 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.

## CONTRACTING FOR RESULTS

The 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. The DHCFP expects potential vendors to prescribe specific solutions that will achieve the DHCFP’s objectives and the service levels described elsewhere in this RFP. The vendor will be held accountable for maintenance of program standards and is responsible to supply the DHCFP with report metrics as outlined in this RFP. 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.

## REPRESENTATIONS

### The DHCFP will consider all representations contained in a proposal as the vendor’s response to this RFP. The 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 the DHCFP. The DHCFP accepts these representations as inducements to enter into a mutually beneficial relationship with the vendor under the terms and conditions of this RFP.

### 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 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.

### If a proposal is silent regarding an RFP requirement, then the DHCFP assumes that the vendor will meet that requirement at no additional cost. However, the 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.

## MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

### The MMIS ensures the effectiveness of 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.

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

#### Nevada Check Up;

#### Hospital Health Care;

#### Surveillance/Utilization Review Subsystem (SURS);

#### Notices of Decision (NODs);

#### Hospice;

#### High Risk Pregnancy Data and Care Coordination;

#### Health Care Cost Containment;

#### Pharmacy; and

#### The Home and Community Based Waiver Services.

### The MMIS vendor provides the following administrative functions:

#### Provider Relations / Training;

#### Third Party Liability Recovery (TPL) for the FFS program only;

#### FFS Payment Authorization Requests;

#### FFS Medical Claims Review;

#### Eligibility determination information for Medicaid and Nevada Check Up; and

#### Data warehousing and encounter data collection which are processed via encounter engine outside the MMIS and then stored in the data warehouse.

# ACRONYMS/DEFINITIONS

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

| **Acronym** | **Description** |
| --- | --- |
| ***Abuse*** | Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to the Dental Program or in reimbursement for services that fail to meet professionally recognized standards for dental care. It also includes member practices that result in unnecessary costs to the Dental Program. |
| ***Access*** | 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. |
| ***Action*** | 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 recipient’s request to exercise his or her right, to obtain services outside the network. |
| ***AC4OH*** | Advisory Committee for Oral Health established under NRS 439.2791 who’s duties are defined under NRS 439.2793. |
| ***Administrative Costs*** | All costs to the contractor related to the administration of the activities required through the RFP. Costs of subcontractors engaged solely to perform a non-medical administrative function for the Contractor specifically to securing or fulfilling the Contractor’s obligation to the State under the terms of the RFP (including but not limited to, claims processing, postage, personnel, rent) is to be an “administrative cost.” |
| ***Administrative Cut-Off Date*** | A date each month selected by the DHCFP. Changes made to the Medicaid recipient eligibility system prior to this date are effective the next month. Changes made to the computer system after this date become effective the first day of the second month after the change was made. |
| ***Adverse Determination*** | 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. |
| ***AFDC*** | Aid to families with dependent children. Refer to definition for TANF. |
| ***AFDC-UP*** | Aid to families with dependent children – Unemployed Parent Program. Refer to definition for two parent TANF. |
| ***AFDC – RMO*** | Aid to families with dependent children related to Medicaid only. |
| ***Age/Sex Rates*** | A set of rates for a given group product in which there is a separate rate for each grouping of age and sex categories. |
| ***Aged Out*** | Children who have aged out of foster care. (AO). |
| ***ADSD*** | Aging and Disability Services Division. |
| ***American Dental Association (ADA)*** | The American Dental Association is the professional association of dentists that works to advance the dental profession on the national, state and local level. |
| ***Appeal*** | A request for review of an action as “action” is defined here in. |
| ***Appropriate*** | 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. |
| ***Assumption*** | An idea or belief that something will happen or occur without proof. An idea or belief taken for granted without proof of occurrence. |
| ***Authorized Representative*** | 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. |
| ***Awarded Vendor*** | The organization/individual that is awarded and has an approved contract with the State of Nevada for the services identified in this RFP. |
| ***BBA*** | 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. |
| ***BBS*** | 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. |
| ***Benefit*** | A schedule of dental services to be administered by the Contractor to members pursuant to the RFP. |
| ***BOE*** | State of Nevada Board of Examiners |
| ***Business Day*** | Any Monday thru Friday except for state observed holidays. |
| ***CAF*** | Credible allegation of Fraud (CAF) is an allegation from any source when it has an “indicia of reliability”. |
| ***CAHPS*** | Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. |
| ***Capitation Payment*** | A payment the State agency makes periodically to a contractor on behalf of each recipient enrolled under a contract for the provision of dental services under the Medicaid State Plan. The State agency makes the payment regardless of whether the particular recipient receives services during the period covered by the payment. |
| ***Cardholder*** | Means the person named on the face of a Medicaid or Nevada Check Up card. |
| ***Care-Coordinator*** | 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. |
| ***Case-Management*** | 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. |
| ***Case Manager*** | An organization or a provider responsible for supervising or coordinating the provision of initial and primary care to patients; for initiating and/or authorizing referrals for specialty care, and for monitoring the continuity of patient care services. |
| ***CDT® - Current Dental Terminology*** | A code set with descriptive terms developed and updated by the American Dental Association (ADA) for reporting dental services and procedures to dental benefit plans. DHCFP designated the CDT code set as the national terminology for reporting dental services, by dentists. |
| ***CFR*** | Code of Federal Regulations |
| ***CHIP*** | 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 205% of the federal poverty level. |
| ***CPT® - Current Procedural Terminology*** | The CPT in its current version is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. DHCFP designated the CPT code set as the national coding standard for physicians and other healthcare professional services and procedures under HIPPA. |
| ***CSHCN*** | 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. |
| ***Claim*** | 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. |
| ***Clean-Claim*** | 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. |
| ***Clinic Services*** | 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:   1. Are provided to outpatients; 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, 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. |
| ***Centers for Medicare and Medicaid Services (CMS)*** | Medicaid and CHIP programs are administered by the states with the Centers for Medicare and Medicaid Services, 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). |
| ***CMS 416 – Annual EPSDT Report*** | The annual EPSDT report (form CMS-416) provides basic information on participation in the Medicaid child health program. The information is used to assess the effectiveness of the state EPSDT programs in terms of the number of individuals under age 21 (by age group and basis of Medicaid eligibility) who are provided child health screening services, referred for corrective treatment, and receive dental services. These data must include services reimbursed directly by the state under fee for service, through managed care, prospective payments, or other payment arrangement or through any other health or dental plans that contract with the state. The state is required to collect encounter data (or other data as necessary) from managed care and prospective payment entities in sufficient detail to provide the information required by this report. |
| ***Coordination of Benefits (COB)*** | 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. |
| ***Cold Call Marketing*** | Any unsolicited personal contact by the vendor or contractor with the potential recipient for the purpose of marketing as defined in this section. |
| ***Competent*** | Properly or well qualified and capable. |
| ***Compliance Review*** | Any investigation, audit, focused data analysis, or other assessment of whether improper payments have been made. |
| ***Concierge Service*** | A service that personally assists recipients to find a service provider. |
| ***Confidential Information*** | 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). |
| ***Confidentiality*** | Confidentiality pertains to all safeguards required to protect all information which concerns Medicaid and CHIP 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. |
| ***Contract Approval Date*** | 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. |
| ***Contract Award Date*** | The date when vendors are notified that a contract has been successfully negotiated, executed and is awaiting approval of the Board of Examiners. |
| ***Contractor*** | 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. |
| ***Covered Services*** | Medically necessary dental services for Medicaid children under 21 years of age and under 19 for CHIP children and limited medically necessary for Medicaid eligible individuals age 21 and over as described in Medicaid Service Manual (MSM) Chapter 1000 Dental, with the exception of Orthodontia Services. |
| ***Cross Reference*** | A reference from one document/section to another document/section containing related material. |
| ***Customer*** | Department, Division or Agency of the State of Nevada. |
| ***Cultural competency*** | An awareness and appreciation of customs, values, and beliefs and the ability to incorporate them into the assessment, treatment and interaction with any individual. |
| ***Culture*** | 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. |
| ***DCFS*** | The Division of Child and Family Services. |
| ***Denied Service*** | Any medical service requested by a provider for a Medicaid recipient for whom the Contractor denies approval for payment. |
| ***Dental Benefits Administrator (DBA)*** | An entity that manages or directs a dental benefits program on behalf of the program’s sponsor. For the purposes of this RFP and resulting contract, the DBA is responsible for administering the DHCFP’s dental program benefits for Title XIX Medicaid members and Title XXI children to include coordination, management and reimbursement of such dental services. |
| ***Dentist*** | A licensed professional to practice as Dentist as defined by NRS 631. |
| ***Dental Hygienist*** | A licensed professional to practice as a Dental Hygienist as defined by NRS 631. |
| ***DHCFP*** | Nevada Division of Health Care Financing and Policy. |
| ***DHHS*** | Department of Health and Human Services may refer to federal or state. |
| ***Dental Provider Network*** | All dental providers that have a contract with the Dental Contractor, or any subcontractor, for the delivery of Medically Necessary Covered Dental Services to the Dental Contractor’s members under this contract. |
| ***Division/Agency*** | The Division/Agency requesting services as identified in this RFP. |
| ***DPBH*** | Division of Public and Behavioral Health |
| ***Eligibility*** | Term that references a person’s status to receive Medicaid or CHIP program benefits. |
| ***Emergency Dental Condition*** | A dental or oral condition that requires immediate services for relief of symptoms and stabilization of the condition; such conditions include severe pain; hemorrhage; acute infection; traumatic injury of the teeth and surrounding tissues; or unusual swelling of the face and gums. |
| ***Emergency Medical Condition*** | Medical condition (including labor and delivery) manifesting itself by the sudden onset of acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonable expect that the absence of immediate medical attention could reasonably be expected to result in either placing an individual's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, resulting in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or serious physical harm to another. |
| ***Emergency Medical Transportation*** | 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 Manual, Chapter 1900. |
| ***Emergency Services*** | 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. |
| ***Encounter*** | 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. |
| ***Encounter Data*** | Data documenting a contact of service delivered to an eligible recipient by a provider. |
| ***Enrollee*** | A Medicaid or Nevada Check Up recipient who is enrolled in a managed care program or Dental Benefits Administrator program. May also be referred to as member, recipient, or beneficiary. |
| ***EPSDT*** | 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). In Nevada, EPSDT is also referred to as Healthy Kids. |
| ***EQR*** | 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. |
| ***EQRO*** | 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. |
| ***Essential Community Providers*** | 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. |
| ***Evaluation***  ***Committee*** | 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. |
| ***EVS*** | Electronic Verification System - A means to verify an individual’s eligibility for services covered by the State of Nevada’s Medicaid program, via the Internet. |
| ***Exception*** | A formal objection taken to any statement/requirement identified within the RFP. |
| ***External Quality Review Protocols*** | A series of procedures or rules to monitor, measure, and document information on quality, timeliness, and access to the health care and services that a vendor or their contractors furnish to Medicaid and Nevada Check Up recipients. |
| ***FFP*** | Federal Financial Participation - Usually expressed as a percentage or fraction of certain expenditures for which the DHCFP is entitled to reimbursement by the federal government in accordance with applicable laws and regulations. |
| ***FFS*** | Fee-for-service Reimbursement - A health care delivery program whereby the DHCFP medical assistance program recipients are served by health care providers reimbursed on a per service or point of service basis. |
| ***First Dental Home*** | A group of benefits designed to establish a Dental Home, provide preventive care, identify oral health problems, provide treatment, and parental/guardian oral health anticipatory guidance to members 6 months through 35 months of age. |
| ***First Step Program*** | 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. |
| ***Fiscal Agent*** | 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:   1. Provide the auditing function for providers under cost reimbursement; 2. Perform a cursory pre-payment review on all claims; 3. Trace, identify and apply any and all prior resources, including third-party liability and subrogation; 4. Supply provider education and provider services; and, 5. Other administrative services. |
| ***FMC*** | Family Medical Coverage – Applications for Medicaid are treated as application for Family Medical Coverage. This includes parents, caretakers, and children in the MAGI medical groups of: AM, AM1, CH, CHI, CH5, TR, PM: Nevada Check Up (NC); and Childless Adults (CA). |
| ***Fraud*** | Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that  constitutes fraud under applicable federal or state law. (42 CFR 455.2). |
| ***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 the DHCFP. |
| ***Geographic Service Area*** | The geographic service area included in the contract will be urban Clark and Washoe County. Other geographic areas may become mandatory managed care during the course of this contract and are to be considered as covered for this RFP. Should the DHCFP expand geographic areas 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 a recipient, or a provider acting on behalf of the recipient with the recipient’s written consent, to any vendor 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. |
| ***Goods*** | The term “goods” as used in this RFP has the meaning ascribed to it in NRS §104.2105(1) and includes, without limitation, “supplies”, “materials”, “equipment”, and “commodities”, as those terms are used in NRS Chapter 333. |
| ***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 basis. |
| ***Health Care Services*** | Any services included in the furnishing to any natural person of medical 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. |
| ***Healthy Kids*** | The Division refers to the EPSDT program as Healthy Kids. |
| ***Hearing*** | 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 MSM 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. |
| ***HEDIS*** | 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. |
| ***HEDIS Compliance Audit*** | 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. |
| ***HIX*** | Health Insurance Exchange. |
| ***Hospital*** | 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 Individuals with Intellectual Disabilities (ICF/IID) regardless of name or licensure. |
| ***Improper Payment*** | A payment made for any Medicaid service which was not authorized, performed, documented, billed, and paid in accordance with Nevada Medicaid policy and all applicable federal and state laws. The term encompasses fraud, waste, and abuse, but also includes errors on the part of the provider or the payer. |
| ***Indian Health Programs*** | 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 IHS 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). |
| ***Inpatient Hospital Services*** | "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. |
| ***IQAP*** | Internal Quality Assurance Programs (IQAPs) |
| ***I&R Unit*** | Investigation and Recovery Unit at DWSS |
| ***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. |
| ***Main Dental Home Provider, Main Dentist, or Dental Home*** | A provider who has agreed with the Dental Contractor to provide a Dental Home to members and who is responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care. Provider types that can serve as Main Dental Home Providers are FQHCs and individuals who are general dentists or pediatric dentists. |
| ***Managed Care Organization (MCO)*** | Managed Care is a system of health care delivery that influences utilization, cost of services and measures performance. An MCO is an entity that must provide its Medicaid or NCU recipients inpatient hospital, outpatient hospital, laboratory, x-ray, family planning, physician, home health services, emergency services, and additional contracted Medicaid State Plan benefits. The MCO provides these services for a premium or capitation fee, regardless of whether the individual recipient receives services. |
| ***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 vendor, including its employees, affiliated providers, agents or contractors, to a Medicaid or Nevada Check Up recipient who is not enrolled with the vendor that can reasonably be interpreted as intended to influence the recipient to enroll with the vendor or either not to enroll in or to disenroll from another vendor’s plan. |
| ***Marketing Materials*** | Means materials that are produced in any medium, by or on behalf of the vendor that can reasonably be interpreted as intended to market to potential recipients. |
| ***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 Medicaid identification is an eleven-digit number formats: Providers use the Medicaid identification 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. |
| ***Medicaid State Plan (aka “The Plan”)*** | The Medicaid 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 Medicaid 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.  The Medicaid 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, Title XXI). 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 Medicaid State Plans (including state plan amendments (SPA) and administrative practice under the plans) originally meet, or continue to meet, the requirements for approval based on relevant federal statutes and regulations. |
| ***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) 1915(c) waivers, 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 Necessity*** | As referenced in Medicaid Service Manual Chapter 100 section 103.1, Medical Necessity is defined as: A health care service or product that is provided for under the Medicaid State Plan and is necessary and consistent with generally accepted professional standards to: diagnose, treat or prevent illness or disease; regain functional capacity; or reduce or ameliorate effects of an illness, injury or disability.  The determination of medical necessity is made on the basis of the individual case and takes into account:  a. Type, frequency, extent, body site and duration of treatment with scientifically based guidelines of national medical or health care coverage organizations or governmental agencies.  b. Level of service that can be safely and effectively furnished, and for which no equally effective and more conservative or less costly treatment is available.  c. Services are delivered in the setting that is clinically appropriate to the specific physical and mental/behavioral health care needs of the recipient.  d. Services are provided for medical or mental/behavioral reasons rather than for the convenience of the recipient, the recipient’s caregiver, or the health care provider.  Medical Necessity shall take into account the ability of the service to allow recipients to remain in a community based setting, when such a setting is safe, and there is no less costly, more conservative or more effective setting. |
| ***Member*** | A Medicaid or Nevada Check Up recipient who is enrolled in a DBA. May also be referred to as enrollee, recipient, or beneficiary. |
| ***MSM*** | Medicaid Services Manual is a compilation of regulations that sets guidelines and limitations regarding how the Division operates and what services are covered. Changes to the MSM are approved at public hearings. |
| ***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**](http://www.leg.state.nv.us)**.** |
| ***NCPDP*** | **National Council for Prescription Drug Programs**, (**NCPDP**) |
| ***NCQA*** | National Committee for Quality Assurance which is 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 Division of Welfare and Supportive Services (DWSS)*** | The Nevada Division of Welfare and Supportive Services (DWSS) determine eligibility for Medical Assistance, Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance to Needy Families (TANF). |
| ***Nevada Early Intervention Services (NEIS)*** | Clinics operating to serve children, from birth to their third (3rd) birthday, providing early intervention services for children with known or suspected developmental delays. These clinics receive Title V funding. |
| ***NOA*** | 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. |
| ***Non-Emergency Transportation (NET) Broker*** | 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. |
| ***NRS*** | Nevada Revised Statutes – All applicable NRS documentation may be reviewed via the internet at: [**www.leg.state.nv.us**](http://www.leg.state.nv.us)**.** |
| ***Open Panel*** | General dentists and pediatric dentists who are accepting new patients for the Dental Program. |
| ***Orthodontics*** | 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 19th year of age. For the purpose of this RFP – orthodontic services will be covered under Fee for Service. |
| ***Other Health Care Coverage (OHC)*** | 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. |
| ***Out of Network Provider*** | These are certain types of providers with whom formal contracts may not be in place with the vendor. However, the vendor benefit package includes Medicaid services for which the vendor will reimburse for specific services. The vendor must negotiate a contract to determine the rate prior to services being rendered or pay no more than the FFS rate established by the DHCFP. |
| ***Outpatient Services*** | 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. Services are provided in variety of settings that include, but are not limited to: the office/clinic, home, institution and outpatient hospital. |
| ***Pacific Time (PT)*** | Unless otherwise stated, all references to time in this RFP and any subsequent contract are understood to be Pacific Time. |
| ***Parity*** | Parity is a state of uniformity or similarity. |
| ***Patient Protection and Affordable Care Act (PPACA) or Affordable Care Act (ACA)*** | The Patient Protection and Affordable Care Act (PPACA) is a United States federal statute signed into law by on March 23, 2010. It represents the most significant regulatory overhaul of the system. Under the act, hospitals and primary physicians would transform their practices financially, technologically, and clinically to drive better health outcomes, lower costs, and improve their methods of distribution and accessibility. The ACA was enacted to increase the quality and affordability of health insurance, lower the uninsured rate by expanding public and private insurance coverage, and reduce the costs of healthcare for individuals and the government. |
| ***Patient Liability (PL)*** | Patient Liability is that portion of a recipient's income that must be paid toward the cost of care. |
| ***Performance Improvement Project (PIP)*** | Activities conducted by managed care organizations designed to improve the quality of care or services received by managed care enrolled recipients. |
| ***Performance Indicators*** | 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. |
| ***Periodicity Schedule*** | The current recommendations by the American Academy of Pediatric Dentists (AAPD) to help practitioners make clinical decisions concerning preventive oral health interventions, including anticipatory guidance and preventive counseling for infants, children and adolescents. |
| ***Personal Representative*** | A personal representative is:   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). |
| ***Plan of Correction (POC)*** | A detailed written plan describing the actions and/or procedures to remedy deviation from the stated standard(s) or contractual and/or legal mandates. |
| ***Post-Stabilization Services*** | Means covered services, related to an emergency medical condition, that are provided after a recipient is stabilized in order to maintain the stabilized condition or are provided to improve or resolve the recipient's condition. |
| ***Potential Recipient*** | A Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given DBA managed care program, but is not yet a recipient of a specific vendor. (Potential recipient definition is applicable to the Information Requirements – in 42 CFR 438.10, not to the Marketing section – in 42 CFR 438.104.) |
| ***Prepaid Benefits Package*** | The set of dental care-related services for which DBA plans will be capitated and responsible to provide. |
| ***Prepaid Ambulatory Health Plan*** | A prepaid ambulatory health plan (PAHP) is a non-comprehensive prepaid health plan that provides only certain outpatient services, such as dental services or outpatient behavioral health care. PAHPs provide no inpatient services and are paid on an at-risk or capitated basis. |
| ***Preventive*** | Aspects of oral health concerned with promoting good oral health and function by preventing or reducing the onset and/or development of oral diseases or deformities and the occurrences of oro-facial injuries. |
| ***Primary Dental Provider (PDP)*** | Dentist who practice general dentistry. |
| ***Primary Care Site*** | 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. |
| ***Primary Dental Services*** | Dental services and laboratory services customarily furnished by or through a primary care dentist for evaluation, diagnosis, prevention and treatment of diseases, disorders or conditions of the oral cavity, maxillofacial areas, or the adjacent and associated structures, through direct service to the member when possible, or through appropriate referral to specialists and/or ancillary providers. |
| ***Prior Resources*** | 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. |
| ***Proprietary Information*** | 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). |
| ***Provider*** | 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. |
| ***Provider Dispute*** | 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 DBAs plan’s operations, activities or behavior, regardless of whether the communication requests any remedial actions. |
| ***Provider Exclusion*** | 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 |
| ***Prudent Layperson*** | 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. |
| ***Public Record*** | 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]). |
| ***Qualified Clinical Staff*** | Those who are appropriately licensed or certified to perform medically necessary dental services or render clinical expertise, evaluation, and judgment in accordance with State and federal laws. |
| ***Qualified Health Maintenance Organization”*** | As defined by 42 USC 300e-9(c) (1) a health maintenance organization which has provided assurances satisfactory to the Secretary that it provides basic and supplemental health services to its members in the manner prescribed by [section 300e(b) of this title](https://www.law.cornell.edu/uscode/text/42/lii:usc:t:42:s:300e:b) and that it is organized and operated in the manner prescribed by [section 300e(c) of this title](https://www.law.cornell.edu/uscode/text/42/lii:usc:t:42:s:300e:c), and (2) an entity which proposes to become a health maintenance organization and which the Secretary determines will when it becomes operational provide basic and supplemental health services to its members in the manner prescribed by [section 300e(b) of this title](https://www.law.cornell.edu/uscode/text/42/lii:usc:t:42:s:300e:b) and will be organized and operated in the manner prescribed by [section 300e(c) of this title](https://www.law.cornell.edu/uscode/text/42/lii:usc:t:42:s:300e:c). |
| ***Quality Assurance (QA)*** | A formal set of activities to review and affect the quality of services provided. Quality assurance includes quality assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services. |
| ***Quality Improvement*** | 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. |
| ***Quality Improvement Organization (QIO)*** | 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).  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). |
| ***Recipient*** | Means a natural person who receives benefits pursuant to the plan. |
| ***Records*** | 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. |
| ***Redacted*** | The process of removing confidential or proprietary information from a document prior to release of information to others. |
| ***Referral*** | 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. |
| ***Regulation*** | 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. |
| ***Reinsurance*** | 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. |
| ***Request for Hearing*** | A clear, written request from either a provider or Medicaid recipient to the Division or its MCO 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 MCO and Division remedies have been exhausted by the provider. |
| ***RFP*** | 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). |
| ***Risk Contract*** | 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. |
| ***Rural Health Clinic (RHC)*** | 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. |
| ***Routine Dental Care*** | A well care (non-urgent) dental visit for preventive services (e.g. screening, cleaning, check-up, evaluation) or follow-up to a previously treated condition and any other routine visit for other than the treatment of dental illness/condition (e.g. sick care). |
| ***Sanction*** | A sanction refers to an action taken either by Nevada Medicaid or the Office of Inspector General (OIG) against a provider or provider applicant. |
| ***Secretary*** | The Secretary of the United States Department of Health and Human Services. |
| ***Service*** | Means any procedure, intervention, or item reimbursable under Medicaid or CHIP. |
| ***Service Area*** | The geographic area served by the vendor as approved by State regulatory agencies and/or as detailed in the certificate of authority. |
| ***Service Levels*** | 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. |
| ***SFY*** | State Fiscal Year, July 1st through June 30th. |
| ***Shall*** | Indicates a mandatory requirement. Failure to meet a mandatory requirement may result in the rejection of a proposal as non-responsive. |
| ***Should*** | 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. |
| ***Specialty Dental Services*** | A dentist, whose practice is limited to a particular branch of dentistry or oral surgery, including one who, by virtue of advanced training is certified by a specialty board as being qualified to so limit his practice. |
| ***State*** | The State of Nevada and any agency identified herein. |
| ***State Public Health Dental Hygienist*** | An appointed position by the Director of Health and Human Services whose qualifications and duties are defined in NRS 439.279. |
| ***State Dental Health Officer*** | An appointed position by the Director of Health and Human Services whose qualifications and duties are defined in NRS 439.272. |
| ***Statement of Work*** | 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. |
| ***State Quality Assessment and Performance Improvement Strategy*** | A written document that describes methods the DHCFP uses to assess and improve the quality of managed care services offered by all managed care organizations. |
| ***Subcontractor*** | Third party, not directly employed by the contractor, who will provide services identified in this RFP. This does not include third parties who provide support or incidental services to the contractor. |
| ***Subrogation*** | 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. |
| ***Supplemental Omnibus Budget Reconciliation Act of 1996 (SOBRA)*** | Legislation of the Omnibus Budget Reconciliation Act (OBRA) of 1986. |
| ***Surveillance and Utilization Review (SUR)Unit*** | The 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. |
| ***Temporary Assistance for Needy Families (TANF)*** | 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. |
| ***7Third Party Liability (TPL)*** | Third parties including health insurers, self-insured plans, group health plans (as defined in section 607 (1) of the Employee Retirement Income Security Act of 1974), service benefit plans, MCOs, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service. TPL includes COB cost avoidance and recovery. |
| ***Trade Secret*** | Information, including, without limitation, a formula, pattern, compilation, program, device, method, technique, product, system, process, design, 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 |
| ***Urgent Dental Condition*** | A dental or oral condition that requires services for relief of symptoms and stabilization of the condition within a reasonable period of time, as determined by the treating dentist, other dental professionals, primary care provider, or triage nurse who is trained in dental care and oral care. Such conditions may include minor tooth fracture, an oral tissue lesion that is visible to the member; and lost restoration. |
| ***User*** | Department, Division, Agency or County of the State of Nevada. |
| ***Utilization*** | The extent to which the recipients of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. It is usually expressed as the number of services used per year or per  100 or one 1,000 persons eligible for the service. |
| ***Utilization Control*** | Utilization Control refers to the federally mandated methods and procedures 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. |
| ***Vaccines for Children (VFC)*** | The VFC program is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. |
| ***Value Added Service*** | A benefit offered to all recipients in specific population groups,  covered by the vendor for which the vendor receives no direct capitation payment from the DHCFP. |
| ***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. |

## STATE OBSERVED HOLIDAYS

The State observes the holidays noted in the following table. 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.’s 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 |
| Veterans' Day | November 11 |
| Thanksgiving Day | Fourth Thursday in November |
| Family Day | Friday following the Fourth Thursday in November |
| Christmas Day | December 25 |

# SCOPE OF WORK

## GENERAL

### The DHCFP intends to contract with highly qualified and experienced vendors, which will administer a DBA program to assist the DHCFP in reaching its goal to provide quality dental care to the targeted populations.

### 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 adhere to all authorities including the Title XIX, Title XXI state plans and amendments, Code of Federal Regulations, and the Medicaid Services Manual.

### The DHCFP intends to procure dental services for eligible individuals in urban Clark and Washoe Counties. Other services, populations and/or geographic areas may be included in the DBA plan during the course of this contract and are to be considered as covered for this Request for Proposal.

### Medicaid has catchment areas in California, Arizona, Idaho and Utah which are treated the same as in state. Out of state treatment for a recipient is required when there is not a provider in Nevada who is able to provide services to the recipient.

## VENDOR DUTIES AND RESPONSIBILITIES

The vendor’s senior staff and other key staff as identified by the vendor shall participate in all designated key meetings scheduled by the DHCFP. The purpose of these meetings includes, but is not limited to, contract compliance, the DHCFP auditing functions and responsibilities, access to care, quality, 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.

## DENTAL SERVICES

These include covered diagnostic, preventive or corrective services and procedures that include treatment of the teeth and associated structures of the oral cavity due to 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 from birth to the 19th year of their birth month. Recipients are also provided emergent and urgent dental care.

Individuals age 21 and over who qualify for full Medicaid benefits receive emergency extractions, palliative care, and may also be eligible to receive prosthetic care (dentures/partials) under certain guidelines and limitations.

Nevada Medicaid offers expanded dental services in addition to the adult dental services for Medicaid-eligible pregnant women.

Except as otherwise provided in this RFP, the vendor’s benefits package provided to the DHCFP recipients 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 Chapter 1000, but may be more than stated therein. Any changes in Title XIX or Title XXI benefit amounts, duration, or scope shall be preceded by a review of impact on capitation amounts.

Each vendor must provide, either directly or through subcontractors, the dental care benefit package, as described in this RFP, to enrolled and eligible recipients to ensure all covered medically necessary dental services covered are available and accessible to them.

The State of Nevada Title XIX and Title XXI State Plans can be accessed on the DHCFP’s website at:

<http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/Manuals/>

Vendor’s are able and encouraged to provide value added services in addition to Title XIX and Title XXI State Plans. The vendor shall describe each of the expanded benefits it proposes to offer its recipients by eligible population.

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 the DHCFP and not to the Medicaid or Nevada Check Up enrolled recipient.

### General Information

The DBA vendors are required to provide all covered medically necessary dental services with the exception of orthodontic services, which are covered under FFS.

Orthodontic services for eligible managed care recipients are covered under FFS pursuant to MSM Chapter 1000. The vendor is responsible for ensuring referral and the coordination of care for orthodontic services, pursuant to this RFP.

The Dental vendor must ensure that enrollees who are receiving orthodontic services are also receiving all medically necessary dental services covered in the dental care benefit package.

The Dental Vendor’s are not responsible for any services provided by an Orthodontist but must ensure coordination of care between a participant’s Orthodontist and primary dental provider.

The Dental vendor as applicable will be required to conduct EPSDT screenings of its recipients under the age of twenty-one (21) years at six (6) month intervals to recipients of orthodontic services. The screening must meet the EPSDT requirements found in the 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 441.62. The vendor must conduct all interperiodic screening on behalf of recipients, as defined in MSM Chapter 1500.

#### 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:

##### 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;

##### 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 recipient; and

##### May place appropriate limits on a service on the basis of criteria applied under the Title XIX and Title XXI State plans, such as medical necessity, or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

#### Must specify what constitutes “medically necessary services” to the extent to which the vendor is responsible for covering services related to the prevention, diagnosis and treatment of oral health impairments; the ability to achieve age appropriate growth and development; and the ability to attain, maintain, or regain functional capacity in a manner that is no more restrictive than that used in the State Medicaid and CHIP programs as indicated in State statutes and regulations, the Title XIX and Title XXI State Plans, and other State policy and procedures, including the Medicaid Services Manual (MSM).

#### The vendor can utilize different authorization requirements than what is used by the State, as long as they are not more restrictive.

##### 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. The DHCFP, at its sole discretion, may require removal of the prior authorization requirement based on reported approval percentage rates, to align prior authorization procedures across delivery entities, and if determined necessary for the proper administration of the Medicaid program.

##### 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 dental professional who has appropriate clinical expertise in treating the recipient’s condition or disease.

##### The vendor shall coordinate prior authorizations and edit patterns with those used in the FFService program.

#### If the vendor elects not to provide, reimburse for or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the vendor must furnish information about the services it does not cover to the DHCFP with its application for a Medicaid contract and whenever it adopts such a policy during the term of the contract.

#### Must allow each recipient to choose his or her dental care professional, including the Primary Dental Provider (PDP) to the extent possible and appropriate.

##### Recipients will have an individual dentist, a clinic or a FQHC assigned as their PDP.

##### Vendor must allow for continued use of a recipient’s provider(s) until the recipient can be transferred to an appropriate network provider(s).

#### 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 all eligible recipients enrolled in the vendor's plan. In establishing and maintaining the network, the vendor must consider the following:

##### The anticipated DHCFP recipient DBA enrollment;

##### The numbers of network providers who currently are and are not accepting new Medicaid and Nevada Check Up recipients;

##### The expected utilization of services including a description of the utilization management software or other process used by the plan, taking into consideration the characteristics and dental care needs of specific Medicaid and Nevada Check Up populations;

##### The numbers and types of providers required to furnish the contracted Medicaid covered services; and

##### The geographic location of providers and enrolled recipients, considering distance, travel time, the means of transportation ordinarily used by recipients, and whether the location provides physical access for recipients with disabilities. Primary Care Provider (PCP) or Primary Care Site may not be more than 25 miles from the enrolled place of residence without the written request of the recipient.

#### Must cover services out of network for the recipient 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 recipient, the vendor must negotiate a contract and determine the rate or pay no more than the FFS rate. Must exhaust all out of network providers located within 25 miles of the recipient’s address before contracting with out of network providers located over 25 miles from recipient’s address.

#### Must provide for a second opinion from a qualified health care professional within the network, or arrange for the recipient to obtain one outside of the network, at no cost to the recipient.

#### Must coordinate with out of network providers with respect to payment.

#### Must ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial recipients or comparable to Medicaid FFS, if the provider services only Medicaid recipients 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 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 can obtain urgent coverage and emergency services after business hours and on weekends. Policies and procedures must include provision of direct contact with qualified dental professionals. Participants should be given the option to speak with a qualified dental professional during an emergency to advise and direct recipients to the correct service location which may include the local emergency departments or dental offices. Urgent coverage means those problems which, though not life-threatening, could result in serious injury or disability unless dental attention is received. Urgent care may be provided directly by the primary care dentist or directed by the DBA plan through other arrangements. Care coordination services should also be in place to monitor recipient utilization of emergency dental services, ensure recipients have properly addressed chief complaint and provide report metrics to the DHCFP.

#### The vendor must participate in State and federal efforts to promote the delivery of services in a culturally competent manner to all recipients, including those with limited English proficiency and diverse cultural and ethnic backgrounds pursuant to MSM Chapter 100. 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 the DHCFP requires that vendors offer accessible and high quality services in a culturally competent manner.

### Vendor Covered Services

#### At a minimum the vendor must provide directly or by subcontract, all covered medically necessary dental services as defined in MSM Chapter 1000 – Dental with the exception of Orthodontic Services. Provider types and services shall include but not limited to the following:

##### General Dentists

##### Pediatric Dentists

##### Oral Surgeon

##### Oral and Maxillofacial Surgeon

##### Endodontists

##### Periodontists

##### Prostodontists

##### Dental Hygienists

The vendor shall ensure that pediatric dental services are provided as medically necessary to children under the age of 21, in accordance with EPSDT federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989, whether or not such services are covered under the DHCFP’s state plan and without regard to any service limits otherwise established in this RFP. This requirement shall be met by either direct provision of the service by the vendor or by referral in accordance with 42 CFR 441.61. Pediatric dental utilization shall be in accordance with The American Academy of Pediatric Dentistry (AAPD) recommendations regarding the periodicity of professional dental services for children, and EPSDT guideline for dental.

#### Limited medically necessary emergency extractions and palliative care for adults over the age of 21 to include dentures/partial dentures under certain guidelines and limitations as defined in MSM Chapter 1000 Dental.

#### Offer expanded dental services in addition to the adult services for Medicaid-eligible pregnant women for periodontal scaling and root planning, to reduce the risk of pregnancy related gingivitis, as well as treatment of inflamed gums around third molars during the pregnancy as defined in MSM Chapter 1000 Dental.

#### The vendor must coordinate with the MCO in obtaining access to facilities and physician services that are necessary to support the dental provider who is providing dental services to a Medicaid or CHIP member under general anesthesia or intravenous (IV) sedation.

#### 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 dental appointments upon request by the DHCFP or the NET Broker.

#### Orthodontic services for eligible managed care recipients are covered under FFS pursuant to MSM Chapter 1000. The vendor is responsible for ensuring referral and coordination of care for orthodontic services, pursuant to this RFP and for management of EPSDT services at six (6) month intervals for recipients of orthodontic services.

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

#### The vendor vendor as applicable will be required to conduct the oral examination component of EPSDT screenings for its recipients under the age of twenty-one (21) years. The screening must meet the EPSDT requirements found in the 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 MSM Chapter 1500.

Through the EPSDT benefits, individuals under the age of 21, receive comprehensive dental care such as periodic and routine dental services needed for restoration of teeth, prevention, and maintenance of dental health.

#### 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 dental services under EPSDT whether or not the service is in the Medicaid State Plan. The vendor is responsible for the coordination of care in order to ensure all medically necessary coverage is being provided under EPSDT.

#### EPSDT screens (for Nevada Medicaid recipients) and Well baby/Well child screens (for Nevada Check Up recipients) are billed using the same codes with the same reimbursement. The vendors are not required to pay for any treatments outside of the Title XXI state plan for Nevada Check Up recipients.

#### The vendor is not required to provide any items or services determined to be unsafe or ineffective, or which are considered experimental. However, if ADA guidelines and/or peer reviewed studies are submitted, verified and determined by the vendor’s Dental Director to demonstrate safety and effectiveness that item or service may be approved for use as non-experimental. Appropriate limits may be placed on EPSDT services based on medical necessity.

#### The vendor is required to provide information and perform broad outreach and educational activities to eligible enrolled children for EPSDT services. These efforts may be reviewed and audited by the DHCFP or its designee. Refer to the MSM, federal documents cited in this Section, and Information Requirements of this RFP.

### Health Promotion and Education Programs

The vendor shall identify relevant community issues and health promotion and education needs of its recipients, and implement plans that are culturally appropriate to meet those identified needs and issues relevant to each of the target population groups of recipients served. The vendor shall use community-based needs assessments and other relevant information available from State and local governmental agencies and community groups. Health promotion and education activities shall be evidence-based, whenever possible, and made available in formats and presented in ways that meet the needs of all recipient groups. The vendors shall comply with all applicable State and federal statues, regulations and protocols on health wellness programs. The vendor shall submit a written description of all planned health promotion and education activities and targeted implementation dates to Nevada Division of Public and Behavioral Health, Chronic Disease Prevention and Health Promotion for approval, prior to implementation, including culturally and linguistically appropriate materials and materials developed to accommodate each of the enrolled target populations. Health promotion topics shall include, but are not limited to, the following:

#### The vendor shall conduct regionally located and regularly scheduled outreach activities to inform members about the availability of dental services and to significantly increase the number of children receiving services. The results of the outreach activities should be measurable and support the overall goal of increasing awareness of and/or utilization of dental services.

#### The vendor must at a minimum develop and implement health education initiatives that effectively and accurately educate members about:

##### How the dental program operates;

##### Medically Necessary Covered Dental Services, benefit limitations, and any Value-Added services offered by the vendor;

##### Dental Exams and preventive care;

##### The importance of oral health, proper nutrition and including the relationship between oral health and systemic/overall health;

##### Oral health literacy; and

##### Non-Emergency Transportation for Medicaid Members.

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.

### Out-of-Network Services

If the vendor’s provider network is unable to provide medically necessary services covered under the plan to a particular recipient, the vendor must adequately and timely cover these services out of network for the recipient for as long as the vendor is unable to provide them. The vendor benefit package includes covered medically necessary dental 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.

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

##### Coordinate the care with out-of-network providers;

##### Offer the opportunity to the out-of-network provider to become part of the network; and

##### Negotiate a contract to determine the rate prior to services being rendered or pay no more than the Medicaid FFS rate.

#### When it is necessary for recipients to obtain 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 TPL. The OOS provider must not bill, accept or retain payments from Medicaid or Nevada Check Up recipients.

### Emergency Dental Services

#### The vendor may not deny payment for emergency services treatment when a representative of the vendor instructs the recipient to seek emergency services care.

#### The vendor shall be responsible for dental related services provided in an emergency.

#### In providing for emergency dental services and care as a covered service, the vendor shall not:

##### Require prior authorization for emergency dental services and care.

##### Indicate that emergencies are covered only if care is secured within a certain period of time.

##### Use terms such as “life threatening” or “bona fide” to qualify the kind of emergency that is covered.

##### Deny payment based on the member’s failure to notify the vendor in advance or within a certain period of time after the care is given.

#### The vendor shall not deny payment for emergency dental care unless it is performed under the medical benefit in a hospital, emergency room or ambulatory surgery center.

#### The vendor shall not deny payment for treatment obtained when a member had an emergency dental condition and stabilization of condition, including cases in which the absence of immediate dental attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of an emergency dental condition.

#### The vendor is not responsible for emergency dental coverage provided on an emergency basis in a hospital, emergency room or ambulatory surgery center under the medical benefit which may include dislocated jaw, traumatic damage to teeth and supporting structures, and removal of cysts; treatment of oral abscess of tooth or gum origin; treatment and devices for correction of craniofacial anomalies; and drugs.

#### The vendor shall not deny emergency dental services claims submitted by a non-contracting provider solely based on the period between the date of service and the date of clean claim submission unless that period exceeds 365 days.

#### Non-emergent services provided in an emergency room are a covered service. Providers are expected to follow national coding guidelines by billing at the most appropriate level for any services provided in an emergency room setting.

#### Post-Stabilization Services

The vendor is financially responsible for:

##### Post-stabilization services obtained within or outside the network that are pre-approved by a network provider or organization representative;

##### 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 recipient's stabilized condition within one (1) hour of a request to the vendor for pre-approval of further post-stabilization care services;

##### 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 recipient'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 recipient'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 recipient 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 recipient’s care or a network physician assumes responsibility for the recipient's care through transfer or the vendor and the treating physician reach an agreement concerning the recipient's care or the recipient is discharged; and

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

#### 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 recipient with the services the recipient may receive from any other vendor. Upon request or notification of need, the vendor is required to communicate with other vendors serving the recipient 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 recipient’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 will be responsible for coordinating services with other appropriate Nevada Medicaid and non-Medicaid programs. This coordination includes electronic data sharing for integrated health care.

##### In addition, the vendor is responsible to ensuring continuity of services for recipients with special needs. These recipients may include, but are not limited to: juveniles temporarily detained by a state or county agency; Seriously Emotionally Disturbed children, adults with Severe Mental Illness and individuals with substance abuse disorders; Children with Special Health Care Needs; homeless recipients; recipients with chronic conditions; women with pregnancies, and referring orthodontic recipients to their appropriate Dental Home for periodic examinations and cleanings.

#### Federally Qualified Health Center (FQHC)

The vendor must pay for services provided by a Federally Qualified Health Center (FQHC). Vendors may enter into contracts with FQHCs provided that payments are at least equal to the amount paid to other providers for similar services. If the vendor does not have a contract with an FQHC, the vendor must pay at a rate equivalent to the 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 include all licensed and qualified FQHC providers in the vendor’s network. Contracting with just one provider at each FQHC does not constitute a good faith effort to include the FQHC in the vendor’s network. The vendor must report to the DHCFP payments and visits made to FQHCs. The DHCFP is responsible for FQHC wrap payments; the vendor will be responsible for quarterly reporting on FQHC activity.

## ENROLLMENT REQUIREMENTS AND LIMITATIONS

### The vendor eligibility and enrollment functions are the responsibility of the DHCFP and the DWSS. The vendor shall establish and implement enrollment procedures and maintain applicable enrolled recipient data. The vendor shall accept each recipient who is enrolled in or assigned to the vendor by the 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 42 CFR 438.6(d)(1) . 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). Per 42 CFR 438.6(d)(3)(4) 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. The vendor must have written policies and procedures for enrolling all eligible populations and receiving monthly and other updates from the DHCFP of recipients enrolled in, the vendor. The vendor will accept as enrolled all recipients appearing on monthly enrollment reports.

### The vendor is responsible for services rendered during a period of retroactive enrollment in situations where eligibility errors have caused an individual to not be properly and timely enrolled with the vendor. In such cases, the vendor shall only be obligated to pay for such services that would have been authorized by the vendor had the individual been enrolled at the time of such services. For in-state providers in these circumstances, the vendor shall pay the providers for such services only in the amounts that would have been paid to a contracted provider in the applicable specialty. Out-of-state providers in these circumstances will be paid according to a negotiated rate between the vendor and the out-of-state provider. The timeframe to make such corrections will be limited to 180 days from the incorrect enrollment date. The DHCFP is responsible for payment of applicable capitation for the retroactive coverage.

### 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:

##### Determine the number of recipients each enrolled PDP will accept as new patients; and

##### Transmit recipient elections regarding PDP assignment for the forthcoming month.

### Provider Enrollment Roster Notification

The vendor must either notify or provide the means for providers to verify recipients’ PDP selection. The vendor must establish and implement a mechanism to inform each PDP about any newly enrolled recipients assigned to the PDP 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 PDPs informed of the enrollment activity.

### Transitioning/Transferring of Recipients

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 recipient has been transferred to another plan or to FFS, the vendor must have written policies and procedures for transferring/receiving relevant patient information, dental records and other pertinent materials to the other plan or current FFS provider. This must be done in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other privacy laws.

## RECIPIENT SERVICES

### Information Requirements

#### The vendor must have written information about its services and access to services including Recipient Services phone number available to recipients and potential recipients. 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 recipient and potential recipient. This applies to all non-English languages, not just those that the State identifies as prevalent.

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

#### The vendor’s written material must use an easily understandable format and language. The vendor must also develop appropriate alternative methods for communicating with visually and hearing-impaired recipients, and accommodating physically disabled recipients in accordance with the requirements of the Americans with Disabilities Act of 1990. All recipients and potential recipients 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 recipients who are eligible for EPSDT services, regardless of any thresholds.

### Member Handbook

The vendor must provide all recipients 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 RECIPIENT.”

#### The vendor must submit the Member Handbook to the DHCFP before it is published and/or distributed. The DHCFP will review the handbook and has the sole authority to approve or disapprove the handbook, in consultation with the Medical Care Advisory Committee (MCAC). 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.

#### The vendor must mail the handbook to all recipients within five (5) business days of receiving notice of the recipient’s enrollment and must notify all recipients 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, as needed, to keep the Member Handbook current. At a minimum, the information enumerated below must be included in the handbook:

##### Orienting new members of its benefits and services including confirmation of the recipient's PDP selection or assigned PDP;

##### Role of the primary care dentist;

##### The days the office or facility is open and services are available;

##### The address and telephone number of the vendor’s office or facility;

##### How to utilize services in sufficient detail to ensure that recipients understand benefit amount, duration and scope including prior authorization requirements;

##### What to do in a dental emergency or urgent dental situation including how to access emergency dental care after hours and on weekends, or out of the service area, inform the member to dial 911 if there is a medical emergency;

##### Information on Grievance, Appeals, and Fair Hearing procedures, as specified in 42 CFR 438.10(g);

##### A list of current network PDPs who are and who are not accepting new patients in the recipient’s service area and all languages spoken;

##### The provider list located on the vendor’s website shall be updated by the vendor monthly;

##### Any restrictions on the recipient’s freedom of choice among network providers;

##### Procedures for changing a PDP;

##### Recipient rights and protections as specified in 42 CFR 438.100. The vendor must maintain written policies and procedures for informing recipients of their rights and responsibilities, and must notify recipients of their right to request a copy of these rights and responsibilities;

##### Procedures for enrollment and disenrollment;

##### Procedure for referral to specialists or other medically necessary dental services;

##### Referral for 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 and recipient regarding services that meet these criteria and in those instances, the State must provide the information on where and how to obtain the service;

##### Any information regarding cost sharing which may apply for a non-covered service;

##### How to access Non-Emergency Transportation;

##### The vendor is required to provide to the recipient upon request, information on the structure and operation of the vendor and information about provider incentive plans as set forth in 42 CFR 438.6(h);

##### Information the member needs in order to decide among all relevant treatment options;

##### The risk, benefits, and consequences of treatment and non-treatment;

##### The member’s right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions;

##### 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 provided to the recipient at no costs and a telephone number which the recipient can call to receive assistance in scheduling an appointment;

##### Notification of the recipient’s responsibility to report any third-party payment service to the vendor and the importance of doing so; and

##### 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.

#### The vendor must give each recipient 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, 30-days before the intended effective date, as described in 42 CFR 438.10(f)(4), when there are material changes that will affect access to services and information about the DBA Program. The vendor will provide notification when a change directly affects the ongoing care of the recipients. The vendor shall also provide such notices in its semi-annual recipient newsletters and shall maintain documentation verifying handbook updates.

#### 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 recipient who received his/her primary care from, or was seen on a regular basis by, the terminated provider.

### Recipient Services Department/Concierge Services

The vendor shall maintain a Recipient Services Department (that also includes a Concierge Service) that personally assists recipients to find a service provider. This department must be adequately staffed with qualified individuals who shall also assist recipient, 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 Recipient Services Department is to be operated at a minimum, traditional business hours of Monday through Friday, 8:00 a.m. through 5:00 p.m., and not less than what is provided to the vendor’s commercial clients, if applicable.

#### Ensure that a toll-free hotline telephone number is operated at a minimum, traditional business hours of Monday through Friday, 8:00 a.m. through 5:00 p.m for recipient access.

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

##### Explaining the operation of the vendor;

##### Explaining covered benefits;

##### Resolving, recording and tracking recipient grievances and appeals in a prompt and timely manner;

##### Responding to recipient inquiries;

##### Providing Concierge Services; and

##### If the recipient requires assistance with accessing care, including finding a provider, the Recipient Services Department will transfer the recipient to the in-person Concierge Services. The in-person Concierge Service staff will assist the recipient to find a provider, this assistance is over and above providing a list of network providers or directing to the web. The Concierge will provide the following assistance:

###### Assisting recipients in selecting and/or changing PDPs or Primary Dental Care Sites. The vendor must report any PDP and/or Primary Dental Care Sites changes electronically to the DHCFP;

###### Assisting recipient to make appointments and obtain services; the vendor is required to find and schedule an appointment if the recipient reports they are unable to access or find a provider or make an appointment;

###### Assisting recipient in obtaining out-of-area and out-of-network care; and

###### While the Recipient 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 recipients can obtain urgent coverage and emergency services after business hours and on weekends. Policies and procedures must include provision of direct contact with qualified dental professionals. Participants should be given the option to speak with a qualified dental professional during an emergency to advise and direct recipients to the correct service location which may include local emergency departments or dental offices. Urgent coverage means those problems which, though not life-threatening, could result in serious injury or disability unless medical attention is received.

### Dental Provider Requirements

#### Primary Dental Provider (PDP) or Primary Dental Care Site

The vendor shall allow each enrolled recipient the freedom to choose from among its participating PDPs and change PDPs as requested. The vendor must implement procedures to ensure that each recipient has an ongoing source of primary care appropriate to their needs.

Each enrolled recipient must be assigned to a PDP or Primary Dental Care Site, within five (5) business days of the effective date of enrollment. The vendor may auto-assign a PDP or Primary Dental Care Site that has traditionally served the Medicaid population to an enrolled recipient who does not make a selection at the time of enrollment.

#### Twenty-Five (25) Mile Rule

The vendor must offer every enrolled recipient a PDP or Primary Dental Care Site located within a reasonable distance from the enrolled recipient’s place of residence. In a county having a population of 100,000 or more, must have a radius of not more than 25 miles between the subscriber or individual enrollee and PDP without the written request of the recipient.

#### Assignment of a PDP or Primary Dental Care Site

If an enrolled recipient does not choose a PDP, the vendor shall match enrolled recipients with PDPs by one or more of the following criteria:

##### Assigning enrolled recipients to a provider from whom they have previously received services, if the information is available;

##### Designating a PDP or Primary Dental Care Site who is geographically accessible to the enrolled recipient per NAC 695C.160 (25 Mile Rule); and

##### Assigning all children within a single family to the same PDP.

#### Changing a PDP or Primary Dental Care Site

##### An enrolled recipient may change a PDP or PDCS for any reason. The vendor shall notify enrolled recipients of the procedures for changing PDPs or Primary Dental Care Sites.

##### In cases where a PDP has been terminated, the vendor must notify enrolled recipients in writing and allow recipients to select another primary Dental 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.

##### The vendor may initiate a PDP or Primary Dental Care Site change for an enrolled recipient under the following circumstances:

###### The enrolled recipient’s residence has changed such that distance to the PDP is greater than twenty-five (25) miles. Such change will be made only with the consent of the recipient;

###### The PDP ceases to participate in the vendor’s network; or

###### Legal action has been taken against the PDP, which excludes provider participation.

##### The vendor shall track the number of requests to change PDPs and the reasons for such requests.

#### Use of Dental Homes

##### The vendor is encouraged to use existing patient-centered Dental homes/health homes, when available and appropriate.

##### Vendor should use supportive provider services and contracting to support the expansion of patient-centered dental homes/health homes.

##### Vendor is encouraged to use other innovative models, when available and appropriate.

### Children with Special Health Care Needs (CSHCN)

#### The vendor must produce a treatment plan for recipients with special health care needs who are determined through an assessment by appropriately qualified health care professionals to need a course of treatment or regular care monitoring. The treatment plan must be:

##### Developed by the recipient’s primary dental provider with recipient participation, and in consultation with any specialists caring for the recipient;

##### Approved by the vendor in a timely manner, if approval is required by the vendor; and

##### In accordance with any applicable State quality assurance and utilization review standards.

#### Must have a mechanism in place to allow these recipients direct access to a specialist through a standing referral or an approved number of visits, as deemed appropriate for the recipient’s condition and identified needs.

## NETWORK

The vendor is required to establish and manage appropriate provider networks and maintain existing written provider agreements with such providers in geographically accessible locations. The vendor must maintain a network of General Dentists, Pediatric Dentists, Endodontists, Oral Surgeons, Oral and Maxillofacial Surgeon, Periodontists and Prostodontists, Dental Hygienists, and ancillary services sufficient to provide access to all services covered in this RFP in a manner that complies with access standards described in this RFP, in the DHCFP’s Access to Care Plan, and the Code of Federal Regulations. Consideration must be given to the number of expected recipients that may enroll. The vendor when establishing and maintaining its network must consider the expected utilization of services and the numbers and types of providers given the characteristics and dental care needs of the specific Medicaid population enrolled with the vendor. The vendor’s management oversight includes, but is not limited to, credentialing, maintenance, provider profiling, peer review, dispute resolution and Dental Director Services. The vendor must conduct secret shopper surveys to a statistically sound sample across their network as part of the Access to Care Monitoring Plan to identify appointment standards and access to services which must be reported annually.

The vendor must describe their approach to network management including if the network will be an open or closed network and if some services are currently planned to be provided through subcontractors, sub capitation, fee for service or alternative models.

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

If the vendor puts a provider group at substantial financial risk for services not provided by the provider group, the vendor must ensure that the provider group has adequate stop-loss protection.

### The vendor must adopt practice guidelines and protocols which:

#### Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

#### Are adopted in consultation with contracting dental professionals; and

#### Are reviewed and updated periodically as needed to reflect current practice standards.

### The Vendor must:

#### Disseminate its practice guidelines to all affected providers prior to the contract start date and, upon request, to recipients and potential recipients, including prior authorization policies and procedures;

#### Ensure that decisions for utilization management, recipient education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines;

#### 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;

#### Ensure that its providers offer hours of operation that are no less than the hours of operation offered to commercial recipients or comparable to Medicaid FFS, if the provider serves only Medicaid recipients;

#### Mechanisms to ensure compliance by providers;

#### Monitor providers regularly to determine compliance;

#### Take corrective action if there is a failure to comply by network providers;

#### Participate in state and federal efforts to promote the delivery of services in a culturally competent manner to all recipients, including those with limited English proficiency and diverse cultural and ethnic backgrounds;

#### 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, specialty or certification. The vendor may not discriminate against particular providers who serve high risk populations or specialized conditions that require costly treatment. 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 recipients; 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 recipients; and

#### Provide to the DHCFP supporting documentation, in a format specified by the DHCFP, which demonstrates it has the capacity to serve the expected enrollment in its service area in accordance with the DHCFP’s standards for access to care at the time it enters into the contract with the State and any time there is a significant change in their operations that impact services. Such documentation must demonstrate that the vendor offers an appropriate range of 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 recipients in the service area. 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.

### Network Management

#### Primary Dental Provider (PDP) or Primary Dental Care Site Responsibilities:

##### The PDP (a General Dentist or Pediatric Dentist) in a Primary Dental Care Site serves as the recipient’s initial point of contact with the vendor. As such, the PDP or the dentist at the Primary Dental Care Site is responsible for the following:

###### Delivery of covered medically necessary, dental services and preventive services, including EPSDT screening services;

###### Referrals for specialty care and other covered medically necessary services in the vendor benefit package;

###### Continuity and coordination of the enrolled recipient’s dental care; and

###### Maintenance of a current Dental record for the enrolled recipient, including documentation of all services provided by the PDP, and specialty or referral services, or out-of-network services.

Although PDPs must be given responsibility for the above tasks, the vendor must agree to retain responsibility for monitoring PDP and Primary Dental Care Site 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.

#### Essential Community Providers

An essential community provider accepts patients on a sliding scale fee, determined on the income of the patient; does not restrict access or services due to financial limitations of a patient; and can demonstrate to the 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 if they provide covered dental services:

##### A Federally Qualified Health Center (FQHC) or Rural Health Center (RHC);

##### The University Medical Center of Southern Nevada;

##### The University of Nevada School of Medicine (UNSOM);

##### The University of Nevada, Las Vegas School of Medicine (UNLV SOM);

##### Division of Public and Behavioral Health (DPBH);

##### Division of Child and Family Services (DCFS);

##### Community Centered Behavioral Health Clinics (CCBHC);

##### County Child Welfare Agencies;

##### Any dental provider designated by the DHCFP as an essential community provider. The DHCFP will notify the Vendor of providers designated by the DHCFP as essential community providers;

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.

### Subcontractors

#### All Subcontracts, excluding network provider contracts but 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 DBA Contract, as amended. The vendor may not delegate any item or requirement in the DHCFP DBA Contract to any subcontractor 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 $25,000 for each incident. 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 sub-contracted dental 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:

##### For the provision of and/or arrangement for the services to be provided under this Contract and to ensure the coordination of care between dental, orthodontia and as applicable medical needs is maintained;

##### For the evaluation of the prospective subcontractor’s ability to perform the activities to be delegated;

##### 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:

###### 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

###### 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.

##### For the oversight and accountability for any functions and responsibilities delegated to any subcontractor. The vendor shall indemnify, defend 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;

##### 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 DBA Contract. This provision includes, but is not limited to, claims processing, recipient services, provider services, cost containment services such as utilization management, third party liability, surveillance and utilization review. 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;

##### 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***;

##### Subcontractor contracts may not be structured to provide financial or other incentives to providers and subcontractors for denying, reducing or limiting medically necessary services; and

##### The use of “gag” clauses in subcontractor contracts is prohibited.

### Access and Availability

The vendor shall:

#### 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.

#### Partner actively with the DHCFP, community providers and stakeholders to identify and address issues and opportunities to improve dental care access and availability for Medicaid and CHIP recipients.

#### Promotion of preventative care services shall be accomplished by completing welcome calls to new recipients. This method ensures orientation with emphasis on access to care and choice of PDP.

#### Maintain an adequate network that ensures the following:

##### 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, pediatric dentist, dental hygienists, and oral surgeons in each geographic service area sufficient to provide necessary access to care. 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 the 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 the DHCFP a detailed description of the dental 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.

#### PDP Network Requirements

Demonstrate that the capacity of the PDP 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 recipients than allowed by the FTE requirement.

#### Primary Dental Provider Participation

Per geographic service area, at least fifty percent (50%) of all of the Network PDPs must contractually agree to accept eligible recipients. At least fifty percent (50%) of the aforementioned PDPs 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 Las Vegas School of Dental Medicine, the dentists of the DBAs can be counted to meet the fifty percent (50%) participation and fifty percent (50%) acceptance requirement. The DHCFP or its designee may audit the vendor’s network monitoring tool for compliance.

#### Dental Specialists

The vendor must provide access to all types of dental specialists for PCP referrals, and it must employ or contract with specialists 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 (1:1500).

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

If a recipient is unable to arrange specialty care from a network provider, the vendor must arrange for services with a provider outside the vendor’s network.

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

##### Emergency dental services provided on an emergency basis in a hospital, emergency room or ambulatory surgery center are provided as part of the medical MCO benefit. The vendor must educate recipients and providers about availability of, and how to access emergency dental services;

##### PDP Appointments

###### Urgent care, including urgent specialty care, must be provided within 24 hours.

###### Therapeutic and diagnostic care must be provided within 14 days.

###### Routine or preventive dental services for eligible recipients within six (6) weeks in accordance with the American Academy of Pediatric Dentistry (AAPD) periodicity schedule.

###### PDP's must make referrals for specialty care on a timely basis, based on the urgency of the Member’s medical condition, but no later than 30 days.

##### Specialist Appointments

For specialty referrals to dental specialists and other diagnostic and treatment health care providers, the vendor shall provide:

###### Same day, emergency appointments within twenty-four (24) hours of referral;

###### Urgent appointments within three (3) calendar days of referral;

###### Routine appointments within thirty (30) calendar days of referral; and

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

##### Appointment Standards

The vendor shall have established written policies and procedures:

###### 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.

###### Concerning the education of its provider network regarding appointment time requirements, the vendor shall:

Monitor the adequacy of its appointment process and compliance; and

Implement a Plan of Correction (POC) when appointment standards are not met.

#### Office Waiting Times

The vendor shall establish written guidelines that a recipient’s waiting time at the PDP’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.

#### Access Exceptions

Document and submit to the DHCFP, in writing within 15 days, justification for exceptions to access standards set forth in this RFP. Such justifications shall include alternative standards that are equal to or better than the usual and customary community standards for accessing care.

#### 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 recipient who received his/her primary care from, or was seen on a regular basis by the terminated provider.

##### If the vendor decredentials, terminates, or disenrolls a provider; the vendor must inform the DHCFP Provider Enrollment Unit within five (5) business days.

##### The vendor at a minimum must provide the DHCFP the basis, reasons or causes for such action and any and all documentation, data, or records obtained, reviewed, or relied on by the vendor including but not limited to:

###### Provider/patient files.

###### Audit reports and findings.

###### Medical necessity reviews.

##### If the decredentialing, termination or disenrollment of a provider is due to suspected criminal actions, or disciplinary actions related to fraud or abuse, the DHCFP is responsible for notifying the MFCU or HHS-OIG.

#### Notification of Significant Network Changes

##### The vendor will notify the DHCFP’s designated staff, within one (1) business day, of any unexpected change that would impair its provider network. This notification shall include:

###### Information about the nature of the change and how the change will affect the delivery of covered services; and

###### The vendor’s plans for maintaining the quality of recipient care if the provider network change is likely to result in deficient delivery of covered services.

##### The vendor must notify the 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 fifteen (15) calendar days prior to the change.

#### 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, gender identity, sexual preference, religion, age, and health status, physical or mental disability, except where medically indicated. Prohibited practices include, but are not limited to, the following:

##### Denying or not providing an enrolled recipient a covered service or available facility;

##### 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;

##### 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;

##### The assignment of times or places for the provision of services on the basis of race, national origin, creed, color, gender, gender identity, sexual preference, religion, age, physical or mental disability, or health status of the recipient to be served;

##### 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 recipient who is his or her patient:

###### For the recipient's health status, dental care, or treatment options, including any alternative treatment that may be self-administered;

###### For any information the recipient needs in order to decide among all relevant treatment options;

###### For the risks, benefits, and consequences of treatment or non-treatment; and

###### For the recipient'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.

##### Employing or contracting with providers excluded from participation in Federal health care programs. [42 CFR 438.214(d)]; and

##### Charging a fee for a medically necessary covered service or attempting to collect a co-payment.

#### 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 the DHCFP or incentives or disincentives are structured to steer enrolled recipients to certain providers) the vendor will be in default of its contract with the 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 the DHCFP.

### Provider Contracts

#### 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.

#### The vendor will provide, for the 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 the DHCFP for review. Provider contracts must meet all state and federal requirements. Vendors are expected to submit all necessary information to demonstrate agreements are complete. The vendor shall submit any of its provider contracts to the DHCFP upon request.

#### 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 the DHCFP’s medical assistance programs or have a signed agreement but do not actively accept eligible recipients. Prior to becoming a network provider, a provider who is a non-Medicaid provider must be referred to the 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.

#### The vendor must also have written policies and procedures for monitoring and complete this monitoring on its providers, and for disciplining providers who are found to be out of compliance with the vendor’s dental management standards.

#### Provider contracts may not be structured to provide financial or other incentives to providers and subcontractors for denying, reducing, or limiting medically necessary services to a recipient.

#### The use of “gag” clauses in Provider contracts is prohibited.

#### All provider contracts must be made available to the DHCFP within five (5) business days of the request.

#### The vendor will support and participate in any future grants awarded to Medicaid that affect vendors or vendor recipients.

#### The vendor will be subject to ACA requirements for Medicaid enrollment.

### Provider Directory

The vendor will publish its provider directory which includes all providers including FQHCs, and any subcontractors’ provider directory via an Internet website upon contract implementation and will update the website on a monthly basis for all geographic service areas. Listed providers in the vendor network must be active, currently providing care or accepting new patients on behalf of the vendor and the provider’s demographic data must be accurate. The vendor will provide the DHCFP with the most current provider directory upon contract award for each geographic service area. Upon request by the DHCFP, the vendor must confirm the network adequacy and accessibility of its provider network and any subcontractor’s provider network. When queried at least 90% of listed providers will confirm participation in the vendor’s network.

On a monthly basis, no later than the tenth (10) day of the month, the Vendor will submit to the DHCFP a list of all providers who have been enrolled and a list of all providers who have disenrolled, deactivated, terminated, decredentials or been removed from the active provider enrollment in the previous month.

### Recipient Communications

All general communications to recipients must be written at an eighth (8th) grade level of understanding reflecting cultural competence and linguistic abilities. The DHCFP must approve initial mass letter mailings and brochures or any subsequent change in content for recipients, exclusive of Dental educational and disease management information, prior to release. If the DHCFP does not respond within ten (10) business days, the vendor may consider the communication approved. This provision does not pertain to communications on specific topics to individual recipients.

### Provider Communications

All general communications to providers including mass mailings, fax-blasts, brochures, batch emails, and communications specifically mentioned in this contract must be copied to the DHCFP. This provision does not pertain to communications on specific topics to individual providers.

### Provider Policy and Procedure Manual

#### The vendor must prepare a Provider Policy and Procedure Manual. The vendor shall document the approval of the provider manual by the vendor’s Dental Director, and shall maintain documentation verifying that the provider manual is reviewed and updated at least annually.

#### The vendor must furnish one (1) copy of the manual to each provider upon recruitment into the network before provider has signed a contract, 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/or 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. If a provider agrees, the manual may be provided in electronic format. One (1) hard copy and one (1) electronic copy of the Provider Manual shall be provided to the 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:

##### The policies and procedures to be implemented by the vendor to ensure provider contract compliance;

##### The procedures governing verification of recipient eligibility and the process for receiving and disseminating recipient enrollment data to participating providers;

##### Prior authorization procedures and requirements;

##### The procedures for claims administration;

##### Provider credentialing criteria;

##### Provider network management;

##### 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;

##### 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;

##### Procedure to dispute adverse payment and contract decisions; and

##### Policies and procedures to be implemented by the Vendor to manage quality improvement and recipient service utilization.

#### 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, recent changes in policy or procedures should be provided. All sessions should reinforce information on 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.

### Network Maintenance

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.

## DENTAL RECORDS

### Complete dental records shall be maintained by the vendor’s contracted providers, for each enrolled recipient in accordance with 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, accessibility and availability, record keeping, and record review process for all dental records. Not more than ten (10) calendar days after submitting a request, the State shall have access to a recipient’s dental record, whether electronic or paper, and has the right to obtain copies at the vendor’s expense.

### The recipient’s dental record is the property of the provider who generates the record. The vendor shall assist the recipient or the parent/legal guardian of the recipient in obtaining a copy of the recipient’s dental 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 recipient or parent/legal guardian of the recipient is entitled to one (1) free copy of the requested dental 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 dental records in their possession to the new provider within ten (10) business days from receipt of the request.

## QUALITY ASSURANCE STANDARDS

### Overview

The common goal of the managed care program is a successful partnership with quality dental plans to provide care to the DHCFP recipients, while focusing on continuous quality improvement.

The role of vendor is to ensure accessibility and availability to appropriate dental care, provide for continuity of care, and provide quality care to enrolled recipients. Recipients benefit from preventive dental 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. The vendor will designate a lead person to work with the DHCFP on quality management. 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.

### Quality Measurements

#### The DHCFP will update Nevada’s Quality Strategy to indicate the set of dental quality measures to be reported. The DHCFP and/or the EQRO may conduct on-site review as needed to validate dental 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 conduct special focus studies and report on additional quality measures when requested.

#### On an annual basis, vendor’s are required to report on all performance measures listed in the State Quality Strategy.

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

##### Standard

###### The vendor shall take affirmative steps to achieve at least a participation rate greater than or equal to the national average for EPSDT dental screenings.

###### The DHCFP and/or the 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 dental care provider contracts, and the process for notification of recipients. Vendor internal quality assurance of the EPSDT program shall include monitoring and evaluation of the referrals that are the result of an EPSDT dental 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 dental line items of the CMS 416 Report applicable for dental care and submit separate reports for the NCU, FMC, and CHIP Medicaid expansion.

###### If the vendor cannot satisfactorily demonstrate to the DHCFP at least a participation rate not less than the Quality Improvement System for Managed Care (QISMIC) improvement measure, as determined by the DHCFP or its contracted EQRO, the DHCFP may require the vendor to submit a Plan of Correction (POC) to the DHCFP.

### Plan of Correction (POC) Procedure

#### The POC should identify improvements and/or enhancements of existing outreach and education, which will assist the vendor to improve the quality rates/scores. A POC must include, but may not be limited to, the following:

##### Specific problem(s) which require corrective action;

##### The type(s) of corrective action to be taken for improvement;

##### The goals of the corrective action;

##### The time-table for action;

##### The identified changes in processes, structure, internal/external education;

##### The type of follow-up monitoring, evaluation and improvement; and

##### The vendor staff person(s) responsible for implementing and monitoring the POC.

#### Unless otherwise specified by the DHCFP, the vendor has thirty (30) calendar days from date of notification by the DHCFP to submit a POC, as specified. The vendor’s POC will be evaluated by the DHCFP to determine whether it satisfactorily addresses the actions needed to correct the deficiencies. If the vendor’s POC is unsatisfactory, the 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) calendar days of receipt of the DHCFP’s second directive. If the vendor’s second plan is unsatisfactory, the DHCFP may declare a material breach. Within ninety (90) calendar days after the vendor has submitted an acceptable POC or one has been imposed, the 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 dental 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 an administrative sanction against the vendor. Such a sanction will disallow further enrollment and may also include adjusting auto-assignment formulas used for the 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.

## STANDARDS FOR INTERNAL QUALITY ASSURANCE PROGRAMS

Federal regulations (42 CFR 438.330) mandate that States must, through its contracts, require each Prepaid Ambulatory Health Plan (PAHP) to have an ongoing quality assessment and performance improvement program for the services it furnishes its recipients. 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.

In accordance with the requirements set forth in 42 U.S.C. §300kk, the vendor must develop and maintain the ability to collect and report data on race, ethnicity, sex, primary language, and disability status for applicant's and recipient's parents or legal guardians if applicants or recipients are minors or legally incapacitated individuals.

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

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

### The vendor must conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time that focus on clinical and non-clinical areas that are expected to have a favorable effect on health outcomes and recipient satisfaction and that involve the following:

#### Measurement of performance using objective quality indicators;

#### Implementation of system interventions to achieve improvement in quality;

#### Evaluation of the effectiveness of the interventions; and

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

### 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 438.330. 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 to be available to the DHCFP for its annual review of the vendor’s quality assessment and improvement program.

### The Vendor must:

#### Submit performance improvement measurement data annually using standard measures required by the DHCFP, including those that incorporate the requirements of 42 CFR 438. Part E..

#### Submit to the DHCFP data specified by the DHCFP which enables the DHCFP to measure the vendor’s performance.

### The DHCFP will use the most current sources for the IQAP guidelines and the most current Standards and Guidelines for the requested quality measures.

### 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:

#### Collect data on recipient and provider characteristics as specified by the DHCFP, and on services furnished to the recipients through an encounter data system or other methods as may be specified by the DHCFP;

#### Verify the data received from providers is accurate, and timely, and screen the data for completeness, logic and consistency in accordance with 42 CFR 438.242(b) (2);

#### Must collect service information received from providers in standardized formats.

#### Make all collected data available as outlined in the reporting guide, attachments or as requested to the DHCFP and upon request to CMS as required; and

#### Designate a lead person to collaborate with the DHCFP on the review and submission of encounter data to the DHCFP.

### Written IQAP Description

The vendor must have a written description of its IQAP. This written description must meet the following criteria:

#### Goals and Objectives.

#### The written description must contain a detailed set of quality assurance (QA) objectives, which are developed annually and include a timetable for implementation and accomplishment.

#### Scope

##### The scope of the IQAP must be comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service. Scope must also include availability, accessibility, coordination, and con­tinuity of care.

##### The IQAP methodology must provide 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 and types of services (e.g., preventive, primary, specialty care, and ancillary) are included in the scope of the review.

#### Specific Activities

The written description must specify 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 must be clearly identified and qualified to develop the studies and analyze outcomes.

#### Continuous Activity

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

#### Provider Review

##### Review by dentists and other health professionals of the process followed in the provision of dental services must be conducted; and

##### The vendor must provide feedback to dental professionals and vendor staff regarding performance and patient health care outcomes.

#### Focus on Health Outcomes

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

### Systematic Process of Quality Assessment and Improvement

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

#### Specification of Dental Services Delivery Areas to be monitored;

#### The IQAP must monitor and evaluate, at a minimum, care and services in certain priority areas of concern selected by the DHCFP. These are selected from among those identified by the CMS and the DHCFP and are identified through the DHCFP Quality Assessment and Performance Improvement Strategy;

#### Performance Improvement Projects (PIPs) in accordance with 42 CFR 438.358(b):

##### Validation of Performance Improvement Projects required by the State to comply with requirements set forth in 42 CFR 438.330; and

##### Projects that was under way during the preceding twelve (12) calendar months.

#### 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 one clinical PIP and one non-clinical PIP. Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, high-volume services, high-risk services, and continuity and coordination of care; non-clinical PIPs include projects focusing on availability, accessibility, and cultural competency of services, interpersonal aspects of care, and appeals, grievances, and other complaints;

#### 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 DBA 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 EQR Protocols;

#### The vendor must implement a system to achieve improvement in quality; evaluate effectiveness of the interventions; and institute 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;

#### At its discretion and/or as required or directed by the DHCFP, the vendor’s IQAP must also monitor and evaluate other important aspects of care and service; and

#### A statistically significant decline in one PIP will result in a quality penalty fee until the measure increases above original measure or matches previous measure prior to decline.

### 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:

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

##### Monitor and evaluate quality of care through studies which include, but are not limited to, the quality indicators also specified by the CMS, with respect to the priority areas selected by the DHCFP;

##### Ensure methods and frequency of data collection; ensure data accuracy; and ensure data is effective and sufficient to detect the need for program change; and

##### Have mechanisms to detect under and over utilization and to follow up appropriately. If fraud and abuse is suspected, a referral must be made to the vendor’s PIU and the DHCFP SUR Unit for appropriate action.

#### Use of Clinical Care Standards/Practice Guidelines

##### The IQAP studies and other activities monitor quality of care against clinical care or health service delivery standards or practice guidelines specified in the Quality Strategy;

##### The standards/guidelines are based on reasonable scientific evidence and developed or reviewed by vendor providers;

##### The standards/guidelines must focus on the process and outcomes of dental care delivery, as well as access to care;

##### The vendor must ensure a mechanism is in place for continuously updating the standards/guidelines;

##### The standards/guidelines must be included in provider manuals developed for use by the vendor’s providers, or otherwise disseminated, including but not limited to, on the provider website, in writing to all affected providers as they are adopted and to all recipients and potential recipients upon request;

##### The standard/guidelines must address preventive dental services;

##### The standards/guidelines must be developed for the full spectrum of populations enrolled in the plan; and

##### 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.

#### Analysis of Clinical Care and Related Services

##### 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 must include the identified quality indicators and use clinical care standards or practice guidelines;

##### 

##### Multi-disciplinary teams are required, when appropriate, to analyze and address systems issues. The Vendor must have mechanisms in effect to assess quality and appropriateness of care furnished to recipients with special health care needs;

##### Clinical and related service areas requiring improvement are identified;

##### The vendor will work collaboratively with the DHCFP to determine recipient race and ethnicity. The vendor will organize interventions specifically designed to reduce or eliminate disparities in health care; and

##### The vendor shall allow the DHCFP access to clinical studies, when available and appropriate.

#### Implementation of Corrective Actions

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

#### These written corrective action procedures must include:

##### Specification of the types of problems requiring corrective action;

##### Specification of the person(s) or body responsible for making the final determinations regarding quality problems;

##### Specific actions to be taken; provision of feedback to appropriate health professionals, providers and staff;

##### The schedule and accountability for implementing corrective actions;

##### The approach to modifying the corrective action if improvements do not occur; and

##### Procedures for terminating the affiliation with the dental provider.

#### Assessment of Effectiveness of Plans of Correction (POC)

##### As actions are taken to improve care, the vendor must monitor and evaluate the POC to assure required changes have been made. In addition, changes in practice patterns must be monitored.

##### The vendor must assure timely follow-up on identified issues to ensure actions for improvement have been effective.

#### Evaluation of Continuity and Effectiveness of the IQAP

##### The vendor must conduct regular and periodic examina­tion of the scope and content of the IQAP to ensure that it covers all types of services in all settings;

##### At the end of each calendar year, a written report on the IQAP must be prepared and submitted to the DHCFP 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; and

##### The report should include evidence that quality assurance activities have contributed to significant improvements in the care delivered to recipients.

### 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:

#### Oversight of IQAP

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

#### 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.

#### 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.

#### 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 the DHCFP in the second calendar quarter and at minimum must include:

##### Studies undertaken;

##### Results;

##### Subsequent actions and aggregate data on utilization and quality of services rendered; and

##### An assessment of the IQAPs continuity, effectiveness and current acceptability.

#### Program Modification

Upon receipt of regular written reports delineating actions taken and improvements made, the Governing Body must take action when appro­priate, and direct 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.

### Active QA Committee

The IQAP must delineate an identifiable structure responsible for performing quality assurance functions within the vendor.

This committee or other structure must have:

#### Regular Meetings

The structure/committee must meet on a regular basis with a specified frequency, no less than quarterly to oversee IQAP activities. This frequency must be sufficient to demonstrate that the structure/committee is following up on all findings and required actions.

#### Established Parameters for Operating

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

#### Documentation

There must be records documenting the structure and committee’s activities, findings, recommendations and actions.

#### Accountability

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

#### Membership

There must be active participation in the IQAP committee from vendor providers, who are representative of the composition of the vendor’s providers.

### IQAP Supervision

There must be a designated senior executive who is responsible for IQAP implementation. The vendor’s Dental Director has involvement in quality assurance activities.

### Adequate Resources

The IQAP must have sufficient material resources and staff with the necessary education, experience, or training to effectively carry out its specified activities.

### Provider Participation in IQAP

#### Participating dentists and other providers must be kept informed about the written IQAP through provider newsletters and updates to the provider manual.

#### The vendor must include in its provider contracts and employment agreements, for dentists and non- dental providers, a requirement securing cooperation with the IQAP.

#### Contracts must specify that hospitals and other vendors will allow the vendor access to the Dental records of its recipients.

### 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 subcontractors or providers, it must:

##### Have a written description of the delegated activities, the delegate’s accountability for these activities, and the frequency of reporting to the vendor;

##### Have written procedures for monitoring and evaluating the implementa­tion of the delegated functions, and for verifying the actual quality of care being provided; and

##### Maintain evidence of continuous monitoring and evaluation, completed at least quarterly of delegated activities, including approval of quality improvement plans and regular specified reports.

### Credentialing and Recredentialing

The IQAP must contain provisions to determine whether dentists and other health care professionals, who are licensed by the State of Nevada and who are under contract to the vendor, are qualified to perform their services. These provisions are:

#### Written Policies and Procedures

The vendor will have written policies and procedures that include a uniform documented process for credentialing, 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.

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

#### Oversight by Governing Body

The Governing Body, or the group or individual to which the Governing Body has formally delegated the credentialing function, will review and approve the credentialing policies and procedures.

#### Credentialing Entity

The vendor will designate a credentialing committee, or other peer review body, which makes recommendations regarding credentialing decisions.

#### Scope

The vendor will identify those practitioners who fall under its scope of authority and action. This must include, at a minimum, all dentists and other licensed independent practitioners included in the vendor’s provider network.

#### Process

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

##### 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.

##### A Valid Drug Enforcement Administration (DEA) certificate for all practitioners authorized by the scope of their license to prescribe drugs.

##### Graduation from Dental school and completion of a residency, or other post-graduate training, as applicable.

##### Work history.

##### Professional liability claims history.

##### The practitioner holds current, adequate malpractice insurance according to the vendor’s policy.

##### Any revocation or suspension of a State license or DEA number.

##### Any curtailment or suspension of medical staff privileges (other than for incomplete Dental records).

##### Any sanctions imposed by the OIG or the DHCFP.

##### Any censure by any state or county Dental Association or any other applicable licensing or credentialing entity.

##### The vendor obtains information from the National Practitioner Data Bank, the Nevada State Board of Dental Examiners, any equivalent licensing boards for out- of-state providers, and any other applicable licensing entities for all other practitioners in the plan.

##### The application process includes a statement by the applicant regarding:

###### Any physical or mental health problems that may affect current ability to provide dental care;

###### Any history of chemical dependency/ substance abuse;

###### History of loss of license and/or felony convictions;

###### History of loss or limitation of privileges or disciplinary activity; and

###### An attestation to correctness/ completeness of the application.

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

##### There is an initial visit to each potential primary dental care practitioner’s office, including documentation of a structured review of the site and Dental record keeping practices to ensure conformance with the vendor’s standards.

##### 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 DHCFP Provider Enrollment Unit within fifteen (15) calendar days.

#### Recredentialing

A process for the periodic re-verification of clinical credentials (recredentialing, reappointment, or recertification) will be described in the vendor’s policies and procedures, including:

##### Evidence that the procedure is implemented at least every sixty (60) months.

##### 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 in required areas.

##### 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 current licensure, if applicable.

##### 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 related to fraud or abuse the DHCFP will notify HHS-OIG.

#### Delegation of Credentialing Activities

If the vendor delegates credentialing and recredentialing, recertification, or reappointment activities, there must be a written description of the delegated activities, and the delegate’s accountability for these activities. There must also be evidence that the delegate accomplished the credentialing activities. The vendor must monitor the effectiveness of the delegate’s credentialing and reappointment or recerti­fication process.

#### 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.

#### Reporting Requirement

The vendor must ensure 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.

#### Provider Dispute Process

The vendor must have a provider appeal process for instances wherein the vendor chooses to deny, reduce, suspend or terminate a practitioner’s privileges with the vendor.

### Recipient Rights and Responsibilities

The vendor must demonstrate a commitment to treating recipients in a manner that acknowledges their rights and responsibilities.

#### Written Policy on Recipient Rights

The vendor must have a written policy that recognizes the following rights of recipients:

##### To be treated with respect, and recognition of their dignity and need for privacy;

##### To be provided with information about the vendor, its services, the practitioners providing care, and recipients’ rights and responsibilities;

##### To be able to choose their primary Dental care practitioner;

##### To participate in decision-making regarding their dental care, including the right to refuse treatment;

##### To pursue resolution of grievances and appeals about the vendor or care provided;

##### To formulate advance directives;

##### To have access to his/her Dental 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;

##### To guarantee the recipient’s right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; and

##### To receive information on available treatment options and alternatives, presented in a manner appropriate to the recipient’s condition and ability to understand.

#### Written Policy on Recipient Responsibilities

The vendor must have a written policy that addresses recipients’ responsibility for cooperating with those providing dental services. This written policy must address recipients’ responsibility for:

##### Providing, to the extent possible, accurate and updated information needed by professional staff in caring for the recipient;

##### Following instructions and oral health care recommendations/ guidelines given by those providing dental services;

##### Recipient obligation to participate in their health care decisions; and

##### Recipient conduct and communication with a dental office including recipient’s responsibility to be on time for scheduled appointments, cancel appointments in a timely manner ie. 24-48 hrs ahead of scheduled appointment, report provider fraud/abuse, provide feedback on recipient needs and expectations, etc.

#### Communication of Recipient Policies to Providers

A copy of the vendor’s policies on recipients’ rights and responsibilities is provided to all participating providers upon initial credentialing and when significant changes are made.

#### Communication of Policies to Recipients

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

#### Recipient Grievance and Appeals Procedures

The vendor must have a system(s) linked to the IQAP for addressing recipients’ grievances and providing recipient appeals. This system must include:

##### Procedures for registering and responding to grievances and appeals within thirty (30) calendar days. Vendors must establish and monitor standards for timeliness;

##### Documentation of the substance of grievances, appeals, and actions taken;

##### Procedures ensuring a resolution of the grievance and providing the recipient access to the State Fair Hearing process for appeals;

##### Aggregation and analysis of grievance and appeal data and use of the data for quality improvement;

##### Compliance with DHCFP due process and fair hearing policies and procedures specific to Nevada Medicaid and Nevada Check Up recipients; and

##### Compliance with 42 CFR 438 Subpart F Grievance and Appeals.

#### Recipient Suggestions

An opportunity must be provided for recipients to offer suggestions for changes in policies and procedures.

#### Steps to Assure Accessibility of Services

The vendor must take steps to promote accessibility of services offered to recipients. These steps include:

##### The points of access to primary dental care, specialty care, are identified for recipients; and

##### At a minimum, recipients are given information about:

###### How to obtain services during regular hours of operations;

###### How to obtain urgent, emergency and after-hour care;

###### How to obtain emergency out-of-service area care;

###### How to obtain the names, qualifications and titles of the professionals who provide and are accepting Dental patients and/or are responsible for their care; and

###### How to access concierge services and assistance from the vendor when needed to gain access to care.

#### Information Requirements

##### Recipient information (for example, subscriber brochures, announcements, and handbooks) must be written at an eighth (8th) grade level that is readable and easily understood.

##### Written information must be available in the prevalent languages of the population groups served.

#### Confidentiality of Patient Information

The vendor must act to ensure that the confidentiality of specified patient information and records is protected. The vendor must:

##### Establish in writing, and enforce, policies and procedures on confidentiality, including confidentiality of Dental records;

##### Ensure patient care offices/sites have imple­mented mechanisms to guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the vendor;

##### 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:

###### It is required by law, or pursuant to a hearing request on the recipient’s behalf;

###### It is necessary to coordinate the recipient’s care with other dental care providers, physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; or

###### It is necessary in compelling circumstances to protect the health or safety of an individual.

##### Must report any release of information in response to a court order to the recipient in a timely manner; and

##### 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.

#### Treatment of Minors

The vendor must have written policies regarding the treatment of minors.

#### Assessment of Recipient Satisfaction

The vendor must conduct periodic surveys of recipient satisfaction annually with its services:

##### The survey(s) must include content on perceived problems in the quality, availability and accessibility of care.

##### The survey(s) assess at least a sample of:

###### All recipients;

###### Recipient requests to change practitioners and/or facilities; and

###### Disenrollment by recipients.

##### As a result of the survey(s), the vendor must:

###### Identify and investigate sources of dissatisfaction;

###### Outline action steps to follow up on the findings; and

###### Inform practitioners and providers of assessment results.

##### The vendor must re-evaluate the effects of the above activities.

### Standards for Availability and Accessibility

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

### Dental Record Standards

#### Accessibility and Availability of Dental Records

##### The vendor must include provisions in all provider contracts for HIPAA compliance with regard to access to Dental 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.

##### Records are available to dental practitioners at each encounter.

#### Record Keeping

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

##### Dental Record Standards – The vendor sets standards for Dental records. The records reflect all aspects of patient care, including ancillary services. These standards shall, at a minimum, include requirements for:

###### Patient Identification Information – Each page on electronic file in the record contains the patient’s name or patient ID number;

###### Personal/Demographic Data – Personal/biographical data includes: age, sex, race, ethnicity, primary language, disability status, address, employer, home and work telephone numbers, and marital status;

###### 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;

###### Past Dental History [for patients seen three (3) or more times] – Past Dental history is easily identified including serious accidents, operations, and illnesses. For children, past Dental history relates to prenatal care and birth and preventive services;

###### Diagnostic information;

###### Medication information;

###### Identification of Current Problems – Significant illnesses, Dental conditions and health maintenance concerns are identified in the Dental record;

###### 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;

###### 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 dentist/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;

###### Emergency care; and

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

History and Physical Examination – Comprehensive subjective and objective information obtained for the presenting complaints;

Plan of treatment;

Diagnostic tests;

Therapies and other prescribed regimens;

Follow-up – Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. A specific time to return is noted in weeks, months, or as needed. Unresolved problems from previous visits are addressed in subsequent visits;

Referrals and results thereof;

All other aspects of patient care, including ancillary services;

###### Entry Date – All entries must have date and time noted;

###### Provider Identification – All entries are identified as to author; and

###### Legibility – The record is legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.

#### Record Review Process

##### The vendor must have a system (record review process) to assess the content of Dental records for legibility, organization, completion and confor­mance to its standards; and

##### The record assessment system must address documentation of the items listed in Dental Records requirements above.

### Utilization Review

#### Written Program Description

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

#### Scope

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

#### Pre-Authorization Review Requirements

##### Pre-authorization decisions must be supervised by qualified Dental professionals;

##### Efforts must be made to obtain all necessary information, including pertinent clinical information, and consult with the treating dentist, as necessary;

##### The reasons for decisions must be clearly documented and available to the recipient;

##### The vendor’s prior authorization policies and procedures must be consistent with provision of covered medically necessary dental care in accordance with community standards of practice;

##### There must be 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;

##### Appeal and grievance decisions are made in a timely manner as warranted by the health of the enrolled recipient;

##### There are mechanisms to evaluate the effects of the program using data on recipient satisfaction, provider satisfaction or other measures;

##### Consistent with 42 CFR 438.210, 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 dental services to any recipient; and

##### If the vendor delegates responsibility for utilization manage­ment, it has mechanisms to ensure that the delegate meets these standards.

### Continuity of Care System

The vendor has put a basic system in place, which promotes continuity of care. 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 care coordination program, partnerships with primary care general dentists or pediatric dentists and specialists, other service providers and recipient participation, recipient/family outreach and education, and the ability to holistically address recipient’s health care needs. Care coordination must include not only the specific diagnosis, but also the complexities of multiple co-morbid conditions.

#### Information Technology System for Care Coordination:

The vendor’s information technology system for its care coordination program must maximize the opportunity for communication between the vendor, PDP, the patient, other service providers and care coordinators. The vendor must have an integrated database that allows vendor staff that may be contacted by a recipient 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, and case notes. For example, vendor recipient services staff must have access to a recipient’s case notes and recent utilization if contacted by that recipient. The information technology system must also have the capability to share relevant information (i.e. utilization reports, etc.) with the recipient, the PDP, and other service providers.

### IQAP Documentation

#### Scope

The vendor must document that it is monitoring the quality of care across all services and all treatment modalities, according to its written IQAP.

#### Maintenance and Availability of Documentation

The vendor must maintain and make available to the DHCFP, and upon request to the Federal Secretary of Health and Human Services or any federal or state regulatory entities, studies, reports, protocols, standards, worksheets, minutes, or such other documentation as requested concerning its quality assurance activi­ties and corrective actions.

### 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.

##### Quality assurance information is used in credentialing, recredentialing, and/or annual performance evaluations.

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

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

1. Network changes;

2. Benefits redesign;

3. Medical management systems (e.g., pre-certification);

4. Practice feedback to practitioners;

5. Patient education; and

6. Recipient services.

### Data Collection

The vendor must provide the DHCFP with uniform utilization, cost, quality assurance, and recipient satisfaction/complaint data on a regular basis, in accordance with 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.

#### Specific areas of study required will be stated in the contract or the DHCFP’s Quality Assessment and Performance Improvement Strategy.

#### Data or studies must be submitted by the required due date, and be accurate and complete.

#### Monitoring and tracking of grievance/appeal information are required by due date.

### Dispute Resolution

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

#### The vendor must resolve ninety percent (90%) of written, telephone or personal contacts within ninety (90) calendar days of the date of receipt with appropriate follow up to provider.

#### A written record in the form of a file or log is to be maintained by the vendor for each provider dispute to include the nature of it, the date filed, dates and nature of actions taken, and final resolution.

## STATE QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY

### The DHCFP has 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. Section E. The State’s 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 recipients in the state.

### The purpose of this quality strategy is to:

#### CFR 438.Section E – State Responsibilities

##### Have a written strategy for assessing and improving the quality of PAHP services offered by the DBA (vendors);

##### 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;

##### Ensure that the vendors comply with standards established by the DHCFP;

##### Conduct periodic reviews to evaluate the effectiveness of the strategy, and update the strategy at a minimum of every three years or, as needed;

##### 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; and

##### 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 438.330– Elements of State Quality Strategies

Quality of care activities will be monitored through information obtained in a quarterly DBA Care Coordination Report. These activities may include monitoring and technical assistance through site visits to the vendor, Chart audits, phone calls, etc. The DHCFP may validate the DBA Care Coordination report and may conduct a more in-depth review and/or request additional information.

##### The Strategy incorporates procedures that:

###### Assess the quality and appropriateness of care and services furnished to all of the DHCFP dental program recipients enrolled with the vendor;

###### Require the vendor to 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 the DHCFP, to all recipients 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. The 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 the 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 the 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;

###### Monitor and evaluate the contracted vendors’ compliance with the standards. It will include a description of how the DHCFP will complete this monitoring in line with the Strategy;

###### Arrange for external quality reviews including a description of the annual independent external quality review of the timeliness, outcomes, and accessibility of the services covered under each vendor contract. This section should include but is not limited to a broad description of calculating measures or designing performance improvement projects;

###### That designates the performance measures and levels developed by CMS in consultation with States and other relevant stakeholders;

###### Designates an information system that supports the initial and ongoing operation and review of the DHCFP’s quality strategy;

###### Designates a description of how the DHCFP uses intermediate sanctions in support of its quality strategy. These sanctions 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

###### Identifies standards, at least as stringent as those in 42 CFR Parts 438 for access to care, structure and operations, and quality measurement and improvement.

## FISCAL REQUIREMENTS

### 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 PAHP standards described in this section.

### Performance Security Deposit

The vendor must 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 the DHCFP in order to guarantee payment of the vendor’s obligations under this contract. The performance security deposit may be utilized by the DHCFP to remedy any breach of contract or sanctions imposed on the vendor.

#### An initial deposit of $4,000,000 must be deposited within ten (10) business days following award of the contract to the vendor, as stated in the ***Attachment E ~ Insurance Schedule***. This amount must be reviewed at the end of the first quarter of the contract period and may need to be increased or decreased to equal the actual required security deposit amount.

The amount of the performance security deposit shall be equal to one hundred and ten percent (110%) of the highest month’s total capitation amount in the first quarter or four million dollars ($4,000,000), 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 recipients for the month.

#### After the initial year of the contract the 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 four million dollars ($4,000,000), whichever is greater.

#### Vendors submitting performance security to the State of Nevada in the form a surety bond must utilize a company that meets the following listed requirements:

##### A.M. Best A-VII rated insurance company;

##### Certified by the Department of Treasury, Financial Management Services for Nevada; and

##### Licensed by the Nevada Department of Business and Industry, Division of Insurance.

#### The vendor must maintain the performance security deposit after the contract term for a length of time to be determined by the DHCFP in order to cover all outstanding liabilities.

### Vendor Liability

The requirements set forth below shall be included in all subcontracts.

#### The vendor must ensure that its recipients are not held liable for any of the following:

##### The vendor’s debts, in the event of the vendor’s insolvency;

##### For services provided to the recipient in the event of the organization failing to receive payment from the State for such services;

##### For services provided to a recipient 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

##### 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.

#### To ensure continuation of services to recipients during insolvency pursuant to the Center for Medicare and Medicaid State Medicaid Manual (SMM) 2086.6.B.

### Payment of Claims

#### 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 PAHP contract or the Nevada Medicaid State Plan. The vendor will adjudicate and pay all claims in accordance with state and federal statutes and regulations. Not meeting all federal requirements, including those for timely claims payment, may be considered a breach.

#### In cases where third party liability is known, the vendor must ensure that third party liability has been billed and processed prior to paying the claim.

#### 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. In addition, the vendor shall have the capability to electronically accept and adjudicate claims.

#### The vendor must allow network and non-network providers to submit an initial claim for covered services. The vendor must allow all in-state network providers to submit claims for reimbursement up to one hundred eighty (180) days from the last date of service and out of state providers three hundred sixty-five (365) days from the last date of service unless a shorter time period is negotiated. The vendor’s claims payment system must use standard claim forms.

#### 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 must pay ninety-five percent (95%) of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within thirty (30) calendar days of the date of receipt. The vendor must pay ninety-nine percent (99%) of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within ninety (90) calendar days of the date of receipt.

The date of receipt is the date the vendor receives the claim as indicated by the date stamp on the claim and the date of payment is the date of the check or other form of payment.

#### The vendor must have written policies and procedures for processing claims submitted for payment from any source and shall monitor its compliance with these procedures.

#### The vendor’s claims processing system must ensure that duplicate claims are denied. In addition, this system must include edits to not allow for unbundling and the ability to pay certain State or local government providers the federal share only.

#### The vendor agrees to the terms of any contract entered into as a result of this RFP to pay interest to a provider of dental services on a claim that is not paid within the time provided in the contract or agreement at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus six percent (6%). The interest must be calculated from thirty (30) days after the date on which the claim is approved until the date on which the claim is paid.

#### 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. If the vendor does not pay claims in accordance with 42 CFR 447.45d, the DHCFP may assess a financial penalty for each day the vendor is out of compliance.

#### The vendor shall accurately pay claims with ninety-five percent (95 %) of claims paid accurately upon initial submission.

#### The vendor shall verify that reimbursed services were actually provided to enrolled recipients by providers and subcontractors.

#### The vendor shall provide the 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.

#### 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 dental clinician(s).

#### The vendor shall comply with 42 CFR 447.26, on Provider Preventable Conditions (PPCs) – Payment Policy. The vendor shall deny or recover payments to healthcare professionals and inpatient hospitals for care related to the treatment of the consequences of PPCs and Other Provider Preventable Conditions (OPPC) that meet the following criteria:

##### Is identified in the Medicaid State plan;

##### Has been found by the DHCFP, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;

##### Has a negative consequence for the recipient;

##### Is auditable;

##### Includes, at minimum, wrong surgical or other invasive procedure performed on a patient;

##### Surgical or other invasive procedure performed on the wrong body part; and

##### Surgical or other invasive procedure performed on the wrong patient.

### 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 the DHCFP with various financial statements and documentation upon request and as outlined in the contract and ***Attachment T, Forms and Reporting Guide***, including any revisions or additions to the document.

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

#### The vendor will submit its quarterly and annual financial reports to the DHCFP.

### Third-Party Liability (TPL)

#### 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 activities included in this contract are the Coordination of Benefits (COB) cost avoidance of Medicaid claims. 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.

#### Nevada Medicaid shall be the payer of last resort of all covered services in accordance with Federal regulations. The DHCFP contracted DBA, as the Division’s vendor, shall act as the State’s authorized agent for the limited purpose of TPL for cost avoiding claims, 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 433.154.  The vendor’s capitated payments include an offset in the rates for these collections. The contracted vendor shall vigorously pursue billing prior resources as these amounts are considered part of their risk based capitation payment. The vendor 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.) and share that information with the DHCFP. Third-party liability (TPL) is a self-reporting element. Vendors are responsible for developing and distributing communication forms to enrolled Medicaid recipients.

#### The vendor shall identify potential TPL, including Medicare, and deny the claim if it is for a service covered by other insurance based on recipient's type of TPL coverage and type of service. Allow for TPL overrides when the other insurance is exhausted or the service is not covered by the other liable party, making Medicaid the payer of last resort for the claim.

#### The DBA PAHP is required to vigorously pursue billing prior resources. Vendor is required to obtain TPL information independently of the DHCFP for the purpose of avoiding claim payments or recovering payments made from liable third parties. All information on the third party, including collections and collection attempts, are to be reported to the DHCFP (including circumstances under which the third party refuses to pay) on the Third Party Monthly Report located in the Forms and Reporting Guide. TPL collections should also be reported to the DHCFP through encounter data and other required reports.

#### The vendor is responsible not only for pursuing third-party resources that it identifies but also for using third-party resources identified and communicated to the DBA PAHP by the DHCFP.

#### TPL recoveries made by either the vendor or the DHCFP will be incorporated into capitated rate development by the DHCFP and its actuary. The vendor has 365 days from claim paid date to recover TPL payment; after 365 days, vendor forfeits the right to recovery to the State unless vendor can provide evidence that the recovery effort is active and/or in dispute. The vendor will be responsible to pay for the cost incurred to complete the recovery of the TPL payment to the DHCFP.

#### The vendor will maintain the minimum historical TPL eligibility data online in accordance with State and Federal rules and regulations, currently established as seventy-two (72) months.

#### Exceptions to the TPL rule are: Indian/Tribal Health Services (IHS); Children with Special Health Care Needs (CSHCN); and State Victims of Crime.

#### Ensure that all existing and new requirements of the MSM, CMS State Medicaid Manual and other State and Federal rules and regulations are met by the TPL business function.

### Subrogation

#### Subrogation in this section 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 vendor must also determine if casualty claims are filed and recover costs through subrogation on behalf of both Medicaid and CHIP recipients. The DBA PAHP shall utilize the EVS eligibility system and TPL data provided to the vendor by the DHCFP to assist in accomplishing this objective.

#### The DHCFP will monitor and evaluate the vendor’s TPL and subrogation collection reports to validate collection activities and results. The vendor will then be expected to meet or exceed baseline target collections as determined by the DHCFP and its actuaries.  The baseline target amount will be built into future rates. If the vendor does not meet or exceed baseline TPL and subrogation collections, the 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 vendor’s costs before the data is used to set future rates.  The DHCFP will prospectively adjust capitation rates to account for expected TPL collections.

### 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 (IBNRs) claims. The vendor must provide documentation of the IBNRs review and certification by an actuary. The vendor must reserve funds 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.

### 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 Medicaid 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 Medicaid State Plan to financial institutions or entities such as provider bank accounts or business agents located outside of the U. S. 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 Medicaid 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 Medicaid 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.

## GRIEVANCES, APPEALS AND FAIR HEARINGS

### The vendor shall establish a system for recipients and providers, which includes a grievance process, an appeal process, and access to the State Fair Hearing system.

#### A grievance is an expression of dissatisfaction about any matter other than one of the actions listed below. Possible issues for grievances include, but are not limited to, access to care, quality of services, interpersonal relationships between vendor staff and recipients or providers, and failure to respect a recipient’s rights.

#### An appeal is a specific request for review of one of the following actions:

##### The denial or limited authorization of a requested service, including the type or level of service;

##### The reduction, suspension or termination of a previously authorized service;

##### The denial, in whole or in part, of payment for a service;

##### The failure to provide services in a timely manner; or

##### The failure of a vendor to process grievances, appeals or expedited appeals within required timeframes including resolution and notification.

#### The vendor must provide information about these systems to recipients at the time of enrollment. The vendor must inform providers and subcontractors at the time they enter into a contract.

##### This information must include:

###### The recipient’s right to file grievances and appeals; the requirements and timeframes for filing;

###### The availability of assistance with filing;

###### The recipient’s right to request continuation of benefits during an appeal or State Fair Hearing although the recipient may be liable for the cost of any continued benefits if the action is upheld;

###### The toll free number to file oral grievances and appeals; and

###### Any DHCFP determined provider’s appeal rights to challenge the failure of the organization to cover a service.

#### The vendor must submit to the DHCFP monthly and quarterly reports that document the grievance and appeal activities listed on the templates located in ***Attachment T, Forms and Reporting Guide***. The report should be broken out by hearing issue, date requested and date resolved, program and outcome for tracking, trending and corrective action.

#### The vendor shall have a contact person who is knowledgeable of the grievance and appeal procedures and shall direct all grievance and appeals, whether verbal or the recipient chooses to file in writing. Should a recipient choose to appeal in writing, the recipient shall be instructed to file via mail or fax to the designated P.O. Box or fax number for medical appeals.

#### The vendor shall have sufficient support staff (clerical and professional) available to process grievance and appeals in accordance with the requirements. The vendor shall notify the DHCFP of the names of appointed staff recipients and their phone numbers. Staff shall be knowledgeable about the applicable state and federal law, vendor's rules and regulations, and all court orders governing appeal procedures, as they become effective.

#### The DHCFP shall conduct an annual audit of the appeals process to ascertain compliance with federal and state regulations as well as contractual compliance.

### Recipient Grievances and Appeals

The authority for the following provisions concerning Recipient 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), 483.23(a) (5) (ii), and 438.404(c) (4).

#### The vendor’s recipient grievance and appeal system must be in writing and submitted to the DHCFP for review and approval at the time the Vendor’s Policies and Procedures are submitted, and at any time thereafter when the vendor’s recipient 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 recipient grievance and appeal system without first obtaining the written approval of the DHCFP.

#### The vendor must allow the recipient, or provider acting on behalf of the recipient, to file an appeal within a reasonable State-defined timeframe that cannot be less than twenty (20) calendar days or exceed ninety (90) calendar days from the date on the entity’s notice of action.

#### The vendor must continue the recipient’s benefits while an appeal is in process if all of the following conditions are met:

##### The appeal is filed on or before the later of the following: a) within ten (10) calendar days plus mailing time of the vendor mailing the Notice of Action; or b) the intended effective date of the vendor’s proposed action;

##### The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

##### The services were ordered by an authorized provider;

##### The authorization period has not expired; and

##### The recipient requests continuation of benefits.

#### The vendor must continue or reinstate the recipient’s benefits while the appeal is pending, and the benefits must be continued until one of the following occurs:

##### The recipient withdraws the appeal;

##### The recipient does not request a State Fair Hearing with continuation of benefits within 10 days from the date the Vendor mails an adverse appeal decision;

##### A State Fair Hearing decision adverse to the recipient is made, or

##### The service authorization expires or authorization limits are met.

#### A recipient or a recipient’s representative (including a provider on behalf of a recipient) 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 recipient’s behalf, with the exception of an expedited appeal, the provider must first obtain the recipient’s written permission.

#### In the case of appeals, the recipient, if after exhausting the vendor’s appeal process, is 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 a recipient’s appeal is not resolved in favor of the recipient. Grievances are not eligible for referral to the State Fair Hearing process.

#### A recipient, or a provider acting on behalf of the recipient, may file an appeal or grievance either orally or in writing. Unless the recipient has requested an expedited resolution, an oral appeal may be followed by a written, signed appeal. The vendor may not require a written signed appeal following an oral request for an expedited 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.

### Authorization and Notice Timeliness Requirements

#### The vendor must provide standard authorization decisions as expeditiously as the recipient’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 recipient 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 recipient’s interests. The vendor must provide written notice of the reason for the extension and inform the recipient of their right to file a grievance.

#### For cases in which a provider indicates or the vendor determines that following the standard timeframe could seriously jeopardize the recipient’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 recipient’s health condition warrants and no later than seventy-two (72) hours after receipt of the request for service. The vendor may extend the (72) hours’ time period by up to fourteen (14) calendar days if the recipient requests an extension or if the vendor justifies (to the DHCFP upon request) a need for additional information and how the extension is in the recipient’s best interest. The vendor must provide written notice of the reason for the extension and inform the recipient of their right to file a grievance.

### Notice of Action

#### The vendor must provide a written Notice of Action to the recipient when the vendor takes action or makes an adverse determination affecting the recipient. If a provider has made a request on a recipient’s behalf and the vendor makes an adverse determination, the provider must be notified but this notification need not be in writing.

#### The notice must meet all of the following requirements:

##### Be available in the State-established prevalent non-English languages;

##### Be available in alternative formats for persons with special needs (visually impaired recipients, or recipients with limited reading proficiency); and

##### Use easily understood language and format requirements of 42 CFR 438.404(c); 42 CFR 438.10(c) and (d).

#### A written Notice of Action to the recipient must meet the following requirements and must explain:

##### The action the vendor or its subcontractor has taken or intends to take;

##### The reasons for the action;

##### The recipient’s or the provider’s right to file an appeal, if he/she disagrees with decision;

##### The recipient’s right to request a State Fair Hearing after the recipient has exhausted the vendor’s internal appeal procedures;

##### The procedures for exercising the recipient’s rights to appeal;

##### The circumstances under which expedited resolution is available and how to request it;

##### The recipient’s rights to have benefits continue if the appeal is filed on or before the latter of the following: within ten (10) calendar days of the vendor mailing the Notice of Action or the intended effective date or the proposed action pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the recipient may be required to pay the costs of these services;

##### That the recipient may represent himself or use legal counsel, a relative, a friend, or other spokesman;

##### The specific regulations that support, or the change in federal or State law that requires the action; and

##### The recipient’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) calendar 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 recipient fraud has been verified.

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

##### In the death of the recipient;

##### A signed written recipient statement requesting termination or giving information requiring termination or reduction of services (where the recipient understands that this must be the result of supplying that information);

##### The recipient’s admission to an institution where he is ineligible for Medicaid services;

##### The recipient’s address is unknown and mail directed to him has no forwarding address; or

##### The recipient has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.

#### The vendor must give a Notice of Action on the date of action when the action is a denial of payment.

#### 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.

#### The recipient’s right to receive written resolution notice that includes the results of the process and the date it was completed. In addition, reasonable efforts shall be made to provide oral resolution notice.

#### For appeals not resolved wholly in favor of the recipients, the notice must include:

##### The right to request a State Fair Hearing, and how to do so;

##### The right to request to receive benefits while the hearing is pending, and how to make the request; and

##### That the recipient may be held liable for the cost of those benefits if the hearing decision upholds the vendor's action.

### Handling of Grievances and Appeals

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

#### Standard disposition of grievances: The vendor is allowed no more than ninety (90) calendar days from the date of receipt of the grievance.

#### Standard resolution of appeals: The vendor is allowed no more than thirty (30) calendar days from the date of receipt of the appeal.

#### Expedited resolution of appeals: The vendor must resolve each expedited appeal and provide notice, as expeditiously as the recipient’s health condition requires, not to exceed three (3) business days after the vendor receives the expedited appeal request. 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 recipient’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 requests an expedited resolution or supports an appeal. If the vendor denies a request for an expedited resolution of an appeal, it must transfer the appeal to the standard timeframe of no longer than thirty (30) calendar days from the day the vendor receives the appeal (with a possible fourteen (14) calendar day extension) for resolution of appeal and give the recipient prompt oral notice of the denial and follow up within two (2) calendar days with a written notice.

##### The vendor must inform the recipient 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.

##### These time frames may be extended up to fourteen (14) calendar days if the recipient 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 recipient’s interests. If the State grants the vendor’s request for an extension, the vendor must give the recipient written notice of the reason for the delay.

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

##### The vendor must provide recipients any reasonable assistance in completing forms and taking other procedural steps, including assisting the recipient and/or the recipient’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 teletypewriter (TTY)/ Telecommunications device for the deaf (TDD) and interpreter capability;

##### Acknowledge receipt of each grievance and appeal;

##### Ensure that the individuals, or their subordinates, who make decisions on grievances and appeals were not involved in any previous level of review or decision-making; and

##### Ensure that the individuals who make decisions on grievances and appeals are health care professionals who have the appropriate clinical expertise in treating the recipient’s condition or disease if the grievance or appeal involves any of the following:

###### An appeal of a denial that is based on medical necessity;

###### A grievance regarding the denial of an expedited resolution of an appeal; or

###### A grievance or appeal that involves clinical issues.

#### The process for appeals also requires:

##### 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 recipient requests expedited resolution;

##### That the recipient is provided a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing, and that the recipient is informed by the Vendor of the limited time available for this in the case of expedited resolution;

##### That the recipient and his/her representative is provided the opportunity, before and during the appeals process, to examine the recipient’s case file, including medical records, and any other document and records considered during the appeals process; and

##### The vendor to include, as parties to the appeal, the recipient and his/her representative or the legal representative of a deceased recipient’s estate.

#### The vendor shall notify the recipient of the disposition of the grievance and appeal 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 recipient, the notice must also include:

##### The right of the recipient to request a State Fair Hearing from the DHCFP and how to do so;

##### The right to request to receive benefits while the hearing is pending and how to make this request; and

##### That the recipient may be held liable for the cost of those benefits if the State Fair Hearing’s 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 DHCFP will review as part of the Division’s quality strategy.

#### The vendor shall devote a portion of its regularly scheduled Quality Management / Quality Improvement committee meetings to the review of recipient complaints and appeals that have been received.

### State Fair Hearing Process

#### The State Fair Hearing process is described in MSM Chapter 3100. A recipient, recipient’s representative or the representative of a deceased recipient’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 is required to inform the recipient of their right to a State Fair Hearing, how to obtain such a hearing, and representation rules must be explained and provided in writing to the recipient 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 vendor will participate in the State Fair Hearing process, at the vendor’s expense, in each circumstance in which a recipient 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.)

### Continuation of Benefits While the Vendor’s Appeal Process and the State Fair Hearing are Pending.

#### The vendor must continue the recipient’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:

##### The appeal is submitted to the vendor on or before the later of the following: within ten (10) days plus mailing time, of the vendor mailing the Notice of Action; or, the intended effective date of the vendor’s proposed action;

##### The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

##### The services were ordered by an authorized provider;

##### The original periods covered by the original authorization have not expired; and

##### The recipient requests an extension of benefits.

#### If, at the recipient’s request, the vendor continues the recipient’s benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

##### The recipient withdraws the appeal;

##### Ten (10) days pass after the vendor mails the notice of action, providing the resolution of the appeal against the recipient, unless the recipient, within the 10-day timeframe has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached;

##### A State Fair Hearing Officer issues a hearing decision adverse to the recipient; and

##### 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 recipient, the vendor may recover the cost of the services furnished to the recipient 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 recipient’s health condition requires. If the vendor or State Fair Hearing Officer reverses a decision to deny authorization of services, and the recipient received the disputed services while the appeal was pending, the vendor must pay for those services.

### 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 recipients. 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 any time 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.

#### 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:

##### Ninety (90) calendar days after a grievance is filed; and

##### Thirty (30) calendar days after an appeal is filed.

#### State Fair Hearings

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). A State Fair Hearing decision will be made within ninety (90) calendar days from the date of request for direct access to a State Fair Hearing. Disputes eligible for the State Fair Hearing process include:

##### Denial or limited authorization of a requested service;

##### Reduction, suspension or termination of a previously authorized service;

##### Denial, in whole or in part, of payment for a service;

##### Demand for recoupment;

##### Failure of the vendor to meet specified timeframes (e.g., authorization, claims processing, appeal resolution); and

##### The denial for disenrollment for good cause.

### Expedited State Fair Hearing

#### The State’s timeframe for reaching an expedited State Fair Hearing decision when the appeal was first heard through the Vendors appeal process is as expeditiously as the recipient’s health condition requires, but no later than three (3) working days from the State’s receipt of a hearing request for a denial of service that:

##### Meets the criteria for an expedited appeal process but was not resolved within the vendor’s expedited appeal timeframes, or

##### Was resolved wholly or partially adversely using the vendor’s expedited appeal timeframes.

#### The State’s timeframe for reaching an expedited State Fair Hearing decision when the appeal was made directly to the State’s Fair Hearing process without accessing the vendor appeal Process is as expeditiously as the recipient’s health condition requires, but no later than 3 working days from the State’s receipt of a hearing request for a denial of service that meets the criteria for an expedited 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 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.

## MANAGEMENT INFORMATION SYSTEM (MIS)

### 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.

### 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 the DHCFP with aggregate performance and outcome data, as well as its policies for transmission of data from network providers as outlined in this RFP, Reporting Guide and Attachments. The vendor shall have internal procedures to ensure that data reported to the DHCFP are valid and to test validity and consistency on a regular basis.

### Eligibility Data

#### 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.

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

#### The vendor shall notify the DHCFP if the addresses of recipients are not accurate.

### Encounter and Claims Records

#### The encounter data reporting system must 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.

#### The vendor shall collect and submit service specific encounter data in the appropriate American Dental Association (ADA) Claims Form format or an alternative format if prior approved by the DHCFP. The data submitted to the actuary must balance with the data submitted to the DHCFP. The data shall be submitted in accordance with the requirements set forth in the contract. The data shall include all services reimbursed by Medicaid.

### Data Requirements and Certification

#### All encounter data must be submitted to the DHCFP or designated contractor per EDI standards and federal regulations.

#### All encounter data must reflect all adjustments and voids.

#### Regardless of collection status, all improper payments must be adjusted or voided from the encounter data within timeframes specified by the DHCFP.

#### The contract requires the vendor to certify enrollment information, encounter data, payment data, and other information submitted to the State for purposes of developing vendor payment. Data must comply with the applicable certification requirements for data and documents specified by DHCFP pursuant to 42 C.F.R. § 438.604, 438.606 and 457.950. A certification, which attests, based on best knowledge, information, and belief that the data are accurate, complete and truthful as required by the State for participation in the Medicaid program and constrained in contracts, proposals and related documents.

#### The data submitted to the state by the vendor for purposes of determining vendor payments must be certified by one of the following:

##### The vendor’s Chief Executive Officer;

##### The vendor’s Chief Financial Officer; or

##### An individual who has delegated authority to sign for, and who reports directly to the vendor’s Chief Executive Officer or the Chief Financial Officer.

#### Compliance with the requirement of data certification in this agreement is a condition for payment by the government. The vendor must agree that he/she has read and understands the data certification requirement and agree to comply with all applicable laws and regulations.

### 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 the DHCFP.

## OPERATIONAL REQUIREMENTS

### Dental Director's Office

The vendor must designate a Dental 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 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-employee 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 Internal Quality Assurance Plan Committee are accountable to the vendor's governing body. The Dental Director must be licensed to practice dentistry in the State of Nevada.

### The responsibilities of the Dental Director include the following:

#### Serves as co-chairman of the vendor's Utilization Management and Quality Assurance Plan committee;

#### 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’ recipients receive;

#### Oversees the development and revision of the vendor's clinical care standards and practice guidelines and protocols;

#### Reviews all potential quality of care problems, and oversees the development, and implementation of, as well as the adherence to, Plans of Correction;

#### Oversees the vendor's referral process for specialty and out-of-network services. All services prescribed by a PDP or requested by a recipient which are denied by the vendor must be reviewed by a dentist with the reason for the denial being documented and logged;

#### Oversees the vendor's provider recruitment and credentialing activities;

#### 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;

#### Serves as the vendor’s consultant to dental staff with regard to referrals, denials, grievances and problems;

#### Ensures coordination of out-of-network services; and

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

### Vendor Operating Structure and Staffing

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

#### Provide the 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. The State must approve all awarded vendor key staff. The State reserves the right to require the removal of any member of the awarded vendor's staff from the project.

#### 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:

##### Executive management;

##### Operations Manager;

##### Accounting and budgeting;

##### Dental Director's office;

##### Dental Management, including quality assurance/utilization review;

##### Recipient services;

##### Provider services;

##### Grievances, appeals, and fair hearings;

##### Claims processing;

##### Management information systems (MIS); and

##### Program Integrity.

#### 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:

##### Administrator;

##### Chief Financial Officer;

##### Dental Director;

##### Recipient Services Manager;

##### Provider Services Manager;

##### Grievance and Appeals Coordinator;

##### Claims Administrator; and

##### Nevada Operations Manager.

### 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:

#### All subcontracts must fulfill the requirements of 42 CFR 438 that are appropriate to the service or activity delegated under the subcontract;

#### 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;

#### 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 $25,000 for each incident;

#### 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;

#### 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;

#### 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;

#### 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;

#### 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;

#### Notify DHCFP, in writing, immediately upon notifying any material subcontractor of the vendor’s intention to terminate any such subcontract;

#### Within thirty-five (35) 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;

#### 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; and

#### 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.

### Implementation

#### Vendor Plan

The vendor shall:

##### 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.

##### 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.

##### Unless otherwise agreed to by the DHCFP, submit to the DHCFP no less than ten (10) business days prior to the service start date, all deliverables to allow for timely DHCFP identified modifications.

##### Beginning no later than sixty (60) 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.

##### Ensure that all workplace requirements the 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.

##### Ensure that there is no interruption of covered services to enrolled recipients and work cooperatively with the DHCFP to meet these requirements.

##### 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 for recipient access and remains in operation for the duration of the contract, unless otherwise directed or agreed to by the 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.

##### Establish and implement enrollment procedures and maintain applicable enrolled recipient data.

##### Establish its Provider Network and maintain existing Provider Agreements with such Providers.

#### Pre-Implementation Readiness Review

DHCFP may conduct Operational and Financial Readiness Reviews on all awarded vendors and will, subject to the availability of the 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; recipient services; provider network; quality improvement; and, management information systems, including claims processing and reporting systems. The vendor shall provide necessary documentation specified by the DHCFP and cooperate with the DHCFP or its designees in conducting the review. The 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.

### Presentation of Findings

The vendor must obtain the 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.

### Vendor Marketing Materials

#### The vendor may develop marketing materials for distribution during any open enrollment period. The vendor must request and obtain permission from the 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 recipients. Vendors are also prohibited from providing materials that contain false or misleading information, and from initiating cold calls to potential recipients.

#### The vendor may not distribute, in any manner, marketing materials related to the managed care program without the prior written approval of the 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 to ensure that, before enrolling, the potential recipient 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 recipients or potential recipients or the DHCFP. Statements that will be considered inaccurate, false, or misleading include but are not limited to any assertion or statement that:

##### The recipient must enroll with the vendor in order to obtain benefits or in order not to lose benefits; or

##### The vendor is endorsed by CMS, the federal or state government, or similar entity.

## PROGRAM INTEGRITY

### General Requirements and Authorities

#### The vendor shall have internal controls for Program Integrity including a Program Integrity Unit (PIU) designed to identify, review, recover and report improper payments, including fraud, waste and abuse (FWA) activities, on an ongoing basis.

#### The vendor must be familiar with and compliant with all federal and state regulations related to Program Integrity, as well as all Nevada Medicaid policies. The Vendor must also require compliance from subcontractors and providers for the same. Medicaid payments to vendors are government funds, funded by federal and state money. These payments made by State Medicaid to vendor entities, including but not limited to pre-paid plans, subcontractors to PAHP, and any sub-subcontractors, and providers of medical services, supplies or drugs, for the benefit of Medicaid recipients may be recovered if obtained by fraud. Any act of health care fraud involving such government funds will be subject to prosecution by the State Attorney General's Office under the State False Claims Act ("FCA''), as well as any other applicable laws. Relevant citations for Program Integrity compliance include, but are not limited to, the citations below.

##### Sections 1128, 1156, and 1902(a)(68) of the Social Security Act;

##### 42 C.F.R.§ 438, Subpart H;

##### 42 C.F.R. § 455 Subpart A, B and E;

##### 42 C.F.R. § 1000 through 1008;

##### 42 C.F.R. § 456.3, 456.4. 456.23;

##### 42 C.F.R. § 457.950(a)(2);

##### Section 6032 of the Federal Deficit Reduction Act of 2005;

##### Nevada Revised Statutes, Chapter 422;

##### Nevada DHCFP Medicaid Services Manual; and

##### Nevada DHCFP Medicaid Billing Guides.

### 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 PDP and specialists and other health care professionals are licensed by the State of Nevada and qualified to perform the services. The vendor may not employ or contract with providers excluded from participation in the federal health care programs under Section 1128 of the Social Security Act.

##### Provide credentialing criteria for review and approval by DHCFP’s Provider Enrollment unit ninety (90) calendar days prior to the start of the contract and ensure that all network providers meet the criteria. Changes to the credentialing process will need to be provided in writing to the DHCFP’s Provider Enrollment unit thirty (30) calendar days prior to the change. If the change is unanticipated, the vendor will notify the DHCFP’s Provider Enrollment unit within five (5) calendar days of the change.

##### Provide Credentials for network providers, subcontractors, or subcontractor’s providers to the DHCFP and/or MFCU upon request, at no cost.

### Provider Enrollment

#### The vendor must comply with federal requirements including the Patient Protection and Affordable Care Act (PPACA) of 2010 for Medicaid enrollments.

#### The vendor may enroll new providers. A provider who is a non-Medicaid provider that has been enrolled by the vendor must be referred to Nevada Medicaid’s fiscal agent for enrollment. Although the vendor may enroll a provider prior to the provider enrolling as a Medicaid provider, the provider is not permitted to provide services to the Medicaid DBA recipients until the provider is enrolled with Nevada Medicaid’s fiscal agent.

#### All providers, both within the state of Nevada and outside the state of Nevada, are required to maintain a license in good standing in the state where services are provided.

#### The vendor may need to enter into single case agreements with non-Medicaid providers as needed. These single case agreements must be reported to the DHCFP.

#### Provider Terminations. If a provider is disenrolled, de-credentialed, terminated or removed from the active Provider List, the vendor at a minimum must provide the DHCFP the basis, reasons or causes for such action and any and all documentation, data, or records obtained, reviewed, or relied on by the vendor including, but not limited to: provider/patient files; audit reports and findings; and medical necessity reviews.

#### On a monthly basis, no later than the tenth (10) calendar day of the month, the vendor will submit to the DHCFP a list of all providers who have been enrolled and a list of all providers who have disenrolled, deactivated, terminated, de-credentialed or been removed from the active provider enrollment. If the provider has been terminated, de-credentialed or disenrolled, the cause and all required documentation of the termination will be supplied to the DHCFP within five (5) business days of the decision to terminate.

### Provider Contracts

#### The Vendor must 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.

#### The Vendor must provide, for the DHCFP 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 the DHCFP for review. Provider contracts must meet all state and federal requirements. The Vendor shall submit any of its provider contracts to the DHCFP within 5 business days upon request.

#### 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 the DHCFP's dental program or have a signed agreement but do not actively accept eligible recipients.

#### 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 dental management standards. The vendor must submit these policies and procedures to the DHCFP within 5 business days upon change of policies and procedures or upon request.

#### Provider contracts must not be structured to provide financial or other incentives to providers and subcontractors for denying, reducing or limiting medically necessary services.

#### The use of “gag” clauses in Provider contracts is prohibited.

#### All provider contracts must be made available to the DHCFP and / or MFCU within five (5) business days upon request.

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

##### Initial and ongoing credentialing;

##### Adding, deleting, and periodic contract renewal;

##### Provider education; and

##### Discipline/termination, etc.

#### 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 dental management standards.

#### The vendor must take appropriate action related to dual FFS and DBA network providers and provide all documentation related to any disciplinary action, sanction, de-credentialing, removal from the provider panel to DHCFP in a time and manner as determined by the DHCFP as follows:

##### 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 the DHCFP’s Provider Enrollment Unit;

##### The vendor is required to check the Office of the Inspector General (OIG) website and DHCFP's excluded Provider list at least monthly to confirm its network providers have not been sanctioned by the OIG or by the DHCFP; and

##### 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.

### Affiliations with Debarred or Suspended Persons

#### Monitoring for Prohibited Affiliations

##### The vendor may not employ or contract with providers excluded from participation in federal healthcare programs.

##### The vendor may not be controlled by a sanctioned individual.

##### The vendor may not have a contractual relationship that provides for the administration and management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly and indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Act.

##### The vendor may not employ or contract, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:

###### Any individual or entity excluded from participation in federal healthcare programs; or

###### Any entity that would provide those services through an excluded individual or entity.

##### The vendor’s must have policies and procedures for ensuring that, pursuant to 42 CFR 438.610, the vendor will not knowingly have a director, officer or partner who is or is affiliated with a person/entity that is debarred, suspended or excluded from participation in federal healthcare programs.

##### The vendor is prohibited from knowingly having a person with ownership of more than 5% of the vendor’s equity who is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participation in federal healthcare programs.

##### The vendor is prohibited from knowingly having an employment, consulting, or other agreement with an individual or entity for the provision of vendor contract items or services who is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participation in federal healthcare programs.

##### If the DHCFP learns that the vendor has a prohibited relationship with a person or entity who is disbarred, suspended, or excluded from participation, the DHCFP will notify the Secretary of noncompliance. The State may continue the existing agreement with the vendor unless the Secretary directs otherwise. The DHCFP may not renew or extend the existing agreement with the vendor unless the Secretary provides to the DHCFP and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

### Compliance Plan

#### Vendors must have a program that includes administrative and management arrangements or procedures, including a mandatory compliance plan to guard against fraud and abuse.

#### Vendors will have written policies, procedures, and standards of conduct that articulate the organizations commitment to comply with all applicable Federal and State program integrity standards.

### General Requirements

##### The vendor must have a comprehensive compliance plan which encompasses the elements necessary to monitor and enforce compliance with all applicable laws, policies, and contract requirements.

##### The compliance plan must be reviewed and approved annually by the DHCFP.

##### The compliance plan must include the following elements, and any others as directed by the DHCFP:

###### Written policies and procedures for the functions in this section;

###### Standards for effective communication between the Compliance Officer, Program Integrity staff, management, vendor staff, and the DHCFP;

###### Mandatory on-going training and education of the Compliance officer, Program Integrity staff, management and staff, and subcontractors on the prevention and detection of fraud, waste, abuse, and improper payments;

###### Delineation of the staff and division of responsibilities within the vendor’s Program Integrity Unit;

###### Specific objectives and goals for Program Integrity operations in the coming year;

###### The process that the vendor will use to enforce program integrity standards through well publicized disciplinary guidelines;

###### The process that the vendor will use to complete internal program integrity monitoring and auditing;

###### How the vendor will promptly respond to detected program integrity offenses and develop corrective action initiatives; and

###### A report on the success of the objectives and goals from the previous year.

### Deficit Reduction Act

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

##### Establish and make readily available written policies for all employees of the vendor, including management, and of any subcontractor or provider, 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);

##### Include as part of such written policies, detailed provisions regarding the vendor's policies and procedures for detecting and preventing fraud, waste, and abuse; and

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

### Under-utilization of Services

#### Vendors must monitor for the potential under-utilization of services by their recipients 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. The vendor’s monitoring efforts must, at a minimum, include the following activities:

##### An annual review of their prior authorization procedures to determine that they do not unreasonably limit a recipient’s access to Medicaid-covered services;

##### 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 recipient’s access to Medicaid-covered services; and

##### Ongoing monitoring of vendor service denials and utilization in order to identify services which may be underutilized.

### Embezzlement and Theft

Vendors must monitor activities on an ongoing basis to prevent and detect embezzlement or theft by employees, providers, and subcontractors. Any evidence of criminal activity must be reported to the appropriate authority and the DHCFP SUR unit within five (5) business days.

### Verification of Services

#### The vendor must verify that services billed by providers were actually provided to recipients.

#### The vendor may use Explanations of Benefits (EOBs) or Verification of Services (VOS) letters for such verification.

#### VOS letters, if used instead of EOBs, must be sent to at least 500 recipients each month.

### Hotline for Reporting Suspected Fraud, Waste, Abuse or Improper Payments

#### The vendor must acquire, maintain and monitor a hotline telephone number for the public, recipients and providers to report allegations of fraud, waste, abuse, or improper payments.

#### The hotline number must be prominently displayed in a stand-alone frame placed on the vendor’s front page of their Nevada Medicaid website.

#### The telephone line may be augmented by a web page used specifically for collecting and reporting to the vendor's Program Integrity Unit complaint information entered by a fraud, waste and abuse complainant.

#### If the vendor also uses a web page for receiving program integrity complaints, it must:

##### Be accessible and simple to use by the public, recipients and providers;

##### Have a stand-alone highlighted button or link on the vendor's front page of their Nevada Medicaid website; and

##### Be identified with language which states clearly the button or link is for use in reporting Medicaid fraud, waste or abuse.

### Vendor’s Program Integrity Unit

#### Unit Composition

##### The vendor must establish and maintain a distinct Program Integrity Unit (PIU) whose responsibilities include the identification, review, recovery, and reporting of improper Medicaid and Nevada Checkup payments, including fraud, waste, and abuse (FWA) activities.

##### The PIU must include a compliance officer and a compliance committee accountable to senior management. The compliance officer shall be available to communicate with the DHCFP Program Integrity and SUR staff by telephone, email, text message, or other communication methods during State business hours.

##### The PIU shall have adequate resources and qualified staffing available to conduct reviews, recovery and reporting of improper payments, including FWA activities, as specified in the vendor contract.

##### The PIU will have adequate resources to meet either in person or via telephone on a monthly basis to provide information and updates on cases.

##### Qualified staff shall have experience in health care claims review, data analysis, professional medical coding or law enforcement.

##### The number of full-time equivalents (FTEs) dedicated to the PIU must be at least one per 50,000 Medicaid recipients.

##### The PIU staff must receive on-going training in conducting compliance reviews, and must travel to the DHCFP for periodic meetings and trainings with SUR Unit staff.

### Fraud Identification and Referral

#### Vendor shall establish policies and procedures to identify and refer credible allegations of fraud to the SUR Unit of the DHCFP.

#### When the vendor receives an allegation or tip related to potential fraud, the vendor must perform a preliminary investigation to determine whether a credible allegation of fraud exists.

#### If the vendor determines that there is credible allegation of fraud, the vendor must submit a fraud referral to the SUR Unit of the DHCFP as soon as possible and within two (2) business days.

#### The vendor’s fraud referral must provide, at a minimum, the following information and any other information specified by the DHCFP:

##### Provider’s name, Medicaid provider number or provider’s National Provider Identifier (NPI);

##### Nevada Medicaid provider type;

##### Recipient’s name and Medicaid number;

##### Date and source of the original complaint or tip;

##### Description of alleged fraudulent activity, including:

###### Specific laws or Medicaid policies violated;

###### Dates of fraudulent conduct; and

###### Approximate value of fraudulently obtained payments.

##### Any other agencies or entities (e.g., medical board, law enforcement) notified by vendor, and any actions they have taken;

##### The findings from the vendor’s preliminary investigation and proposed actions;

##### After submitting the fraud referral, the vendor will take no further action on the specific allegation until the SUR Unit responds;

##### If the SUR Unit notifies the vendor that the fraud referral is declined, the vendor must proceed with its own investigation to comply with the reporting requirements contained in this contract; and

##### If the SUR Unit notifies the vendor that the fraud referral is accepted, the vendor will be instructed as to what further actions, if any, they may take which will not impair the investigation by the MFCU or other law enforcement agency. The vendor must provide the MFCU access to conduct private interviews of DBA personnel, subcontractors and their personnel, witnesses and recipients. DBA personnel, subcontractors and their personnel must cooperate fully in making DBA personnel, subcontractors and their personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conference, and hearings, at their own expense.

### Payment Suspensions

The vendor must establish policies and procedures to implement payment suspensions as directed by DHCFP, including those related to Credible Allegations of Fraud (CAF).

If the DHCFP instructs the vendor to suspend payments to an entity or individual, and the vendor fails to do so, the DHCFP may impose penalties.

### Compliance Reviews

The vendor’s PIU must specifically address the identification, review, recovery, prevention, and reporting of improper payments, including fraud, waste, and abuse.

### Identification

#### The PIU will review all tips, complaints and referrals in a timely manner. Sources may include, but are not limited to:

##### Fraud hotline or website;

##### Referrals from the DHCFP;

##### Referrals from the vendor's own organization including utilizations of data systems to identify issues such as provider profiling or data analysis; or

##### Verification of Service letters/EOB’s complaints.

#### All tips, complaints and referrals which allege recipient misconduct must be referred to the Division of Welfare and Social Services (DWSS) Investigations and Review (I & R) Unit. The DHCFP must be copied on the referral.

#### All tips, complaints and referrals must be tracked and reported to the DHCFP monthly regardless of the outcome.

### Review

#### The PIU will conduct a review of any identified issues by collecting and analyzing available relevant information, including, but not limited to:

##### Encounter data;

##### Provider credentialing and enrollment records;

##### Provider self-audits;

##### Provider treatment records;

##### Prior authorization records;

##### Recipient verification of service letters/EOB’s;

##### Nevada Medicaid Services Manual (MSM); and

##### Nevada Medicaid Billing Guidelines.

#### The PIU will determine which, if any, encounters were improper payments.

### Recovery and Education

#### The PIU will notify the provider of the identified overpayment. The notification will include:

##### The amount of the overpayment;

##### A detailed listing of the encounters affected;

##### Education and citations supporting the findings;

##### Options for repayment;

##### Any internal appeal rights afforded by the Vendor; and

##### The provider's right to an Administrative Fair Hearing through the DHCFP after internal appeals with the vendor are exhausted.

#### The PIU must collect and retain the overpayments resulting from a vendor fraud and abuse investigation or audit.

#### All affected encounters will be adjusted or voided within sixty (60) calendar days following the identification of the overpayments, regardless of whether the vendor is able to recover the overpayment from the provider.

### Monetary Recoveries by State or Federal Entities

#### If any government entity including the Attorney General’s Office, either from restitutions, recoveries, penalties, fraud prosecutions, or fines imposed following a criminal prosecution or guilty plea, or through a civil settlement or judgment, or any other form of civil action, receives a monetary recovery from any entity, the entirety of such monetary recovery belongs exclusively to the State of Nevada and the vendor has no claim to any portion of this recovery.

#### Furthermore, the vendor is fully subrogated, and shall require its subcontractors to agree to subrogate, to the State of Nevada for all criminal, civil and administrative action recoveries undertaken by any government entity, including, but not limited to, all claims the vendor or subcontractors has or may have against any entity that directly or indirectly receives funds under this Contract including, but not limited to, any health care provider, manufacturer, wholesale or retail supplier, sales representative, laboratory, or other provider in the design, manufacture, marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, durable medical equipment, or other health care related products or services.

#### Any funds recovered and retained by a government entity will be reported to the actuary to consider in the rate-setting process.

#### If any specific payments are identified as improper, those encounters must be adjusted or voided, as appropriate.

#### For the purposes of this Section only, “subrogation” means the right of any State of Nevada government entity or local law enforcement to stand in the place of a vendor or client in the collection against a third party.

### Reporting Requirements

#### All information provided to the DHCFP must be submitted according to the format in the forms and reporting guide.

#### The vendor must report certain information to the DHCFP on a per occurrence basis. This includes, but is not limited to:

##### Every allegation, complaint, or referral pertaining to overpayments whether caused by fraud, waste, abuse or billing errors;

##### Every CAF;

##### Every employee of the vendor who is employed by, has ownership interest in, or contracts with, any provider enrolled with Nevada Medicaid; and

##### Every provider that is de-credentialed or denied credentialing for whatever reason.

#### The vendor must report certain information to the DHCFP on a monthly basis. This includes, but is not limited to:

##### All active reviews and their status; and

##### All completed reviews with a detailed reason, and the amount of each overpayment recovered from the vendor’s fraud and abuse investigation or audits. Each review must be reported even if the determination was that there was no overpayment.

#### Upon request, vendor must provide encounter data to the MFCU at no cost.

### Provider Compliance Reviews by the DHCFP

#### The DHCFP may conduct reviews of encounter data and vendor providers to ensure compliance with Nevada Medicaid policies.

#### Any improper payments discovered by the DHCFP, which have not been reported by the vendor as being under review, may be recovered and retained by the DHCFP.

#### The DHCFP may instruct the vendor to withhold payment to a provider in its network as a result of an overpayment discovered by the DHCFP.

#### All improper payments identified by the DHCFP, must be adjusted or voided from the encounter data within sixty (60) days after notification from DHCFP.

### Provider Preventable Conditions (PPC)

The vendor must identify and report and require all providers and subcontractors to identify and report to the SUR Unit in DHCFP, provider preventable conditions that are associated with claims for Medicaid payment of with courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available.

### Vendor Disclosures: Information on Ownership and Control

Vendors must disclose information to the DHCFP on ownership and control; information related to business transactions; and information on persons convicted of a crime. If the vendor does not disclose required information under 42CFR 455.104, any federal funds withheld or recouped from or any penalties assessed upon the DHCFP will be withheld and recouped from or assessed upon the vendor.

#### Disclosures are due at any of the following times:

##### Upon the vendor submitting the proposal in accordance with the State's procurement process.

##### Upon the vendor executing the contract with the State.

##### Upon renewal or extension of the vendor’s contract.

##### Within five (5) calendar days after any change in ownership of the vendor.

#### Disclosures on Ownership and Control by Vendor.

##### The following disclosures must be provided by the vendor (42 CFR 455.104(b), 1903(m)(2)(A)(viii), 1124(a)(2)(A)):

###### Any person or business entity with an ownership or control interest in the vendor that:

Has direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the vendor’s equity.

Owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the vendor if that interest equals at least five percent (5%) of the value of the vendor’s assets.

Is an officer or director of a vendor organized as a corporation.

Is a partner in a vendor organized as a partnership.

###### The name and address of any person (individual or business entity) with an ownership or control interest in the vendor. The address for business entities must include as applicable primary business address, every business location, and P.O. Box address.

###### Date of birth and Social Security Number (in the case of an individual).

###### Other tax identification number (in the case of a business entity) with an ownership or control interest in the vendor or in any subcontractor in which the vendor has a 5 percent (5%) or more interest.

###### If your firm is not a Qualified Health Maintenance Organization, provide the disclosures described at 42 U.S.C. 1396b(m)(4)(A).”

#### Whether the person (individual or business entity) with an ownership or control interest in the vendor is related to another person with ownership or control interest in the vendor as a spouse, parent, child, or sibling; or whether the person (individual or business entity) with an ownership or control interest in any subcontractor in which the vendor has a 5 percent (5%) or more interest is related to another person with ownership or control interest in the vendor as a spouse, parent, child, or sibling.

#### The name of any other Medicaid provider or fiscal agent in which the person or corporation has an ownership or control interest.

#### The name, address, date of birth, and Social Security Number of any managing employee of the vendor.

#### Vendor requirements for collecting and validating information related to ownership and business transactions from providers or subcontractors.

##### The vendor must enter into an agreement with each provider under which the provider agrees to furnish upon request, information related to ownership and business transactions.

###### The vendor must require the provider or subcontractors to submit full and complete information about:

The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

#### Vendor’s requirements for collecting and validating information related to providers/subcontractors convicted of crimes. (42 CFR 455.106)

#### Before the vendor enters into or renews a provider agreement, or at any time upon written request by the vendor, the provider must disclose to the vendor the identity of any person who:

##### Has ownership or control interest in the provider, or is an agent or managing employee of the provider/subcontractors; and

##### Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

### Denial or Termination of Provider Participation.

#### The vendor may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX Services Program.

#### The vendor may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required.

#### The vendor must also promptly notify the DHCFP Provider Enrollment Unit of any action it takes on the provider's application for participation in the program.

## REPORTING

The vendor must meet all reporting requirements and timeframes as required in ***Attachment T, 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,” information or documents received from the 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, audits and findings, and pertinent litigation data.

Vendor may clearly label individual documents as a "trade secret" or "confidential" provided that the vendor agrees to indemnify and defend the State for honoring such a designation. The failure to 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) business 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 act shall constitute a complete waiver.

### 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 within ninety (90) calendar days of receipt of encounter.

### Summary Utilization Reporting

The vendor shall produce reports using quality measures identified in the DHCFP Quality Assessment and Performance Improvement Strategy (QAPIS) and must submit these reports in addition to other reports required by this contract in a timely manner.

### Dispute Resolution Reporting

#### The vendor must provide the DHCFP with reports documenting the number and types of provider disputes, recipient grievances, appeals and fair hearing requests received by the vendor and its subcontractors.

#### 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.

### Quality Assurance Reporting

Performance Improvement Projects (PIPs) will be performed by the vendors pursuant to guidelines established jointly by the vendors, the 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 the DHCFP or its EQRO.  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, areas of concern, or areas of noncompliance noted by the DHCFP or its EQRO.

### Recipient Satisfaction Reporting

Each vendor must collect and submit to DHCFP a recipient satisfaction survey prior to the third quarter of each contract year. The DHCFP may request a specific sample, and/or survey tool. Survey results must be disclosed to the State, and, upon State’s or recipient’s request, disclosed to recipients.

### 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.

### Sales and Transaction Reporting

The vendor must report transactions between the vendor and parties in interest that are provided to the State or other agencies available to recipients upon reasonable request.

### Other Reporting

The vendor shall be required to comply with additional reporting requirements upon the request of the 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 the DHCFP with the information necessary to better assess the vendor’s performance.

## INFORMATION SYSTEMS AND TECHNICAL REQUIREMENTS

### Data Requirements

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

#### Enrollment;

#### Eligibility;

#### Provider Network Data;

#### PDP Assignment;

#### Claims Payment; and

#### Encounter Data.

### 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:

#### Health Plan - Encounter Data (encounter data reflects all services provided to clients for whom the health plan pays.).

#### Health Plan - Network Data File.

#### Health Plan - Client Update File.

#### MMIS - Encounter Data Error File (HIPAA X12 837 and NCPDP).

#### MMIS - Encounter Data Informational Errors File.

#### MMIS - Health Plan Error File.

#### MMIS - Third Party Liability Update File.

#### MMIS - Client Demographic Data.

#### MMIS - Daily Health Plan Recipient File.

#### MMIS - Health Plan Recipient File.

#### MMIS - Network Data Exception File.

#### MMIS - Network Primary Dental Provider (PDP) Updates.

#### MMIS - Client PDP changes.

#### MMIS - Client Enrollment Updates.

#### MMIS - 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, vendors will find EDI Companion Guides at the following website: <https://www.medicaid.nv.gov/providers/edi.aspx>. These companion guides contain HIPAA-compliant technical specifications.

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

### Encounter Data Report Files

The vendor must provide encounter data report files in prescribed data fields to the DHCFP’s encounter data processing agent on a monthly basis. The DHCFP will provide the required data fields and data transfer instructions. In developing the encounter data interface, the vendor will be provided with companion guide and details of any applicable edits and descriptions of the edits.  The vendor will have adequate access to fiscal agent staff to assist in the development of the interface.

#### Encounters must:

##### 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.

##### Successfully pass encounter edits with a minimum of ninety-five percent (95%) of the data successfully passing all encounter edits within the first six (6) months of submission, with ninety-seven percent (97%) or as required by federal regulation, whichever is more stringent, 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.

##### Be complete and accurate to establish capitation rates. Providing inaccurate or incomplete encounter data may create a false claim under the FCA and other laws. The undersigned hereby certifies the completeness, accuracy and truthfulness of the encounter data.

Failure to demonstrate affirmative, good faith effort: if, after delivery of a plan of correction and reasonable, agreed to timeframe to comply, the vendor will have an additional 30 days to correct whereupon the DHCFP may, at its discretion, impose sanctions in the form of liquidated damages. The liquidated damages would be two percent (2%) of one (1) month’s capitation, or ten thousand dollars ($10,000), whichever is greater until the Contractor is in compliance, as well as any fines or sanctions imposed upon the DHCFP by regulatory agencies as a result if the vendor’s non-compliance.

### HIPAA Transaction Requirements

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

#### Premium payments (X12F 820);

#### Enrollment and disenrollment into a health plan (X12N 834);

#### Eligibility inquiry and response (X12N 270-inquiry and 271-response and approval of authorization);

#### Referrals and prior authorizations (X12N 278-both request and approval of authorization);

#### Claims encounter data (X12N 837 and NCPDP);

#### Claims status Inquiry and response (X12N 276-inquiry and 277-response); and

#### 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: <https://www.medicaid.nv.gov/providers/edi.aspx>. These companion guides contain HIPAA compliant technical specifications for each transaction.

### NPI Transaction Requirements

#### The vendor must provide the DHCFP with a National Provider Identifier, (NPI), including any taxonomy code(s), with their proposal. The vendor 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 vendor information system(s) or the systems of any of the vendor 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 the DHCFP, through its fiscal agent, the NPI on all providers, including billing, servicing, and OPR (ordering, prescribing, and referring).

#### Without exception, all providers contracting through the vendor must be registered with the DHCFP as a Medicaid provider. This includes any providers who are required to have 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 the 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. Encounter data must include the individual NPI to identify the rendering provider or prescribing provider.

### Contractor must maintain current International Classification of Diseases (ICD) and Electronic Data Interchange (EDI) compliance as defined by CMS regulation and policy and no funding will be provided for contractor’s compliance.

## DHCFP RESPONSIBILITIES

DHCFP will be responsible for the following:

### 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, outcomes, timeliness of, and access to the services provided by the vendor covered under the RFP. These reviews will be conducted at least annually.

### Due Process

#### The DWSS is responsible for all appeals pertaining to eligibility for Medicaid and Nevada Check Up. The DHCFP is responsible for 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.

#### 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.

### 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.

### Actuarial Services

The DHCFP will provide or 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.

### 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 vendor must submit the encounter data. In addition, the vendor encounter data, when requested, must be submitted to the DHCFP’s actuary.

### Website Access

The DHCFP will maintain an Internet link on its official website at which the vendor’s website can be accessed.

### Operation Oversight

The DHCFP has procedures for monitoring the vendor’s operations related to recipient enrollment and disenrollment; processing grievance and appeals; violations subject to intermediate sanctions; violations of the conditions for receiving federal financial participation; and all other provisions of the contract.

## 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 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.

## LIQUIDATED DAMAGES AND SANCTIONS

The vendor must comply with all terms and conditions stipulated in the current Contract, the RFP, and all attachments, including the Forms and Reporting Guide. The vendor must file accurate, timely and complete reports to DHFCP. If the vendor fails to meet the contract requirements, liquidated damages or intermediate sanctions may be assessed. In addition to liquidated damages and intermediate sanctions, the vendor will be responsible for any fines or sanctions imposed upon the DHCFP by regulatory agencies as a result of the vendor’s non-compliance.

DHCFP may refuse to enter into a contract and may suspend or terminate an existing contract if the vendor fails to provide required reports, or disclose ultimate ownership or control information and related party transactions as required by DHCFP policy.

***See Attachment O ~ Liquidated Damages and Intermediate Sanctions.***

# COMPANY BACKGROUND AND REFERENCES

## VENDOR INFORMATION

### 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: |  |

### **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.

### 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://nvsos.gov>.

| **Question** | **Response** |
| --- | --- |
| Nevada Business License Number: |  |
| Legal Entity Name: |  |

Is “Legal Entity Name” the same name as vendor is doing business as?

|  |  |  |  |
| --- | --- | --- | --- |
| Yes |  | No |  |

If “No”, provide explanation.

### 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.

### Has the vendor ever been engaged under contract by any State of Nevada agency?

|  |  |  |  |
| --- | --- | --- | --- |
| Yes |  | No |  |

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: |  |

### 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 |  |

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.

### 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 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: |  | |

### Vendors must review the insurance requirements specified in ***Attachment E, Insurance Schedule for RFP 3290*** Does your organization currently have or will your organization be able to provide the insurance requirements as specified in ***Attachment E.***

|  |  |  |  |
| --- | --- | --- | --- |
| Yes |  | No |  |

Any exceptions and/or assumptions to the insurance requirements ***must*** be identified on ***Attachment B, Technical Proposal Certification of Compliance with Terms and Conditions of RFP.*** Exceptions and/or assumptions will be taken into consideration as part of the evaluation process; however, vendors must be specific. If vendors do not specify any exceptions and/or assumptions at time of proposal submission, the State will not consider any additional exceptions and/or assumptions during negotiations.

Upon contract award, the successful vendor ***must*** provide the Certificate of Insurance identifying the coverages as specified in ***Attachment E, Insurance Schedule for RFP 3290.***

### 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.

### Length of time vendor has been providing services described in this RFP to the public and/or private sector. Please provide a brief description.

### Financial information and documentation to be included in ***Part III, Confidential Financial Information*** of vendor’s response in accordance with ***Section 9.5, Part III – Confidential Financial Information***.

#### Dun and Bradstreet Number

#### Federal Tax Identification Number

#### The last two (2) years and current year interim:

##### Profit and Loss Statement

##### Balance Statement

## SUBCONTRACTOR INFORMATION

### Does this proposal include the use of subcontractors?

|  |  |  |  |
| --- | --- | --- | --- |
| Yes |  | No |  |

If “Yes”, vendor must:

#### Identify specific subcontractors and the specific requirements of this RFP for which each proposed subcontractor will perform services.

#### If any tasks are to be completed by subcontractor(s), vendors must:

##### Describe the relevant contractual arrangements;

##### Describe how the work of any subcontractor(s) will be supervised, channels of communication will be maintained and compliance with contract terms assured; and

##### Describe your previous experience with subcontractor(s).

#### Vendors must describe the methodology, processes and tools utilized for:

##### Selecting and qualifying appropriate subcontractors for the project/contract;

##### Ensuring subcontractor compliance with the overall performance objectives for the project;

##### Ensuring that subcontractor deliverables meet the quality objectives of the project/contract; and

##### 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.

#### Provide the same information for any proposed subcontractors as requested in ***Section 4.1, Vendor Information***.

#### Business references as specified in ***Section 4.3, Business References*** must be provided for any proposed subcontractors.

#### Vendor shall not allow any subcontractor to commence work until all insurance required of the subcontractor is provided to the vendor.

#### 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 4.2, Subcontractor Information***. The vendor must receive agency approval prior to subcontractor commencing work.

## BUSINESS REFERENCES

### 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.

### 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:** | |  | | |
| ***Identify role company will have for this RFP project***  ***(Check appropriate role below):*** | | | | |
|  | ***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? | | |  | |

### Vendors must also submit ***Attachment F, Reference Questionnaire*** to the business references that are identified in ***Section 4.3.2***.

### The company identified as the business references must submit the Reference Questionnaire directly to the Purchasing Division.

### 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 8, 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.

### The State reserves the right to contact and verify any and all references listed regarding the quality and degree of satisfaction for such performance.

## VENDOR STAFF RESUMES

A resume must be completed for each proposed key personnel responsible for performance under any contract resulting from this RFP per ***Attachment G, Proposed Staff Resume.***

# COST

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 H, Cost Schedule***).

## ADMINISTRATIVE COSTS

There are two separate cost components in administrative costs:

### Non-Medical Administrative Costs:

### Those costs (both direct and indirect) necessary to administer the Medicaid managed care program.

#### Direct Expenses: Those expenses that can be charged directly as a part of the overall administrative costs; and,

#### 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.).

### 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).

## 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:

### Profit: The percentage of profit which the Contractor anticipates receiving after expenses (net income, divided by total revenues received from DHCFP); and,

### Risk and contingencies: That amount which the Contractor anticipates setting aside (as a percentage of the revenues received) for potential unknown risks and contingencies.

Requirements:

Consideration shall be paid on a risk-based capitated rate basis. The methodology used to determine rates is certified to be actuarially sound.

Each Vendor is required to submit a not-to-exceed Administrative rate bid for calendar year 2017 relative to the rates effective at the time of the proposal. The DHCFP reserves the right to further negotiate this Administrative Rate prior to contract signing. Note that this process may result in the participating health plans having different rates.

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. .

# FINANCIAL

## PAYMENT

### Upon review and acceptance by the State, payments for invoices are normally made within 45 – 60 days of receipt, providing all required information, documents and/or attachments have been received.

### Pursuant to NRS 227.185 and NRS 333.450, the State shall pay claims for supplies, materials, equipment and services purchased under the provisions of this RFP electronically, unless determined by the State Controller that the electronic payment would cause the payee to suffer undue hardship or extreme inconvenience.

## BILLING

### The State does not issue payment prior to receipt of goods or services.

### The vendor must bill the State as outlined in the approved contract and/or payment schedule.

### Vendors may propose an alternative payment option. Alternative payment options must be listed on ***Attachment I, 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.

# WRITTEN QUESTIONS AND ANSWERS

In lieu of a pre-proposal conference, the Purchasing Division will accept questions and/or comments in writing regarding this RFP as noted below:

## QUESTIONS AND ANSWERS

### The RFP Question Submittal Form is located on the Solicitation Opportunities webpage at <http://purchasing.nv.gov>. Select the Solicitation Status, Questions dropdown and then scroll to the RFP number and the “Question” link.

### The deadline for submitting questions is as specified in ***Section 8, RFP Timeline***.

### All questions and/or comments will be addressed in writing. An email notification that the amendment has been posted to the Purchasing website will be issued on or about the date specified in ***Section 8, RFP Timeline***.

# 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.

| **Task** | **Date/Time** |
| --- | --- |
| Deadline for submitting questions | 11/16/16 @ 12:00 PM |
| Answers posted to website | On or about 11/23/16 |
| Deadline for submittal of Reference Questionnaires | No later than 4:30 PM on 12/14/16 |
| Deadline for submission and opening of proposals | No later than 2:00 PM on 12/15/16 |
| Evaluation period (approximate time frame) | 12/16 ~ 12/28 |
| Selection of vendor | On or about 12/28/16 |
| Anticipated BOE approval | 2/2017 |
| Contract start date (contingent upon BOE approval) | 7/1/17 |

# PROPOSAL SUBMISSION REQUIREMENTS, FORMAT AND CONTENT

## PROPOSAL SUBMITTAL REQUIREMENTS

Proposals must be received by the due date and time and at the location stated on the front page of this RFP. Proposals received after the deadline will be late and will not be considered.

All electronic files must be saved in “PDF” format.

***Failure to submit proposal in the formats outlined in this RFP may result in the rejection of the submitted proposal.***

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.

### NUMBER OF COPIES

Proposals must be submitted in two forms. Each proposal must include the following:

#### One (1) master proposal in paper (hard copy).

#### One (1) in an electronic (soft copy) format on either a CD or Thumb/Flash Drive.

#### One (1) “Public Records CD or Flash Drive” This CD or Thumb/Flash Drive must not contain any confidential or proprietary information.

The Redacted Technical Proposal submitted on the CD will be posted to the Purchasing Website upon the Notice of Award.

### PROPOSAL PACKAGING

#### Proposals must be received at the address referenced below no later than the date and time specified in ***Section 8, RFP Timeline***. Proposals that are not received by proposal opening time and date WILL NOT BE ACCEPTED. Vendors may submit their proposal any time prior to the above stated deadline.

#### 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. Proposal may be modified by facsimile, e-mail or written notice provided such notice is received prior to the opening of the proposals.

#### The outermost package must fully describe the contents and be clearly marked as follows:

|  |  |
| --- | --- |
| Ronda Miller State of Nevada, Purchasing Division 515 E. Musser Street, Suite 300 Carson City, NV 89701 | |
| RFP: | 3290 |
| PROPOSAL OPENING DATE: |  |
| PROPOSAL OPENING TIME: | 2:00 PM |
| FOR: | Dental Benefits Administrator |
| VENDOR’S NAME: |  |

### GENERAL SUBMISSION REQUIREMENTS

#### All information must be completed as stated in the request for proposal.

#### If discrepancies are found between the electronic and paper proposal, the master copy will provide the basis for resolving such discrepancies. If the paper copy of the proposal is not clearly marked “MASTER,” the State will deem the paper copy as the master.

#### 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 easily identifiable and placed immediately following the applicable RFP question, statement and/or section. Exceptions/assumptions to this RFP may be considered during the evaluation process.

#### 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 to be submitted. Emphasis should be concentrated on describing how the vendor proposes to meet the items listed in the scope of work, 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 vendor’s lack of environmental and cost consciousness.

#### 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:

##### Be submitted on recycled paper;

##### Not include pages of unnecessary advertising;

##### Be printed on both sides of each sheet of paper; and

##### Use binder clips rather than spiral bound or binders.

#### If a vendor changes any material RFP language, vendor’s response may be deemed non-responsive per NRS 333.311.

## PROPOSAL ORGANIZATION REQUIREMENTS

Vendors’ proposals must be separated into six (6) separate sections. Each section must be separated by tabs in the paper original. Each section must be submitted as one (1) PDF file in the electronic copy (One PDF file for section 1, one PDF file for section 2, etc.). These sections are as follows:

### SECTION 1: STATE DOCUMENTS

#### The State Documents section must include and be organized as follows:

##### **Title Page**: The title page must include the following:

|  |  |
| --- | --- |
| RFP Title: | Dental Benefits Administrator |
| RFP: | 3290 |
| Vendor Name: |  |
| Address: |  |
| Proposal Opening Date: |  |
| Proposal Opening Time: | 2:00 PM |

##### **Table of Contents**: An accurate table of contents must be provided.

##### **Other Documents**:

###### The **signature page** from all amendments with an original signature by an individual authorized to bind the organization. Please do not include the entire amendment.

###### **Attachment A**: Confidentiality and Certification of Indemnification with an original signature by an individual authorized to bind the organization.

###### **Attachment B:** Technical Proposal Certification of Compliance with Terms and Conditions of RFP

###### **Attachment B** with an original signature by an individual authorized to bind the organization must be included in this section.

###### If the exception and/or assumption require a change in the terms or wording of any section of the RFP, the contract, or any incorporated documents, vendors ***must*** provide the specific language that is being proposed on **Attachment B**.

###### Only technical exceptions and/or assumptions should be identified on **Attachment B**.

###### The State will not accept additional exceptions and/or assumptions if submitted after the proposal submission deadline. If vendors do not specify any exceptions and/or assumptions in detail at time of proposal submission, the State will not consider any additional exceptions and/or assumptions during negotiations.

##### **Attachment C:** Vendor Certifications with an original signature by an individual authorized to bind the organization.

###### Copies of applicable certifications and licenses.

## SECTION 2: COMPANY INFORMATION

The Company Information section must include and be organized as follows:

### Vendor information

Vendors must complete and submit a company profile ***Vendor Information Sheet***.

#### **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.

#### If proposing to perform services in Nevada, 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>.

#### 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.

#### 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.

#### Any exceptions and/or assumptions to the insurance requirements must be identified on Attachment B, Technical Proposal Certification of Compliance with Terms and Conditions of RFP. Exceptions and/or assumptions will be taken into consideration as part of the evaluation process; however, vendors must be specific. If vendors do not specify any exceptions and/or assumptions at time of proposal submission, the State will not consider any additional exceptions and/or assumptions during negotiations.

Upon contract award, the successful vendor must provide the Certificate of Insurance identifying the coverages as specified in ***Attachment E, Insurance Schedule***.

#### Business references

Business References are separated into two sections. The first section is the reference information filled out by the vendor and submitted with the proposal. The second section is a form that the vendor sends to the reference. The company being used as a reference completes the form and submits it directly to Nevada State Purchasing.

##### Reference information to be submitted with the proposal:

###### 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.

###### Vendors shall complete and submit one reference information form (***Section 4.3, Business References***) for every business reference provided by the vendor and/or subcontractor:

##### Reference information to be submitted by the reference:

###### Vendors must send ***Attachment J, Reference Questionnaire*** to the business references that are identified in ***Section 4.1, Vendor Information.***

###### The company identified as the business references must submit the Reference Questionnaire directly to the Purchasing Division.

###### 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 8, 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.

##### The State reserves the right to contact and verify any and all references listed regarding the quality and degree of satisfaction for such performance.

#### Vendor staff resumes

A resume form ***(Attachment G – Proposed Staff Resume)*** must be completed for each proposed key personnel responsible for performance under any contract resulting from this RFP. No more than 50 resume forms may be submitted.

#### Subcontractor information (If applicable)

If this proposal includes the use of subcontractors, the proposal must include:

##### Identify specific subcontractors and the specific requirements of this RFP for which each proposed subcontractor will perform services.

##### If any tasks are to be completed by subcontractor(s), vendors must:

###### Describe the relevant contractual arrangements;

###### Describe how the work of any subcontractor(s) will be supervised, channels of communication will be maintained and compliance with contract terms assured; and

###### Describe your previous experience with subcontractor(s).

##### Vendors must describe the methodology, processes and tools utilized for:

###### Selecting and qualifying appropriate subcontractors for the project/contract;

###### Ensuring subcontractor compliance with the overall performance objectives for the project;

###### Ensuring that subcontractor deliverables meet the quality objectives of the project/contract; and

###### 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.

##### Provide the same information for any proposed subcontractors as requested in ***Section 4.3, Vendor Information***.

##### Business references as specified in ***Section 4.3, Business References*** must be provided for any proposed subcontractors.

##### Vendor shall not allow any subcontractor to commence work until all insurance required of the subcontractor is provided to the vendor.

##### 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 4.2, Subcontractor Information***. The vendor must receive agency approval prior to subcontractor commencing work.

## SECTION 3: TECHNICAL PROPOSAL

The technical proposal is a detailed explanation of how the vendor proposes to meet the Scope of Work. The technical proposal should be drafted to meet the specific requirements of this RFP. Do not submit company literature, brochures and marketing materials that have not been prepared specifically for this solicitation. The total technical proposal must not exceed 15 pages per category.

Proposals must be organized and sections must be separated as stated in ***Section 9,* *Proposal Submission Requirements, Format and Content*.**

Any material that the vendor believes to be confidential must be specifically identified and referenced by page, section and/or paragraph where the confidential information can be located on ***Attachment A, Confidentiality and Certification of Indemnification*** and comply with the requirements stated in ***Section 9, Redacted Technical*** Proposal.

If complete responses cannot be provided without referencing confidential information, a fully redacted version of the technical proposal must be provided as stated in ***Section 9.5, Redacted Technical Proposal***. If no redacted technical proposal is submitted, it may be determined that there is no confidential information in the technical proposal.

The Technical Proposal section must include and be organized as follows:

### Response to Scope of Work

Vendor’s written response(s) must be easily identifiable and placed immediately following the applicable RFP question, statement and/or section.

### Company Background/History

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.

## SECTION 4: REDACTED TECHNICAL PROPOSAL

### As a potential contractor of a public entity, vendors are advised that full disclosure is required by law.

### 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.

### Vendors acknowledge that material not marked as “confidential” will become public record upon contract award.

### 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.

### Vendors only need to submit ***Section 4: Redacted Technical Proposal if the Technical Proposal*** includes confidential technical information ***(Refer to Attachment A, Confidentiality and Certification of Indemnification)***. If there is no confidential information, nothing needs to be submitted for this section.

### Vendors must follow the same layout and content requirements for the Redacted Technical Proposal as for the Technical Proposal.

## SECTION 5: COST/FINANCIAL

All cost information must be submitted in ***Section 5, Cost***, and must not be included in any other section of the proposal. 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”.

The Cost section must include and be organized as follows:

### Cost Schedule

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 H, Cost Schedule***).

### Cost Proposal Certification of Compliance with Terms and Conditions of RFP.

#### ***Attachment I Cost Proposal Certification of Compliance with Terms and Conditions*** of RFP 3290 with an original signature by an individual authorized to bind the organization must be included in this section.

#### In order for any cost exceptions and/or assumptions to be considered, vendors must provide the specific language that is being proposed in ***Attachment I Cost Proposal Certification of Compliance with Terms and Conditions*** of RFP 3290.

#### Only cost exceptions and/or assumptions should be identified on ***Attachment I Cost Proposal Certification of Compliance with Terms and Conditions*** of RFP 3290. 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. If vendors do not specify any exceptions and/or assumptions in detail at time of proposal submission, the State will not consider any additional exceptions and/or assumptions during negotiations.

## SECTION 6: CONFIDENTIAL FINANCIAL

### The Confidential Financial section must include and be organized as follows:

#### Dun and Bradstreet Number.

#### Federal Tax Identification Number

#### The last two (2) years and current year interim:

##### Profit and Loss Statement

##### Balance Statement

# PROPOSAL EVALUATION AND AWARD PROCESS

*The information in this section does not need to be returned with the vendor’s proposal.*

## 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.**

## 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).

## 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. Refer generally to NRS 333.335.

## 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.

## 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.

## Any contract resulting from this RFP shall not be effective unless and until approved by the Nevada State Board of Examiners (NRS 333.700).

# TERMS AND CONDITIONS

## 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.

### This procurement is being conducted in accordance with NRS Chapter 333 and NAC Chapter 333.

### 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.

### The State reserves the right to waive informalities and minor irregularities in proposals received.

### For ease of responding to the RFP, vendors are encouraged to download the RFP from the Purchasing Division’s website at [http://purchasing.nv.gov](http://purchasing.state.nv.us).

### The failure to separately package and clearly mark ***Part IB 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.

### 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.

### The State reserves the right to reject any or all proposals received prior to contract award (NRS 333.350).

### The State reserves the right to limit the scope of work prior to award, if deemed in the best interest of the State. (NRS 333.350)

### 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).

### 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.

### A description of 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.

### Alterations, modifications or variations to a proposal may not be considered unless authorized by the RFP or by addendum or amendment.

### 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.

### 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.

### 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).

### 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.

### 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.

### 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.

### The Nevada Attorney General will not render any type of legal opinion regarding this transaction.

### Any unsuccessful vendor may file an appeal in strict compliance with NRS 333.370 and Chapter 333 of the Nevada Administrative Code.

## 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.

### 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.

### 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.

### The State will not be liable for Federal, State, or Local excise taxes per NRS 372.325.

### ***Attachment B and Attachment I*** 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. If vendors do not specify any exceptions and/or assumptions at time of proposal submission, the State will not consider any additional exceptions and/or assumptions during negotiations.

### 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.

### 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.

### 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.

### 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.

## 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.

### Award of Related Contracts

#### 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.

#### All subcontractors shall be required to abide by this provision as a condition of the contract between the subcontractor and the prime contractor.

### 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.

### Inspection/Acceptance of Work

#### It is expressly understood and agreed all work done by the contractor shall be subject to inspection and acceptance by the State.

### Travel

#### The State is not responsible for payment of any premium, deductible or assessments on insurance policies purchased by vendor for a rental vehicle.

### Right to Publish

#### 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 Services or designee.

#### 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 Services or designee.

#### 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.

#### 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 Services or designee.

#### Throughout the term of the contract, the contractor must secure the written approval of the State per ***Section 11.3.5.2*** prior to the release of any information pertaining to work or activities covered by the contract.

### Protection of Sensitive Information

Protection of sensitive information will include the following:

#### Sensitive information in existing legacy applications will encrypt data as is practical.

#### Confidential Personal Data will be encrypted whenever possible.

#### Sensitive Data will be encrypted in all newly developed applications.

# 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 IA– 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 Informational Material |  |
| **Part IB – 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 I - Cost Proposal Certification of Compliance with Terms and Conditions of RFP |  |
| **Part III – Confidential Financial Information Submission Requirements** | |  |
| Required number of Confidential Financial Proposals per submission requirements | |  |
| Tab I | Title Page |  |
| Tab II | Financial Information and Documentation |  |
| **CDs or Flash Drives Required** | |  |
| One (1) | Master CD or Flash Drive with the technical and cost proposal contents only |  |
| One (1) | Public Records CD or Flash Drive 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 and Part B 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 IB – Confidential Technical Information** | | | |
| YES |  | NO |  |
| **Justification for Confidential Status** | | | |
|  | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **A Public Records CD or Flash Drive has been included for the Technical and Cost Proposal** | | | |
| YES |  | NO (See note below) |  |
| ***Note: By marking “NO” for Public Record CD or Flash Drive included, you are authorizing the State to use the “Master CD or Flash Drive” for Public Records requests.*** | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **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 ***all*** 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. |

If the exception and/or assumption require a change in the terms in any section of the RFP, the contract, or any incorporated documents, vendors ***must*** provide the specific language that is being proposed in the tables below. If vendors do not specify in detail any exceptions and/or assumptions at time of proposal submission, the State will not consider any additional exceptions and/or assumptions during negotiations.

|  |  |  |  |
| --- | --- | --- | --- |
|  | | |  |
| Company Name | | |  |
|  |  |  |  |
| Signature |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Print Name |  |  | Date |

***Vendors MUST use the following format***. Attach additional sheets if necessary.

**EXCEPTION SUMMARY FORM**

| **EXCEPTION #** | **RFP SECTION NUMBER** | **RFP**  **PAGE NUMBER** | **EXCEPTION**  **(Complete detail regarding exceptions must be identified)** |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**ASSUMPTION SUMMARY FORM**

| **ASSUMPTION #** | **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.

If exceptions and/or assumptions require a change to the Contract Form, vendors ***must*** provide the specific language that is being proposed on ***Attachment B, Technical Proposal Certification of Compliance with Terms and Conditions of RFP.***

Please pay particular attention to the insurance requirements, as specified in ***Paragraph 16 of the embedded contract*** and ***Attachment E, Insurance Schedule for RFP3290***.



*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*](mailto:srvpurch@admin.nv.gov) *for an emailed copy.*

# ATTACHMENT E – INSURANCE SCHEDULE FOR RFP 3290

The following Insurance Schedule is provided as a courtesy to vendors interested in responding to this RFP. Please review the terms and conditions in the Insurance Schedule, as this is the standard insurance schedule used by the State for all services of independent contractors.

If exceptions and/or assumptions require a change to the Insurance Schedule, vendors ***must*** provide the specific language that is being proposed on ***Attachment B, Technical Proposal Certification of Compliance with Terms and Conditions of RFP.***

******

*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*](mailto:srvpurch@admin.nv.gov) *for an emailed copy.*

# 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 and/or Part B of the Reference Questionnaire. |
| 2. | Proposing vendor **MUST** send the Reference Questionnaire to **EACH** business reference listed for completion of Part D, Part E and Part F. |
| 3. | Business reference is requested to submit the completed Reference Questionnaire via email or facsimile to:  State of Nevada, Purchasing Division  Subject: ***RFP 3290***  Attention: ***Purchasing Division***  Email: [rfpdocs@admin.nv.gov](mailto:rfpdocs@admin.nv.gov)  Fax: 775-684-0188  Please reference the RFP number in the subject line of the email or on the fax. |
| 4. | The completed Reference Questionnaire **MUST** be received ***no later than 4:30 PM PT December 14, 2016*** |
| 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. |

******

*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*](mailto:srvpurch@admin.nv.gov) *for an emailed copy.*

# ATTACHMENT G – PROPOSED STAFF RESUME

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff using the State format.



*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*](mailto:srvpurch@admin.nv.gov) *for an emailed copy.*

# ATTACHMENT H – COST SCHEDULE

******

*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*](mailto:srvpurch@admin.nv.gov) *for an emailed copy.*

# ATTACHMENT I – COST PROPOSAL CERTIFICATION OF COMPLIANCE

**WITH TERMS AND CONDITIONS OF RFP**

I have read, understand and agree to comply with ***all*** 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. |

If the exception and/or assumption require a change in the terms in any section of the RFP, the contract, or any incorporated documents, vendors ***must*** provide the specific language that is being proposed in the tables below. If vendors do not specify in detail any exceptions and/or assumptions at time of proposal submission, the State will not consider any additional exceptions and/or assumptions during negotiations.

***Note: Only cost exceptions and/or assumptions should be identified on this attachment. Do not restate the technical exceptions and/or assumptions on this attachment.***

|  |  |  |  |
| --- | --- | --- | --- |
|  | | |  |
| Company Name | | |  |
|  |  |  |  |
| Signature |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Print Name |  |  | Date |

***Vendors MUST use the following format***. Attach additional sheets if necessary.

**EXCEPTION SUMMARY FORM**

| **EXCEPTION #** | **RFP SECTION NUMBER** | **RFP**  **PAGE NUMBER** | **EXCEPTION**  **(Complete detail regarding exceptions must be identified)** |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |

**ASSUMPTION SUMMARY FORM**

| **ASSUMPTION #** | **RFP SECTION NUMBER** | **RFP**  **PAGE NUMBER** | **ASSUMPTION**  **(Complete detail regarding assumptions must be identified)** |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |

**This document must be submitted in Tab III of vendor’s cost proposal.**

**This form MUST NOT be included in the technical proposal.**

# ATTACHMENT J – CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, “Disclosure of Lobbying Activities,” in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub awards at all tiers (including subcontracts, sub grants, and contracts under grants, loans, and cooperative agreements) and that all sub recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

|  |  |  |  |
| --- | --- | --- | --- |
| By: |  |  |  |
|  | Signature of Official Authorized to Sign Application |  | Date |

|  |  |
| --- | --- |
| For: |  |
|  | Vendor Name |

|  |
| --- |
|  |
| Project Title |

**This document must be submitted in Tab IV of vendor’s technical proposal**

# ATTACHMENT K – 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 L – PROVIDER TYPES



*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*](mailto:srvpurch@admin.nv.gov) *for an emailed copy.*

# ATTACHMENT M– MANDATORY MCO ZIP CODES



*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*](mailto:srvpurch@admin.nv.gov) *for an emailed copy.*

# ATTACHMENT N– DISENROLLMENT FORM



*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*](mailto:srvpurch@admin.nv.gov) *for an emailed copy.*

# ATTACHMENT O– LIQUIDATED DAMAGES AND INTERMEDIATE SANCTIONS



*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*](mailto:srvpurch@admin.nv.gov) *for an emailed copy.*

# ATTACHMENT P– CY16 MC DENTAL RATES



*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*](mailto:srvpurch@admin.nv.gov) *for an emailed copy.*

# ATTACHMENT Q– PROGRAM INTEGRITY PROVIDER REFERRAL FORM



*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*](mailto:srvpurch@admin.nv.gov) *for an emailed copy.*

# ATTACHMENT R– PROGRAM INTEGRITY RECIPIENT REFERRAL FORM



*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*](mailto:srvpurch@admin.nv.gov) *for an emailed copy.*

# ATTACHMENT S– APPEALS AND GRIEVANCES



*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*](mailto:srvpurch@admin.nv.gov) *for an emailed copy.*

# ATTACHMENT T– FORMS AND REPORTING GUIDE

 

 

 

 

*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*](mailto:srvpurch@admin.nv.gov) *for an emailed copy.*