Part IA – Redacted Technical Proposal

RFP Title:	***Dental Benefits Administrator***
RFP:	***3290***
Vendor Name:	***LIBERTY Dental Plan of Nevada, Inc.***
Address:	***6385 South Rainbow Boulevard*** ***Suite 200*** ***Las Vegas, NV 89118***
Proposal Opening Date:	***December 15, 2016***
Proposal Opening Time:	***2:00 PM***

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December 13, 2016

Ms. Ronda Miller, Purchasing Officer II
State of Nevada, Purchasing Division
515 E. Musser Street, Suite 300
Carson City, NV 89701

RE: Request of Proposal No. 3290 for DENTAL BENEFITS ADMINISTRATOR

Dear Ms. Miller:

On behalf of LIBERTY Dental Plan of Nevada, Inc. ("LIBERTY"), we are pleased to submit our proposal to the State of Nevada for the implementation, administration and maintenance of your Nevada Medicaid and Nevada Check Up (NCU) Dental Managed Care Programs. We appreciate the opportunity to partner with the State of Nevada's Department of Health and Human Services (DHHS), and believe we are well-positioned to bring high quality, efficient and innovative dental administration to your programs.

We currently administer a full array of dental benefits and services to approximately 3 million recipients in public and commercial programs in 50 states, including to over 2 million Medicaid managed care recipients. Our unique care management model and progressive technology enable us to care for children and adult recipients, including pregnant women and those with special needs. We believe every individual has the right to affordable, quality care, and with 10 + years as a full-service Medicaid dental plan administrator, we are confident in our ability to enhance and improve oral health care for the State of Nevada's most vulnerable citizens. We believe that dental care is more than just administration of a program. For LIBERTY, it is about ***care management***: knowing that members have access to qualified providers; implementing outreach programs that encourage continuity of care; and proactively identifying and eliminating fraud, waste, and abuse. It is about helping members establish a ***dental home:*** ensuring that each individual is perfectly matched to the right provider to receive the right care. It is also about ***progressive technology***: operating our entire scope of services within a customized, single source platform that seamlessly integrates and synthesizes data in a manner that is unmatched in the industry.

Our enclosed proposal highlights all of the combined experience, resources and capabilities that we will bring to the Nevada Medicaid and NCU Dental Managed Care Programs should we be awarded this contract. Together, we can improve the oral health—and general well-being—of the citizens of Nevada's Clark and Washoe County. That is your commitment to them; and it is our commitment to you.

If you have any questions about the information contained within our proposal, or require additional clarification, please do not hesitate to contact me at (888) 273-2997 ext. 202 or on my mobile phone at (949) 903-1393.

We appreciate the opportunity to present our proposal, and thank you for your consideration.

Respectfully,

Amir Neshat
Chief Executive Officer
LIBERTY Dental Plan of Nevada, Inc.

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SECTION 1: STATE DOCUMENTS

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9.2.1.1.C.1: Signature Page

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.

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Amendment 1 – Signature Page

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possible but has accommodated dentists with phone testimony. For Southern Nevada, the Fair Hearings are held in Las Vegas and in Northern Nevada they are held in Carson City.

62. Does the Dental Director need to be located in Nevada, or just licensed in Nevada?

The Dental Director must be licensed to practice dentistry in the State of Nevada.

63. Please provide a census by zip code

Amend 1 quest 63.xlsx

ALL ELSE REMAINS THE SAME FOR RFP 3290.

Vendor must sign and return this amendment with proposal submitted.

Vendor Name: LIBERTY Dental Plan of Nevada, Inc.

Authorized Signature:

Title: Amir Neshat, CEO Date: December 12, 2016

This document must be submitted in the "State Documents" section/tab of vendors' technical proposal.

Amendment 2 – Signature Page

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ALL ELSE REMAINS THE SAME FOR RFP 3290.

Vendor must sign and return this amendment with proposal submitted.

Vendor Name: **LIBERTY Dental Plan of Nevada, Inc.**

Authorized Signature:

Title: **Amir Neshat, CEO** Date: **December 12, 2016**

This document must be submitted in the "State Documents" section/tab of vendors' technical proposal.

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Amendment 3 – Signature Page

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State of Nevada
Department of Administration
Purchasing Division
515 E. Musser Street, Suite 300
Carson City, NV 89701

Brian Sandoval
Governor

Jeffrey Haag
Administrator

SUBJECT:	Amendment 3 to Request for Proposal 3290
RFP TITLE:	Dental Benefits Administrator
DATE OF AMENDMENT:	December 6, 2016
DATE OF RFP RELEASE:	November 7, 2016
OPENING DATE:	December 15, 2016
OPENING TIME:	2:00 PM
CONTACT:	Ronda Miller, Procurement Staff Member

The following shall be a part of RFP ***3290.*** If a vendor has already returned a proposal and any of the information provided below changes that proposal, please submit the changes along with this amendment. You need not re-submit an entire proposal prior to the opening date and time.

1. Can you provide more detail about the basis for the trend assumption in the cost of care build, in particular the 0% utilization trend assumption on the Expansion population?

   For the Expansion population, utilization trends were chosen to be generally lower than TANF and Check-Up. It is expected that the Expansion population cost trends will reflect larger management impacts relative to the base period data since the transition to managed care is relatively recent.

ALL ELSE REMAINS THE SAME FOR RFP 3290.

Vendor must sign and return this amendment with proposal submitted.

Vendor Name: **LIBERTY Dental Plan of Nevada, Inc.**

Authorized Signature: Amir Neshat

Title: CEO Date: December 12, 2016

This document must be submitted in the "State Documents" section/tab of vendors' technical proposal.

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9.2.1.1.C.2: Attachment A: Confidentiality and Certification of Indemnification

Attachment A: Confidentiality and Certification of Indemnification with an original signature by an individual authorized to bind the organization.

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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	X	NO	
Justification for Confidential Status			
Confidential information as defined in this RFP has been labeled "trade secret" or "confidential" and submitted in the Confidential Technical binder. The information we consider confidential is proprietary client information, proprietary case studies, proprietary system information, proprietary process information, proprietary policy information, proprietary program and proprietary reports. Information related to disclosures of ownership and control is confidential, as it contains information about our directors/officers that is not made public. Additionally, we consider our client information and premium information confidential, as it can cause competitive harm to release. Following are the items that are confidential and included in the Technical binder section: Section 3.15.24 Ownership Information (pages 554 -557) Section 4.3 Business Reference premium information page (79, 80, 81 and 82) Section 3.9.19 – Trade Secret – Figure 3.9.19.3-2 – Proprietary MIS System (page 380) Section 3.9.20 – Trade Secret – Figure 3.9.20-1- Proprietary Phone App (page 391) Section 3.9.20 – Trade Secret – Figure 3.9.20-3 - Proprietary MIS System (page 393) Section 3.14.5 – Trade Secret – Figure 3.14.5.1-1 - Implementation Plan – Proprietary Process (page 490) Section 3.16.4 – Trade Secret - Figure Sealant Utilization – Proprietary improvement plan (page 567) Section 3.17.1 – Trade Secret - Figure 3.17.1-1 PDP Assignments – Proprietary MIS System (page 574) Section 3.20.1 – Trade Secret - Figure – 3.20-1A – 3.20-1D – Proprietary System (pages 592 - 595) Attachment 15 - Trade Secret - FWA Program – Proprietary program Attachment 6 – QIP 2016-Q1 16 Interim Report – Proprietary report			

A Public Records CD or Flash Drive has been included for the Technical and Cost Proposal			
YES	X	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	X	NO	
Justification for Confidential Status			
Financial Information binder as instructed in the RFP for LIBERTY Dental Plan and Subcontractors.			

LIBERTY Dental Plan of Nevada, Inc.
Company Name

Signature

Amir Neshat, CEO
Print Name

December 13, 2016
Date

This document must be submitted in Tab IV of vendor's technical proposal

9.2.1.1.C.3: 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.

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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 X 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.

LIBERTY Dental Plan of Nevada, Inc.
Company Name

Signature

Amir Neshat, CEO
Print Name

December 12, 2016
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

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9.2.1.1.D: Attachment C: Vendor Certifications

Attachment C: Vendor Certifications with an original signature by an individual authorized to bind the organization. Copies of applicable certifications and licenses.

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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.

LIBERTY Dental Plan of Nevada, Inc.
Vendor Company Name

Vendor Signature

Amir Neshat, CEO
Print Name / Title

December 12, 2016
Date

This document must be submitted in Tab IV of vendor's technical proposal

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Certificate of Authority

STATE OF NEVADA
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INSURANCE
Carson City, Nevada

Nevada ID #:	**104054**
THE	**LIBERTY DENTAL PLAN OF NEVADA, INC.**
Incorporated in the State of	**NEVADA**
Home office at	**LAS VEGAS, NEVADA**

having duly qualified, is hereby licensed to transact:

**** PREPAID LIMITED HEALTH SERVICE ORGANIZATION ****
(Service Area – All Zip Codes Within the State of Nevada)

insurance business within the State of Nevada until terminated at the request of the insurer or suspended or revoked by the Commissioner of Insurance.

Original Dated at Carson City, Nevada

this 2nd day of October, 2008

Corrected this 29th day of July, 2013

Commissioner of Insurance

SECRETARY OF STATE

STATE OF NEVADA

CERTIFICATE OF EXISTENCE
WITH STATUS IN GOOD STANDING

I, BARBARA K. CEGAVSKE, the duly elected and qualified Nevada Secretary of State, do hereby certify that I am, by the laws of said State, the custodian of the records relating to filings by corporations, non-profit corporations, corporation soles, limited-liability companies, limited partnerships, limited-liability partnerships and business trusts pursuant to Title 7 of the Nevada Revised Statutes which are either presently in a status of good standing or were in good standing for a time period subsequent of 1976 and am the proper officer to execute this certificate.

I further certify that the records of the Nevada Secretary of State, at the date of this certificate, evidence, **LIBERTY DENTAL PLAN OF NEVADA, INC.**, as a corporation duly organized under the laws of Nevada and existing under and by virtue of the laws of the State of Nevada since June 8, 2007, and is in good standing in this state.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on September 22, 2016.

Barbara K. Cegavske

BARBARA K. CEGAVSKE
Secretary of State

Electronic Certificate
Certificate Number: C20160922-2379
You may verify this electronic certificate online at **http://www.nvsos.gov/**

Attachment J: Certification Regarding Lobbying

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: _____ December 12, 2016
Amir Neshat , CEO (Signature of Official Authorized to Sign Application) Date

For: LIBERTY Dental Plan of Nevada, Inc.
Vendor Name

Request for Proposal No. 3290 DENTAL BENEFITS ADMINISTRATOR
Project Title

This document must be submitted in Tab IV of vendor's technical proposal

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SECTION 2: COMPANY INFORMATION

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9.3.1 Vendor information

Vendors must complete and submit a company profile Vendor Information Sheet.

A completed Vendor Information Sheet is provided on the following page.

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VENDOR INFORMATION SHEET

V1	Company Name	***LIBERTY Dental Plan of Nevada, Inc.***

V2	Street Address	***6385 South Rainbow Boulevard, Suite 200***

V3	City, State, ZIP	***Las Vegas, NV 89118***

V4	Telephone Number		
	Area Code: ***888***	Number: ***401-1128***	Extension:

V5	Facsimile Number		
	Area Code: ***888***	Number: ***401-1129***	Extension:

V6	Toll Free Number		
	Area Code: ***888***	Number: ***401-1128***	Extension:

V7	Contact Person for Questions / Contract Negotiations, including address if different than above
	Name: ***John Carvelli***
	Title: ***Executive Vice President***
	Address: ***340 Irvine, Suite 100, Irvine, CA 92602***
	Email Address: jcarvelli@libertydentalplan.com

V8	Telephone Number for Contact Person		
	Area Code: ***888***	Number: ***273-2997***	Extension: ***202***

V9	Facsimile Number for Contact Person		
	Area Code: ***949***	Number: ***270-0106***	Extension:

V10	Name of Individual Authorized to Bind the Organization	
	Name: ***John Carvelli***	Title: ***Executive Vice President***

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

9.3.1.1 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.

9.3.1.2 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.

9.3.1.3 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.

9.3.1.4 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.

9.3.1.5 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.

9.3.1.6 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.

A. Reference information to be submitted with the proposal:

1. Vendors should provide a minimum of three (3) business references from similar projects performed for private, state and/or large local government clients within the last three (3) years.

2. 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:

9.3.1.7 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.

9.3.1.8 Subcontractor information (If applicable)

If this proposal includes the use of subcontractors, the proposal must include:

A. Identify specific subcontractors and the specific requirements of this RFP for which each proposed subcontractor will perform services.

B. If any tasks are to be completed by subcontractor(s), vendors must:

1. Describe the relevant contractual arrangements;

2. Describe how the work of any subcontractor(s) will be supervised, channels of communication will be maintained and compliance with contract terms assured; and

3. Describe your previous experience with subcontractor(s).

C. Vendors must describe the methodology, processes and tools utilized for:

1. Selecting and qualifying appropriate subcontractors for the project/contract;

2. Ensuring subcontractor compliance with the overall performance objectives for the project;

3. Ensuring that subcontractor deliverables meet the quality objectives of the project/contract; and

4. 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.

D. Provide the same information for any proposed subcontractors as requested in Section 4.3, Vendor Information.

E. Business references as specified in Section 4.3, Business References must be provided for any proposed subcontractors.

F. Vendor shall not allow any subcontractor to commence work until all insurance required of the subcontractor is provided to the vendor.

G. 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.

As instructed by Amendment 2, Question and Answer #10, we are providing answers to RFP Section 4 as our response to Section 9.3, Company Information.

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4.1 VENDOR INFORMATION

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4.1 VENDOR INFORMATION

4.1.1 Vendors must provide a company profile in the table format below.

Question	Response
Company name:	***LIBERTY Dental Plan of Nevada, Inc.***
Ownership (sole proprietor, partnership, etc.):	***a Nevada Corporation***
State of incorporation:	***Nevada***
Date of incorporation:	***June 08, 2007***
# of years in business:	***9 in Nevada and 15 overall***
List of top officers:	***Amir Neshat - CEO*** ***Randy Brecher – President*** ***John Carvelli – Secretary/Vice President*** ***Maja Kapic – Treasurer / CFO***
Location of company headquarters:	***340 Commerce, Suite 100*** ***Irvine, CA 92602***
Location(s) of the company offices:	***6835 S. Rainbow Blvd, Suite 200*** ***Las Vegas, NV 89118***
Location(s) of the office that will provide the services described in this RFP:	***6835 S. Rainbow Blvd, Suite 200*** ***Las Vegas, NV 89118***
Number of employees locally with the expertise to support the requirements identified in this RFP:	***Nevada – 54***
Number of employees nationally with the expertise to support the requirements in this RFP:	***California – 291*** ***Florida – 59***
Location(s) from which employees will be assigned for this project:	***Nevada, California and Florida offices. Additional remote employees in other states (IL, KS, MO, NJ, NY, NC, and TX).***

4.1.2 *Please be advised, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state must register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.*

LIBERTY Dental Plan of Nevada, Inc. is registered in the state of Nevada, Secretary of State Office.

4.1.3 The selected vendor, prior to doing business in the State of Nevada, must be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS76. Information regarding the Nevada Business License can be located at http://nvsos.gov.

Question	Response
Nevada Business License Number:	***NV20071098062***
Legal Entity Name:	***LIBERTY Dental Plan of Nevada, Inc.***

Is "Legal Entity Name" the same name as vendor is doing business as?

Yes	***X***	No	

If "No", provide explanation.

Not applicable.

4.1.4 Vendors are cautioned that some services may contain licensing requirement(s). Vendors shall be proactive in verification of these requirements prior to proposal submittal. Proposals that do not contain the requisite licensure may be deemed non-responsive.

We understand and will comply with requirement 4.1.4. LIBERTY holds a Certificate of Authority to operate as a Prepaid Limited Health Service Organization (PLHSO) issued by the Nevada Department of Insurance. The license was issued on October 10, 2008, and

has been inforce continuously since its date of issuance. We provided a copy of the license, and a letter of good standing, in Part IB, Tab IV – State Documents.

4.1.5 Has the vendor ever been engaged under contract by any State of Nevada agency?

Yes		No	***X***

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:	

4.1.6 Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

Yes		No	***X***

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.

LIBERTY is not currently employing or has employed within the past two years a person who is or has been an employee of an agency of the State of Nevada.

4.1.7 Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP must also be disclosed.

Does any of the above apply to your company?

Yes		No	***X***

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:		

4.1.8 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	***X***	No	

See Figure 4.1.8-1 for Letter of Intent for Insurance Coverage.

FIGURE 4.1.8-1. LETTER OF INTENT FOR INSURANCE COVERAGE

PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

November 22, 2016

Ronda Miller, Purchasing Officer II
Nevada Department of Health and Human Services
Division of Health Care Financing and Policy
515 East Musser Street, Suite 300
Carson City, Nevada 89701

RE: Liberty Dental Plan Corporation
3200 El Camino Real #290
Irvine, CA 92602

Liberty Dental Plan of Nevada, Inc.
RFP #3290 for Dental Benefits Administrator
Estimated Contract Price: $4,000,000

Ms. Ronda Miller:

Philadelphia Indemnity Insurance Company (PHLY), through its operating entities, has provided surety bonds to Liberty Dental Plan Corporation since 2012 during which time we have favorably considered projects up to $15,000,000 single and $20,000,000 aggregate. Our experience with Liberty Dental Plan Corporation has been excellent, and we highly recommend them.

As surety for Liberty Dental Plan Corporation PHLY will favorably consider providing a 100% Performance Bond and a 100% Payment Bond for the above captioned project, provided a contract is awarded to, and executed by Liberty Dental Plan Corporation. According to the 570 circular as of July 1, 2014, issued by the Department of Treasury, PHLY has a surety underwriting limitation of $215,671,000 per bond. Also, PHLY has an A.M Best rating "A++ XV" with a stable outlook.

Please understand that any arrangement for any bonds is a matter between Liberty Dental Plan Corporation and PHLY and we assume no liability to third parties or you if, for any reason, we do not issue requested bonds on behalf of Liberty Dental Plan Corporation.

PHLY expressly reserves the right to review the terms and conditions of the contract, contract amount and bond form, evaluate pertinent underwriting data, and verify the adequacy of project financing prior to the issuance of bonds for the referenced project.

This letter will expire ninety (90) days from the above date.

Very Truly Yours,

Darius M. Cook
Darius M. Cook, Senior Underwriting Specialist – Commercial Surety

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.

LIBERTY has no exceptions or additional assumptions to the insurance requirements.

4.1.9 Company background/history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.

LIBERTY Dental Plan of Nevada, Inc. ("LIBERTY") is pleased to submit our proposal to The State of Nevada, to coordinate dental care for Nevada's Medicaid and Check Up recipients under the direction of the Division of Health Care Financing and Policy (DHCFP).

The key reasons we represent an ideal partner to DHCFP are summarized below. We offer several differentiating features that are in alignment with DHCFP's goals and requirements.

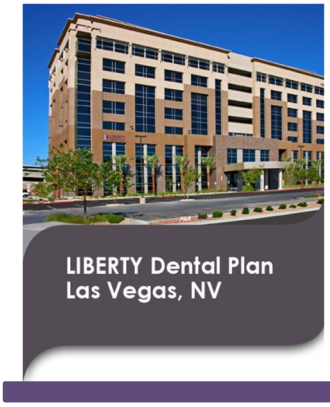
- ***Dental care coordination for Medicaid populations is our core focus. More than half of the members LIBERTY serves nationwide are Medicaid recipients. Our staffing, information systems, and business processes are tailored to address the broad array of access barriers impoverished persons must overcome. Making a positive difference in these persons' lives, at less overall cost to the Medicaid agency and the taxpayer, energizes our organization and is a fulfilling mission.***

- ***We have significant operations in Nevada. LIBERTY currently has 54 Nevada-based employees. We provide dental coverage and care coordination to over 64,000 Nevadans through a delivery system including more than 1,300 dental providers. This RFP creates an exciting opportunity for us to serve the Medicaid population in Nevada where we already have such a strong operational foundation.***

- ***Our model of care works extremely well. We work with great energy and sophistication to facilitate access to preventive care and minimize the need for***

OUR CULTURE

LIBERTY is committed to being the industry leader in providing quality, innovative and affordable dental benefits with the utmost focus on member satisfaction.



"back-end" restorative care (root canals, periodontics, etc.). Our focus is on minimizing overall costs. Our model requires "spending to save" with regard to the administrative activities that are needed to achieve the front-end access to preventive and routine care. For instance, in the California Dental Managed Care Program over the past four years, LIBERTY has increased annual dental visits by 120% for school-aged children, and by 250% in the 0-3 age group category.

- ***We will bring Nevada stakeholders together to elevate oral health. Driving dental access, quality of care, and oral health upward requires a collaborative effort, and we excel at congealing a broad team to achieve this. LIBERTY will create a Dental Advisory Committee (DAC), to meet quarterly to include representatives from DHCFP, dental providers, Medicaid MCOs, advocates, Medicaid recipients, and other community-focused entities. With DHCFP's input, we will establish the DAC membership and our staff will organize the meetings, provide the venue and refreshments, take minutes, etc. The input we obtain through the DAC's activities will help ensure we are all taking advantage of opportunities to achieve our aligned objectives. This forum can also help us identify and address any specific problem areas that may arise.***

- ***We reward high-performing providers. While we are a provider-friendly organization, founded and led by a dentist, LIBERTY creates an accountable care structure that systematically measures and rewards strong provider performance and improvements. Our Centers of Excellence designation (which 12 of our Nevada dental offices have achieved) motivates providers to achieve high performance, both for the visibility of achieving that designation but also for the bonus payment and recipient steerage advantages that earning this designation brings.***

- ***We excel at identifying and eliminating fraud, waste and abuse. In the fee-for-service setting there is a considerable risk that some Medicaid providers will take advantage of the lack of oversight. LIBERTY's initiatives serving Medicaid in Illinois resulted in the elimination of 108 Illinois providers that we felt provided inappropriate quality, inappropriate billing and/or presented a danger to our members. While they were eliminated from our network, 100 of these providers still appear in the directories of our competitors.***

- ***Our management team has over 200 years combined industry experience.***

- ***We have proven experience in timely and complex program implementation including transitioning Fee for Service programs into the managed care setting.***

- ***Mobil units to perform dentistry.***
- ***Our diverse and targeted outreach programs facilitate member education.***
- ***We have customized reporting capabilities under a scalable infrastructure that will meet all of the reporting needs of DHCFP.***
- ***We offer new members 120 days of continuity of care when they have been utilizing non-network providers.***

LIBERTY secured our Prepaid Limited Health Service Organization (PLHSO) Nevada license in 2008, and we also function as a national Dental Benefits Administrator (DBA) designed to and now servicing Medicaid State Child Health Insurance Programs in several states through direct and subcontracting relationships.

Understanding DHCFP's Mission to Improve Nevadans' Dental Health

This contract allows us to expand our substantial existing operations in Nevada with our proven track record of delivering tailored care coordination services to Medicaid recipients. Understanding that healthcare is local, we are looking forward to adding even more Nevadans to our dental operations staff. We opened our Las Vegas based operational center in 2008. Our current staff of 54 includes member service and fulfillment representatives, claims processors, local dental consultants, and provider network representatives. Our Nevada team has built strong and long term relationships with providers and advocates in the Nevada oral health community. We have proudly served the management employees of the MGM Resorts International and Las Vegas Sands Corp groups for 6 years. Our direct Nevada presence, knowledge, and history combined with our national Medicaid experience allows us to develop a tailored program to meet the needs of the Medicaid and NCU Programs and to implement the program on an efficient and timely basis. We are familiar with the unique needs of Clarke and Washoe Counties, as well as the Nevada oral health community and are prepared to serve the Nevada Medicaid population.

Our Experience in Medicaid

We consider our core business to be Medicaid and other similar government reimbursement programs. LIBERTY currently serves over 3 million individuals, nationwide, over 2 million of whom are Medicaid recipients. Since 2005, we have served Medicaid recipients through direct contracts and on behalf of health plans, improving the oral health of our members through improved adherence to preventative care, and access to quality dental treatment. We have proven we can deliver quality, cost-controlled appropriate care through ongoing oversight of our provider practice patterns and utilization trends, which identify gaps in care that we are able to immediately address and resolve.

One of the many reasons we enjoy focusing on the Medicaid population is that the care coordination we deliver is the <u>only</u> means available for achieving meaningful overall cost savings. In the commercial arena, for example, patient cost-sharing and provider rate discounts are key levers for driving costs downward. Such cost reduction approaches are not viable for an impoverished population nor for a dental provider community that is already challenged to accept patients at the Medicaid fee schedule.

We work with great energy and sophistication to facilitate access to preventive care and minimize the need for "back-end" restorative care (root canals, periodontics, etc.). This requires "spending to save" with regard to the administrative activities that are needed to achieve the front-end access to preventive and routine care. The access barriers the Medicaid population faces are such that we must work intensively to track utilization and conduct outreach to ensure that front-end care occurs. These investments, however, pay off both for our members, in terms of improved oral health, and for the State Medicaid agencies we support (and ultimately, for the taxpayer).

Our prior activities have yielded expansion of our existing client relationships with a client retention rate of over 90%, and have also positioned us to continually win business from our competitors.

- ***We have successfully implemented multiple Medicaid programs in several states within relatively short timeframes, including those of DHCFP's size and scope. We implemented the Florida Medicaid Managed Medical Assistance (MMA) and Illinois' Temporary Assistance for Needy Families (TANF), for effective dates of May 2014 and July 2014, respectively, at the same time for over 1 million members between the two states.***

- ***We excel at effectively partnering with health plans and Medicaid agencies to develop unique programs and solutions that improve existing initiatives. These***

relationships have established strong partnerships and trust between us and our clients. We have, thus, frequently been called upon to replace ineffective dental benefit administrators in the Medicaid industry. For example, in 2012, the California Department of Managed Health Care requested that we take over serving Medi-Cal recipients for two low performing dental plans including Community Dental Services (SmileCare) and American HealthGuard.

> ***"Unfortunately, just about all of us have experienced severe tooth pain. Early in my career I took great pride as a clinical healer, seeing how much better off my patients were on the way out of my office than how they felt on the way in. Knowing that dental issues are all treatable and reversible drove me to seek out better more efficient ways to get people in a continuum of care in an effort to minimize the degree to which dental crises were occurring in the first place.***
>
> ***I founded LIBERTY to help that occur on a large scale. We invest heavily up front in tailored staff and information technologies as we partner with each local dental provider community to maintain oral health and prevent dental flare-ups from happening. It's a great model for our members and their health, and it also achieves the lowest overall costs. We very much look forward to extending our mission and services to Nevada's Medicaid population, if our proposal is selected."***
>
> ***Amir Neshat. DDS. President and CEO. LIBERTY Dental Plan***

4.1.10 Length of time vendor has been providing services described in this RFP to the public and/or private sector. Please provide a brief description.

LIBERTY Dental Plan of California, Inc. (LIBERTY) began providing dental administrative services to the public sector in 2003. LIBERTY's first Medicaid program began in 2005. LIBERTY Dental Plan of Nevada, Inc. began providing services to the public sector in Clark County in 2008.

4.1.11 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.

4.1.11.1 Dun and Bradstreet Number

Please refer to Part III, Confidential Financial Information.

4.1.11.2 Federal Tax Identification Number

Please refer to Part III, Confidential Financial Information.

4.1.11.3 The last two (2) years and current year interim:

A. Profit and Loss Statement

B. Balance Statement

Please see Attachment 1 for our 2014 -2016 LIBERTY Financial Statements in Part III, Confidential Financial Information.

Attachment 1 includes the Statutory Basis financial statements of LIBERTY Dental Plan of Nevada, Inc. for the last two years ending December 31, 2015 and 2014, and for the nine month interim period ending September 30, 2016. LIBERTY Dental Plan of Nevada, Inc. is a wholly owned subsidiary of LIBERTY Dental Plan Corporation. Therefore, in Attachment 1 we have also included the Consolidated Audited financial statements of LIBERTY Dental Plan Corporation, for the three years ending June 30, 2016, and the interim unaudited statement for the period ending September 30, 2016. In order to show the full financial strength of the LIBERTY organization, we also included in Attachment 1, the Combined financial statements of LIBERTY Dental Plan Corporation, and its sister company, LIBERTY Dental Plan Of California for the three years ending June 30, 2016, and the interim period ending September 30, 2016.

4.2 SUBCONTRACTOR INFORMATION

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4.2.1 Does this proposal include the use of subcontractors?

Yes	*X*	No	

If "Yes", vendor must:

4.2.1.1 Identify specific subcontractors and the specific requirements of this RFP for which each proposed subcontractor will perform services.

We directly perform the vast majority of our operational functions, including all aspects of claims processing. We view this to be the best model for ensuring quality, cost-effective service. However, for some services, using a specialized vendor provides greater quality, efficiency and/or value for recipients, providers and the State. In line with this, LIBERTY plans to use the following specialized subcontractors if awarded the Nevada contract:

- ***Orange County Direct Mail (OCDM)***
- ***MAGNUS***
- ***VerifPoint/CreDENTALs Inc.***

We have a proven and successful working relationship with all three of these subcontractors for the states in which we currently operate. Details of each contractual relationship are provided in the next sections.

4.2.1.2 If any tasks are to be completed by subcontractor(s), vendors must:

A. Describe the relevant contractual arrangements;

B. Describe how the work of any subcontractor(s) will be supervised, channels of communication will be maintained and compliance with contract terms assured; and

C. Describe your previous experience with subcontractor(s).

Orange County Direct Mail (OCDM)

A) OCDM produces and distributes direct-mail individual insurance identification cards to LIBERTY members according to the contractual timeframes and instructions LIBERTY provides them. After distribution OCDM confirms their processing date.

B) LIBERTY's Fulfillment Department fulfills new member materials onsite, but we outsource high-volume requests to OCDM. When work is outsourced, we have a tracking mechanism to monitor and evaluate OCDM's performance. Our process can be electronically tracked from receipt of eligibility files to confirmation of mailing by

OCDM. First, an electronic export file is produced and transmitted to OCDM via secure FTP delivery with PGP encryption. OCDM then produces and mails the materials according to contractual timeframes and guidelines we provide them, and confirms their processing date. Appended to each electronic export is a seed record, which is addressed to LIBERTY and serves as confirmation of not only the mailing date of all records in a given file, but also confirms the accuracy of the packet contents. Large-volume files may have multiple seed records. Upon receipt by LIBERTY, these seed packets are examined by Fulfillment staff and compared to source documents as a post-mailing quality control validation. Additionally, an internal ID Card Lag Time report is reviewed regularly to ensure all materials mailed by our vendor are timely by comparing the initial date an enrollment file was received against OCDM's mailing date.

C) This vendor has consistently met or exceeded all contractual performance expectations throughout the 5 years of our business relationship.

MAGNUS

A) MAGNUS is a health care focused language services vendor used by LIBERTY for print and web translations, as well as telephonic, video remote, and in-person interpretation.

B) For print and web translations, MAGNUS provides services upon demand. Each separate request is tracked through an internal ticket system with assigned due dates. Each request is submitted for an estimate of time and cost and is tracked accordingly. Each completed request is returned with a statement certifying the credentials of the translator as well as their expertise in the field of healthcare terminology. Lag time reports can be run from the internal ticket system to confirm elapsed time between request and delivery of the finished product.

For all other translations, which are also provided on demand, they occur in real-time and require the presence of a LIBERTY staff member. The recipient participates in a 3-way conversation where they can ask questions and obtain plan information and assistance in their native language. Member satisfaction is ensured prior to the termination of the call, and the LIBERTY Member Service representative takes responsibility for any follow-up by completing a work flow. Our contract with MAGNUS stipulates specific minimum requirements for interpreter qualifications, including National Board Certifications.

We audit MAGNUS annually to ensure they meet our performance and compliance standards, including privacy, security, fraud, waste, and abuse, and general compliance requirements. MAGNUS has demonstrated its understanding of the

healthcare industry, the managed care regulatory environment, and the importance of clear recipient communications from a legal, quality-of-care, and ethical viewpoint. It has a strong track record of helping health plans comply with CMS and state requirements related to the delivery of prompt and high quality health care communications to recipients in their preferred language.

C) This vendor has consistently met or exceeded all contractual performance expectations throughout the 9 years of our business relationship.

VerifPoint/CreDENTALs Inc.

A) VerifPoint/CreDENTALs Services, Inc. is a leading Credentials Verification Organization (CVO). VerifPoint's core competency is to collect, verify, and organize data and document images in order to generate online practitioner credentialing reports, including management reports that keep LIBERTY continually apprised of the status of our network's dental providers.

B) LIBERTY's Credentialing Committee, chaired by our Dental Director, is ultimately accountable for all functions performed within its purview, whether those functions are performed directly or indirectly by our CVO. The quality and timeliness of VerifPoint's work is essential to our overall credentialing process and is closely monitored by our Credentialing Department. On a daily basis, our staff reviews our credentialing log and performs additional outreach to ensure all credentialing and recredentialing files are completed in a timely manner, including placing calls to providers or following up with VerifPoint on items that risk falling out of cycle. Additionally, LIBERTY's Credentialing Supervisor conducts an annual audit of all services delegated to VerifPoint. This annual oversight audit reviews a random selection of 15 initial credentialing files and 15 recredentialing files, along with all VerifPoint Policies and Procedures and NCQA and URAC Certifications.

C) VerifPoint has consistently scored above our 90% benchmark during their delegation reviews, and the most recent audit, conducted in May 2015, found all certifications and Policies and Procedures to be compliant, and all initial and recredentialing files passed with 100% scores.

4.2.1.3 Vendors must describe the methodology, processes and tools utilized for:

A. Selecting and qualifying appropriate subcontractors for the project/contract;

B. Ensuring subcontractor compliance with the overall performance objectives for the project;

C. Ensuring that subcontractor deliverables meet the quality objectives of the project/contract; and

D. Providing proof of payment to any subcontractor(s) used for this project/contract, if requested by the State. Proposal should include a plan by which, at the State's request, the State will be notified of such payments.

A) We follow an established competitive process to identify qualified subcontractors, request bids, and select the most appropriate provider for each project/contract. We vetted OCDM, Magnus and VerifPoint/CreDENTALs Inc. the established process. All prospective and existing subcontractors must, at a minimum, supply the following information for review by our legal team:

- ***Completed LDP New Vendor form;***
- ***W9;***
- ***Proof of applicable insurance coverage;***
- ***Results of background check conducted by LDP;***
- ***Demonstration of ability to comply with any applicable HIPAA or compliance regulations.***

B) Our legal team works with all prospective subcontractors to complete the vetting process and presents Executive Staff with all qualified subcontractors. Once chosen, LIBERTY and the subcontractor agree upon overall performance guarantees and specific project objectives, which are negotiated into the contract. Only after all required documents are signed and fully executed by both parties can the subcontractor commence work.

C) Performance metrics and reporting methodology are identified and assigned to the applicable operational area, whereby each department at LIBERTY is responsible for basic managerial oversight, while our legal and executive teams support any challenges or performance failures of the agreement. Each department leader has an understanding of the deliverables and expectations of any subcontractor with whom they are involved, and consequently is responsible for escalating any issues or concerns with subcontractor performance or compliance.

D) LIBERTY agrees to provide proof of payment to any subcontractors used for this project upon request by Nevada Check Up. Systems are in place with reporting capabilities, and will be designed in accordance with specific data requirements once they are identified.

4.2.1.4 Provide the same information for any proposed subcontractors as requested in Section 4.1, Vendor Information.

4.2.1.5 Business references as specified in Section 4.3, Business References must be provided for any proposed subcontractors.

Information for each of our subcontractors addressing RFP requirements 4.1 and 4.3 can be found below.

Orange County Direct Mail (OCDM)

4.1.1 Vendors must provide a company profile in the table format below.

Question	Response
Company name:	***Orange County Direct Mail (OCDM)***
Ownership (sole proprietor, partnership, etc.):	***Sole Proprietor***
State of incorporation:	***California***
Date of incorporation:	***1996***
# of years in business:	***26***
List of top officers:	***Mark Cretz***
Location of company headquarters:	***3400 S. Susan St. Santa Ana CA***
Location(s) of the company offices:	***3400 S. Susan St. Santa Ana CA***
Location(s) of the office that will provide the services described in this RFP:	***3400 S. Susan St. Santa Ana CA***
Number of employees locally with the expertise to support the requirements identified in this RFP:	***0***
Number of employees nationally with the expertise to support the requirements in this RFP:	***51***
Location(s) from which employees will be assigned for this project:	***3400 S. Susan St. Santa Ana CA***

4.1.2 Please be advised, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state must register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.

4.1.3 The selected vendor, prior to doing business in the State of Nevada, must be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS76. Information regarding the Nevada Business License can be located at http://nvsos.gov.

Question	Response
Nevada Business License Number:	***N/A***
Legal Entity Name:	

Is "Legal Entity Name" the same name as vendor is doing business as?

Yes		No	

If "No", provide explanation.

We will obtain a Nevada Business License Number upon LIBERTY Dental Plan being awarded the contract for RFP 3290. Once we obtain the license, we will provide the above information to the State of Nevada and to LIBERTY Dental Plan.

4.1.4 Vendors are cautioned that some services may contain licensing requirement(s). Vendors shall be proactive in verification of these requirements prior to proposal submittal. Proposals that do not contain the requisite licensure may be deemed non-responsive.

4.1.5 Has the vendor ever been engaged under contract by any State of Nevada agency?

Yes		No	***X***

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:	***N/A***
State agency contact name:	
Dates when services were performed:	
Type of duties performed:	
Total dollar value of the contract:	

4.1.6 Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

Yes		No	***X***

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.

We do not have any employees who work for the State of Nevada currently or within the last two years.

4.1.7 Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP must also be disclosed.

Does any of the above apply to your company?

Yes		No	***X***

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:	***N/A***
Parties involved:	
Description of the contract failure, contract breach, or litigation, including the products or services involved:	

Question	Response	
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:		

4.1.8 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	X	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.

Acknowledged, we will comply upon contract award.

4.1.9 Company background/history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.

Founded in 1990, OCDM is a fully integrated Direct Mail facility offering Mailing, Data, Fulfillment, Offset and Digital Printing Solutions.

We use our comprehensive data programming, printing, and lettershop capabilities to produce all types of jobs from small focused projects to multi-million piece national and international distributions.

Our secure data services are Sarbanes-Oxley and HIPAA compliant using the latest technology for encrypted data transfer, processing and destruction.

At our core, OCDM is a mail house. Our specialty is our extensive knowledge of all USPS postal regulations to obtain the best postal discounts, while ensuring that each mail piece is delivered to the recipient in the most accurate and efficient manner.

We employ modern lettershop methods for inkjet addressing, folding, bindery, inserting and tracking using 2D barcode systems for optical matching and quality control. This ensures that the right letter, catalog, ID card, or other personalized material is inserted into the exact matching envelope every time.

Our on-site Printing services include 4-color offset printing presses and production level digital black/white and digital CMYK color sheeted laser printers capable of high speed variable data printing for personalized letters, brochures, cards and small books. Having on-site printing ensures that your data will not be sent out to any 3rd party vendor, but will remain in our secure facility.

Our wide range of clientele are small business owners, car dealerships, city and county government publishing agencies, credit and insurance companies, medical membership organizations, nonprofits, mortgage and financial institutions, schools and universities, national law offices and courts, among others.

Since 2012, OCDM provides complete data processing, digital printing of identification cards, production and distribution of member packets for LIBERTY Dental Plan in Irvine, California. This includes regular distribution projects for LIBERTY Dental Plan of California, Health Net Dental, Staywell of Tampa, Florida, as well as other projects that arise.

4.1.10 Length of time vendor has been providing services described in this RFP to the public and/or private sector. Please provide a brief description.

OCDM has been providing direct mail and marketing services to both the public and private sector for over 26 years. OCDM was founded in 1990.

4.1.11 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.

4.1.11.1 Dun and Bradstreet Number

Please refer to Part III, Confidential Financial Information.

4.11.2 Federal Tax Identification Number

Please refer to Part III, Confidential Financial Information.

4.1.11.3 The last two (2) years and current year interim:

A. Profit and Loss Statement

B. Balance Statement

Please see Attachment 2 for OCDM's financial statements in Part III, Confidential Financial Information.

4.3.1 Vendors should provide a minimum of three (3) business references from similar projects performed for private, state and/or large local government clients within the last three (3) years.

4.3.2 Vendors must provide the following information for every business reference provided by the vendor and/or subcontractor:

The "Company Name" must be the name of the proposing vendor or the vendor's proposed subcontractor.

Reference #:	***1***		
Company Name:	***Orange County Direct Mail (OCDM)***		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	**X**	SUBCONTRACTOR
Project Name:	**City of Cerritos**		
Primary Contact Information			
Name:	***Laurie Kajiwara***		
Street Address:	***18125 S. Bloomfield Ave***		
City, State, Zip:	***Cerritos, CA 90703***		
Phone, including area code:	***(562) 916-1320***		
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:	***Direct mail packages, including data processing and postal sorting for best available, addressing material, delivery to post office and coordinating dropships.***
Original Project/Contract Start Date:	***2012***
Original Project/Contract End Date:	***2013. 3 annual extensions awarded thru 2016***
Original Project/Contract Value:	***$200,000***
Final Project/Contract Date:	***SEPT 2016. Annual contract awarded again OCT 2016.***
Was project/contract completed in time originally allotted, and if not, why not?	***Yes***
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***Yes***

Reference #:	***2***		
Company Name:	***Orange County Direct Mail (OCDM)***		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	**X**	SUBCONTRACTOR
Project Name:	**Anthony & Associates**		
Primary Contact Information			
Name:		***Roger Anthony***	
Street Address:		***106 W. Fourth Street, 4th Floor***	
City, State, Zip:		***Santa Ana, CA 92701***	
Phone, including area code:		***(174) 972-8114***	
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:	***One of many projects quoted since 2011:*** ***Monthly direct mail packages, including data processing and postal sorting for best postage available, laser printing with addressing, bindery, delivery to post office and coordinating dropshipping as needed.***
Original Project/Contract Start Date:	***NOV 2016***
Original Project/Contract End Date:	***NOV 2016***
Original Project/Contract Value:	***$18,000***
Final Project/Contract Date:	***NOV 2016***
Was project/contract completed in time originally allotted, and if not, why not?	***YES***
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***YES***

Reference #:	***3***		
Company Name:	***Orange County Direct Mail (OCDM)***		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	***X***	SUBCONTRACTOR
Project Name:	***Computershare***		
Primary Contact Information			
Name:			***James Rothmuller***
Street Address:			***462 south Fourth Street***
City, State, Zip:			***Louisville, KY 40202***
Phone, including area code:			***(502) 318-0454***
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:	***One of many projects quoted since 2013:*** ***Direct mail, including data processing and postal sorting for best postage available, offset printing, laser printing with addressing, bindery, delivery to post office.***
Original Project/Contract Start Date:	***OCT 2016***
Original Project/Contract End Date:	***NOV 2016***
Original Project/Contract Value:	***$41,000***
Final Project/Contract Date:	***NOV 2016***
Was project/contract completed in time originally allotted, and if not, why not?	***YES***
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***YES***

MAGNUS

4.1.1 Vendors must provide a company profile in the table format below.

Question	Response
Company name:	***Magnus International Trade Services Corp.***
Ownership (sole proprietor, partnership, etc.):	***Corporation***
State of incorporation:	***California***
Date of incorporation:	***08/26/1993***
# of years in business:	***23***
List of top officers:	***Richard Antoine***
Location of company headquarters:	***Walnut, CA***
Location(s) of the company offices:	***Walnut, CA*** ***Lima, Perú***
Location(s) of the office that will provide the services described in this RFP:	***1313 N Grand Ave, #280*** ***Walnut, CA 91789***
Number of employees locally with the expertise to support the requirements identified in this RFP:	***0***
Number of employees nationally with the expertise to support the requirements in this RFP:	***3,200***
Location(s) from which employees will be assigned for this project:	***USA (Interpreting & HIPAA translations) & Lima, Perú (non-HIPAA translation management)***

4.1.2 Please be advised, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state must register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.

4.1.3 The selected vendor, prior to doing business in the State of Nevada, must be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS76. Information regarding the Nevada Business License can be located at http://nvsos.gov.

Question	**Response**
Nevada Business License Number:	***N/A***
Legal Entity Name:	

Is "Legal Entity Name" the same name as vendor is doing business as?

Yes	***X***	No	

If "No", provide explanation.

4.1.4 Vendors are cautioned that some services may contain licensing requirement(s). Vendors shall be proactive in verification of these requirements prior to proposal submittal. Proposals that do not contain the requisite licensure may be deemed non-responsive.

4.1.5 Has the vendor ever been engaged under contract by any State of Nevada agency?

Yes		No	***X***

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:	***N/A***
State agency contact name:	
Dates when services were performed:	
Type of duties performed:	
Total dollar value of the contract:	

4.1.6 Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

Yes		No	***X***

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.

Not applicable.

4.1.7 Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP must also be disclosed.

Does any of the above apply to your company?

Yes		No	***X***

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:	***N/A***
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:		

4.1.8 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	***X***	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.

MAGNUS will comply upon contract award.

4.1.9 Company background/history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.

MAGNUS is unique in the language industry because of its broad range of well-developed services and its sole focus on healthcare. MAGNUS clients receive:

1. ***A single point of contact to secure all language services and ensure consistency of message.***
2. ***An experienced contact who understands the healthcare industry and both its unique needs and regulatory environment.***
3. ***An experienced management team which understands the complex challenge of communicating with a linguistically and culturally diverse community.***

4. ***Experienced linguistic, content-development and training teams which are familiar with healthcare terminology and practice globally, with specific expertise on terminology and practice within the United States.***
5. ***A dynamic organization, focused on enabling communications in a culturally competent manner.***

MAGNUS is a focused organization, dedicated to leading and improving quality within the healthcare and language industries. As a long time corporate member of the ATA, one of the first members of CHIA, the California Healthcare Interpreters Association, and a founding member of the Association of Language Companies, MAGNUS has consistently taken a leadership role in efforts to improve quality and ensure that the patients, whom we ultimately serve, understand how to best choose the care they need.

At MAGNUS, we work to understand the goals of each of our clients and to develop an approach and working relationship which lasts over the long term.

History

For over 20 years, MAGNUS has been dedicated to providing language services specifically for the healthcare industry. Key highlights in our history include securing our first client, Maxicare, early in 1994 and providing the translation of vital documents, including the health plan's EOC. We also translated materials in support of many of California's local initiatives (County- government managed health plans) as they established their operations and began offering services in the mid '90s.

In 2004, MAGNUS formalized its design capabilities and began offering this service to clients. This capability has continued to grow and we now offer writing services, with the goal of reducing healthcare disparities. Our experience includes the development of culturally sensitive materials optimized for people with Limited English Proficiency as well as low literacy and cognitive impairments.

In 2005, MAGNUS re-branded its interpreting offering as the MAGNUS Language Valet. Through this program, hospitals, health insurance companies and clinics nationwide have access to professional interpreters 24 hours per day, every day of the year in over 150 languages either in-person or by phone.

In 2010, MAGNUS established its training offering, beginning with linguistic assessments and expanding to include language and interpreter training in 2012.

Our commitment to healthcare is current, long-term, and ongoing. Our clients in the past 3 months include general and specialty health insurance companies like Delta Dental (Since 1998) and United Healthcare (Since 1989), Hospitals like IU North Medical Center in Carmel, Indiana (Since opening in 2005) and Presbyterian Intercommunity Hospital in Whittier, California (Since 2003), Patient Care Clinics, Health Research Organizations, Survey Research companies, Health Education Publishers, Medical

Groups and non-profits. This is only a partial description of our client base and, again, these are the types of clients we have worked with in the previous 3 months.

Throughout the years, we have also added well-respected national accounts related to the health industry. The Rand Corporation, NCQA, Datastat, National Research Corp and Mathematica Policy Research are all companies which conduct studies in the healthcare field. These are all long-term MAGNUS clients for whom consistent, understandable and accurate translations are critical to project success.

Organization and Services

MAGNUS provides the following services to its healthcare client base:

- ***Document translation, including support services such as document formatting, file prepress, multilingual design, readability analysis and consulting, coordination of community reviews.***
- ***Website design, translation and localization, including testing for groups with special needs.***
- ***Telephonic interpreting via the MAGNUS Language Valet. The Language Valet provides our healthcare clients' access to professionally trained interpreters 24 hours per day, every day of the year in over 150 languages, simply by dialing a toll-free access number.***
- ***Face-to-Face interpreting. MAGNUS also provides experienced, professional in-person interpreters in over 100 languages.***
  - ***InterpreterEd.com training and testing programs:***
  - ***Medical Healthcare Interpreter Training program, to meet the requirements of both The Certification Commission for Healthcare Interpreters (CCHI) and The National Board of Certification for Medical Interpreters (National Board).***
  - ***Spanish for Health Professionals, to help clinical staff learn basic language and cultural skills for communicating with Spanish speaking patients.***
  - ***Linguistic assessments, informal testing to confirm staff language capabilities in any of the over 160 languages we support.***

All of our services are backed by our guarantee of your complete satisfaction.

Memberships / Credentials

MAGNUS holds the following memberships:

- ***Founding Member, Association of Language Companies (www.alcus.org)***
- ***Corporate Member, American Translators Association (www.atanet.org)***
- ***Member, California Healthcare Interpreters Association (www.chia.ws)***
- ***Member, ASTM Committee F43 on Language Services and Products (www.astm.org)***

4.1.10 Length of time vendor has been providing services described in this RFP to the public and/or private sector. Please provide a brief description.

For over 20 years, MAGNUS has been dedicated to providing language services specifically for the healthcare industry. Key highlights in our history include securing our first client, Maxicare, early in 1994 and providing the translation of vital documents, including the health plan's EOC. We also translated materials in support of many of California's local initiatives (County- government managed health plans) as they established their operations and began offering services in the mid '90s.

4.1.11 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.

4.1.11.1 Dun and Bradstreet Number

Please refer to Part III, Confidential Financial Information.

4.11.2 Federal Tax Identification Number

Please refer to Part III, Confidential Financial Information.

4.1.11.3 The last two (2) years and current year interim:

A. Profit and Loss Statement

B. Balance Statement

Please see Attachment 3 for MAGNUS' financial statements in Part III, Confidential Financial Information.

4.3.1 Vendors should provide a minimum of three (3) business references from similar projects performed for private, state and/or large local government clients within the last three (3) years.

4.3.2 Vendors must provide the following information for every business reference provided by the vendor and/or subcontractor:

The "Company Name" must be the name of the proposing vendor or the vendor's proposed subcontractor.

Section 4.3.2 Subcontractor Reference – Magnus

Reference #:	***1***		
Company Name:	***MAGNUS***		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	**X**	SUBCONTRACTOR
Project Name:	***Alignment Healthcare***		
Primary Contact Information			
Name:	***Lily Wendt***		
Street Address:	***1100 W. Town and Country Road, #1600***		
City, State, Zip:	***Orange, CA 92868***		
Phone, including area code:	***(657) 218-7430***		
Facsimile, including area code:	***(323) 728-1460***		
Email address:	***LWendt@ahcusa.com***		
Alternate Contact Information			
Name:	***1100 W. Town and Country Road, #1600***		
Street Address:	***Orange, CA 92868***		
City, State, Zip:			
Phone, including area code:	***(323) 728-1460***		
Facsimile, including area code:	***mpreciado@ahcusa.com***		
Email address:	***1100 W. Town and Country Road, #1600***		
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:	***Telephonic interpreting support for national call centers.***		
Original Project/Contract Start Date:	***9/2007***		
Original Project/Contract End Date:	***N/A***		
Original Project/Contract Value:	***Not disclosed***		
Final Project/Contract Date:	***N/A***		
Was project/contract completed in time originally allotted, and if not, why not?	***Currently servicing, no contract end date***		
Was project/contract completed within or under the original budget/	***Currently servicing, no contract end date***		

cost proposal, and if not, why not?	

Reference #:	***2***		
Company Name:	***MAGNUS***		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	***X***	SUBCONTRACTOR
Project Name:	***Datastat***		
Primary Contact Information			
Name:	***Marielle Weindorf***		
Street Address:	***3975 S. Research Park Drive***		
City, State, Zip:	***Ann Arbor MI 48108***		
Phone, including area code:	***(734) 994-0540 x186***		
Facsimile, including area code:	***(734) 972-5406***		
Email address:	***mweindorf@datastat.com***		
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:	***Translation and telephone answering support for large, multilingual survey projects***		
Original Project/Contract Start Date:	***9/2000***		
Original Project/Contract End Date:	***N/A***		
Original Project/Contract Value:	***Not disclosed***		
Final Project/Contract Date:	***N/A***		
Was project/contract completed in time originally allotted, and if not, why not?	***Currently servicing, no contract end date***		
Was project/contract completed	***Currently servicing, no contract end date***		

within or under the original budget/ cost proposal, and if not, why not?	

Reference #:	***3***		
Company Name:	***MAGNUS***		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	***X***	SUBCONTRACTOR
Project Name:	***Maricich Health, agency for LA Care***		
Primary Contact Information			
Name:	***Mark Maricich, CEO***		
Street Address:	***18201 McDurmott W., Suite A***		
City, State, Zip:	***Irvine, CA 92614***		
Phone, including area code:	***949-223-6455***		
Facsimile, including area code:	***949-223-6451***		
Email address:	***mark@maricich.com***		
Alternate Contact Information			
Name:			
Street Address:	***18201 McDurmott W., Suite A***		
City, State, Zip:	***Irvine, CA 92614***		
Phone, including area code:	***949-223-6455***		
Facsimile, including area code:	***949-223-6451***		
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:	***Full translation, formatting and quality control of annual enrollment package. Project expanded from 3 languages to 8. High quality document designs with strict formatting specifications and tight deadlines.***		
Original Project/Contract Start Date:	***9/2009***		
Original Project/Contract End Date:	***3/2010***		
Original Project/Contract Value:	***$60,000***		
Final Project/Contract Date:	***3/2016***		
Was project/contract completed in time originally allotted, and if not, why not?	***On time***		

Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***Within budget***

VerifPoint/CreDENTALs Inc.

4.1.1 Vendors must provide a company profile in the table format below.

Question	Response
Company name:	***CreDENTALs Services, Inc. dba VerifPoint***
Ownership (sole proprietor, partnership, etc.):	***Corporation***
State of incorporation:	***CA***
Date of incorporation:	***5/28/2013***
# of years in business:	***20 Years***
List of top officers:	***Asim, Shary, CEO***
Location of company headquarters:	***25381 Commercentre Dr. Suite 200 Lake Forest, CA 92630***
Location(s) of the company offices:	***25381 Commercentre Dr. Suite 200 Lake Forest, CA 92630***
Location(s) of the office that will provide the services described in this RFP:	***25381 Commercentre Dr. Suite 200 Lake Forest, CA 92630***
Number of employees locally with the expertise to support the requirements identified in this RFP:	***60***
Number of employees nationally with the expertise to support the requirements in this RFP:	***N/A***
Location(s) from which employees will be assigned for this project:	***25381 Commercentre Dr. Suite 200 Lake Forest, CA 92630***

4.1.2 Please be advised, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state must register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.

4.1.3 The selected vendor, prior to doing business in the State of Nevada, must be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS76. Information regarding the Nevada Business License can be located at http://nvsos.gov.

Question	Response
Nevada Business License Number:	***N/A***
Legal Entity Name:	***CreDENTALs Services, Inc. dba VerifPoint***

Is "Legal Entity Name" the same name as vendor is doing business as?

Yes	***X***	No	

If "No", provide explanation.

4.1.4 Vendors are cautioned that some services may contain licensing requirement(s). Vendors shall be proactive in verification of these requirements prior to proposal submittal. Proposals that do not contain the requisite licensure may be deemed non-responsive.

4.1.5 Has the vendor ever been engaged under contract by any State of Nevada agency?

Yes		No	***X***

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:	

4.1.6 Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

Yes		No	***X***

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.

4.1.7 Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP must also be disclosed.

Does any of the above apply to your company?

Yes		No	***X***

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:	***N/A***
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:	

Question	Response	
If the matter has resulted in a court case:	Court	Case Number
Status of the litigation:		

4.1.8 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	***X***	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.

VerifPoint will comply upon contract award.

4.1.9 Company background/history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.

Our Vision is to become the premier credentialing verification organization (CVO) against which all other CVOs are judged. Our ability to adapt to change and our foundation of technological advancement has enabled VerifPoint/Credentialing Solutions to become a leader in the credentialing industry. This achievement can only be continued by providing consistent quality service at a competitive price, adhering to our performance standards and customer expectations.

Our Mission is to consistently lead the industry as the lowest cost, highest tech supplier, of timely, accurate practitioner information.

BRIEF HISTORY

VerifPoint is a leading Credentials Verification Organization based in Lake Forest, southern California whose mission is to consistently lead the industry as the lowest cost, highest tech supplier of timely, accurate health care practitioner information.

VerifPoint is a DBA for CreDENTALs Services, Inc. which was founded in 1996. Additionally, VerifPoint acquired Credentialing Solutions, LLC in 2007.

VerifPoint offers services to improve and expedite the credentialing process of health care providers. Fully certified by NCQA and accredited by URAC, VerifPoint provides primary source verification that meets industry and regulatory standards such as NCQA, JCAHO, URAC, and AAAHC.

It is the core competency of VerifPoint to collect, verify and organize data and document images in order to generate online practitioner credentialing reports. Additionally, many provider network management reports are included with the credentials reports to keep clients constantly informed of the status of the health care practitioners in their network.

4.1.10 Length of time vendor has been providing services described in this RFP to the public and/or private sector. Please provide a brief description.

VerifPoint has been in business since 1996.

4.1.11 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.

4.1.11.1 Dun and Bradstreet Number

Please refer to Part III, Confidential Financial Information.

4.11.2 Federal Tax Identification Number

Please refer to Part III, Confidential Financial Information.

4.1.11.3 The last two (2) years and current year interim:

A. Profit and Loss Statement

B. Balance Statement

Please see Attachment 4 for VerifPoint's financial statements in Part III, Confidential Financial Information.

4.3.1 Vendors should provide a minimum of three (3) business references from similar projects performed for private, state and/or large local government clients within the last three (3) years.

4.3.2 Vendors must provide the following information for every business reference provided by the vendor and/or subcontractor:

The "Company Name" must be the name of the proposing vendor or the vendor's proposed subcontractor.

Section 4.3.2 Subcontractor Reference – VerifPoint/CreDENTALs, Inc.

Reference #:	***1***		
Company Name:	***VerifPoint/CreDENTALs, Inc.***		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	**X**	SUBCONTRACTOR
Project Name:	***Credentialing services***		
Primary Contact Information			
Name:	***Tammy D Lord*** ***United Concordia Companies, Inc.***		
Street Address:	***4401 Deer Path Road DP/3B***		
City, State, Zip:	***Harrisburg PA 17110***		
Phone, including area code:	***717-260-7503***		
Facsimile, including area code:	***717-260-6938***		
Email address:	***tammy.lord@ucci.com***		
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:	***Perform initial and recredentialing for their network of providers.***
Original Project/Contract Start Date:	***2011***
Original Project/Contract End Date:	***Present***
Original Project/Contract Value:	***Did not disclose***
Final Project/Contract Date:	***Ongoing***
Was project/contract completed in time originally allotted, and if not, why not?	***On Time***
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***Within Budget***

Reference #:	***2***		
Company Name:	***VerifPoint/CreDENTALs, Inc.***		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	***X***	SUBCONTRACTOR
Project Name:	***Credentialing Services***		
Primary Contact Information			
Name:	***Rachel Cox GEHA/Connection Dental***		
Street Address:	***P.O. Box 4665***		
City, State, Zip:	***Independence, MO 64051***		
Phone, including area code:	***(800)505-8880, Ext 4703***		
Facsimile, including area code:			
Email address:	***rachel.cox@geha.com***		
Alternate Contact Information			
Name:	***Shannon Reynolds GEHA/Connection Dental***		
Street Address:	***P.O. Box 4665***		
City, State, Zip:	***Independence, MO 64051***		
Phone, including area code:	***816-434-4464***		

Facsimile, including area code:	
Email address:	***Shannon.reynolds@geha.com***
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:	***Perform initial and recredentialing for their network of providers.***
Original Project/Contract Start Date:	***2010***
Original Project/Contract End Date:	***Present***
Original Project/Contract Value:	***Did not disclose***
Final Project/Contract Date:	***Ongoing***
Was project/contract completed in time originally allotted, and if not, why not?	***Yes***
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***Yes***

Reference #:	***3***		
Company Name:	***VerifPoint/CreDENTALs, Inc.***		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	**X**	SUBCONTRACTOR
Project Name:	***Credentialing Services***		
Primary Contact Information			
Name:	***Scott Chandler, RPh*** ***Evolve Vision***		
Street Address:	***112 Zebulon Court***		
City, State, Zip:	***Rocky Mount, NC 27804***		
Phone, including area code:	***252-544-9329***		
Facsimile, including area code:	***844-698-9702***		
Email address:	***Scott.Chandler@envolvehealth.com***		
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:	***Perform initial and recredentialing for their network of providers.***
Original Project/Contract Start Date:	***2010***
Original Project/Contract End Date:	***Present***
Original Project/Contract Value:	***Did not disclose***
Final Project/Contract Date:	***Ongoing***
Was project/contract completed in time originally allotted, and if not, why not?	***Yes***
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***Yes***

4.2.1.6 Vendor shall not allow any subcontractor to commence work until all insurance required of the subcontractor is provided to the vendor.

We understand and will comply with requirement 4.2.1.6. As part of our subcontracting process, we will confirm insurance certification to verify all insurance requirements are met prior to execution of a contract. No work will be permitted to commence until all requirements are met.

4.2.1.7 Vendor must notify the using agency of the intended use of any subcontractors not identified within their original proposal and provide the information originally requested in the RFP in Section 4.2, Subcontractor Information. The vendor must receive agency approval prior to subcontractor commencing work.

We understand and will comply with requirement 4.2.1.7. We understand that if we intend to use any subcontractor not identified within this proposal, we will provide all requested information in Section 4.2, Subcontractor Information. We will not execute any subcontracts without prior agency approval.

4.3 BUSINESS REFERENCES

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4.3 BUSINESS REFERENCES

4.3.1 Vendors should provide a minimum of three (3) business references from similar projects performed for private, state and/or large local government clients within the last three (3) years.

4.3.2 Vendors must provide the following information for every business reference provided by the vendor and/or subcontractor:

The "Company Name" must be the name of the proposing vendor or the vendor's proposed subcontractor.

Reference #:	*1*		
Company Name:	*LIBERTY Dental Plan of Nevada, Inc.*		
Identify role company will have for this RFP project (Check appropriate role below):			
X	VENDOR		SUBCONTRACTOR
Project Name:	***Health Net***		
Primary Contact Information			
Name:	***Sean O'Brien***		
Street Address:	***101 North Brand Blvd., 15th Floor***		
City, State, Zip:	***Glendale, CA 91203***		
Phone, including area code:	***Office: 818-543-9021; cell: 626-487-7384***		
Facsimile, including area code:	***(818) 543-9185***		
Email address:	***Sean.obrien@healthnet.com***		
Alternate Contact Information			
Name:	***Robert E. Shechet***		
Street Address:	***2239 Linnington Ave.***		
City, State, Zip:	***Los Angeles, CA 90064***		
Phone, including area code:	***(619) 655-0166 or (619) 249-5581***		
Facsimile, including area code:			
Email address:	***robert.e.shechet@healthnet.com***		
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:	***Dental Benefits Administration including Claims Processing, Member Services Call Center, Quality Assurance, Network Management, Account Management***		
Original Project/Contract Start Date:	***7/1/2008***		
Original Project/Contract End Date:	***Renewed on an annual basis***		
Original Project/Contract Value:			

Final Project/Contract Date:	***Contract ongoing***
Was project/contract completed in time originally allotted, and if not, why not?	***Ongoing***
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***Ongoing***

Reference #:	***2***		
Company Name:	***LIBERTY Dental Plan of Nevada, Inc.***		
Identify role company will have for this RFP project (Check appropriate role below):			
X	VENDOR		SUBCONTRACTOR
Project Name:	***Agency for Health Care Administration***		
Primary Contact Information			
Name:	***Tysha Washington***		
Street Address:	***2727 Mahan Drive, Mail Stop #50***		
City, State, Zip:	***Tallahassee, FL 32308***		
Phone, including area code:	***(850) 412-4056***		
Facsimile, including area code:	***(850) 410-1676***		
Email address:	***Tysha.Washington@ahca.myflorida.com***		
Alternate Contact Information			
Name:	***Pamela Hull, Administrator Medicaid Plan Management Operations***		
Street Address:	***2727 Mahan Drive***		
City, State, Zip:	***Tallahassee, FL 32308***		
Phone, including area code:	***(850) 412-4299***		
Facsimile, including area code:	***(850) 410-1439***		
Email address:	***Pamela.Hull@ahca.myflorida.com***		
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:	***Dental Benefits Administration including Claims Processing, Member Services Call Center, Quality Assurance, Network Management, Account Management, Utilization Management***		
Original Project/Contract Start Date:	***5/1/2014***		
Original Project/Contract End Date:	***Renewed on an annual basis***		
Original Project/Contract Value:			
Final Project/Contract Date:	***Contract ongoing***		
Was project/contract completed in time originally allotted, and if not, why	***Ongoing***		

not?	
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***Ongoing***

Reference #:	***3***		
Company Name:	***LIBERTY Dental Plan of Nevada, Inc.***		
Identify role company will have for this RFP project (Check appropriate role below):			
X	VENDOR		SUBCONTRACTOR
Project Name:	***AlohaCare Medicare Advantage Dental***		
Primary Contact Information			
Name:	***John McComas*** *(CEO)*		
Street Address:	***1357 Kapiolani Blvd, Suite 1250***		
City, State, Zip:	***Honolulu, HI 96814***		
Phone, including area code:	***(808) 973-0690***		
Facsimile, including area code:	***(808) 973-2625***		
Email address:	***jmccomas@alohacare.org***		
Alternate Contact Information			
Name:	***Paula Arcena*** *(Chief Customer Officer)*		
Street Address:	***1357 Kapiolani Blvd. Ste 1250***		
City, State, Zip:	***Honolulu, HI 96814***		
Phone, including area code:	***(808) 973-6428***		
Facsimile, including area code:	***(808) 973-2625***		
Email address:	***parcena@alohacare.org***		
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:	***Dental Benefits Administration including Claims Processing, Member Services Call Center, Quality Assurance, Utilization Management, Network Management and Account Management.***		
Original Project/Contract Start Date:	***9/1/2014***		
Original Project/Contract End Date:	***Reviewed on an annual basis.***		
Original Project/Contract Value:			
Final Project/Contract Date:	***Contract ongoing.***		
Was project/contract completed in time originally allotted, and if not, why not?	***Ongoing***		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***Ongoing***		

Reference #:	***4***		
Company Name:	***LIBERTY Dental Plan of Nevada, Inc.***		
Identify role company will have for this RFP project (Check appropriate role below):			
X	VENDOR		SUBCONTRACTOR
Project Name:	***AlphaCare of New York Medicare – Medicaid Dental***		
Primary Contact Information			
Name:	***Brian Morgan***		
Street Address:	***335 Adams Street, Suite 2600***		
City, State, Zip:	***Brooklyn, NY 11201***		
Phone, including area code:	***(929) 258-7512***		
Facsimile, including area code:			
Email address:	***bkmorgan@magellanhealth.com***		
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:	***Dental Benefits Administration including Claims Processing, Member Services Call Center, Quality Assurance, Utilization Management, Network Management and Account Management.***		
Original Project/Contract Start Date:	***4/1/2013***		
Original Project/Contract End Date:	***Reviewed on an annual basis.***		
Original Project/Contract Value:			
Final Project/Contract Date:	***Contract ongoing.***		
Was project/contract completed in time originally allotted, and if not, why not?	***Ongoing***		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***Ongoing***		

4.3.3 Vendors must also submit Attachment F, Reference Questionnaire to the business references that are identified in Section 4.3.2.

In accordance with requirement 4.3.3, Attachment F, Reference Questionnaires were provided to the business references identified in section 4.3.2.

4.3.4 The company identified as the business references must submit the Reference Questionnaire directly to the Purchasing Division.

In accordance with requirement 4.3.4, LIBERTY requested the identified business references to directly submit Attachment F, Reference Questionnaires, to the Purchasing Division.

4.3.5 It is the vendor's responsibility to ensure that completed forms are received by the Purchasing Division on or before the deadline as specified in Section 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.

In accordance with requirement 4.3.5, LIBERTY requested identified business references to submit Attachment F, Reference Questionnaires to the Purchasing Division on or before the deadline as specified in Section 8 of the RFP.

4.3.6 The State reserves the right to contact and verify any and all references listed regarding the quality and degree of satisfaction for such performance.

We understand the State reserves the right to contact and verify all references listed regarding the quality and degree of satisfaction of vendor performance.

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4.4 VENDOR STAFF RESUMES

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4.4 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.

Resumes are provided on the following page as well as Attachment 17.

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Attachment 17 - Resumes

RESUMES/JOB DESCRIPTION

- Administrator – Dave Meadows
- Chief Financial Officer – Maja Kapic
- Recipient Services Manager – Melinda Fife
- Provider Services Manager – Laurie Hargrave
- Grievance and Appeals Coordinator – Megan Peak
- Claims Administrator – Beatriz Angulo
- Nevada Operations Manager – Open Position (Job Description Included)
- Dental Director – Open Position (Job Description Included)

SUBCONTRACTORS

- OCDM
- VerifPoint
- Magnus

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PROPOSED STAFF RESUME FOR RFP 3290

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***LIBERTY Dental Plan***

Check the appropriate box as to whether the proposed individual is prime contractor staff or subcontractor staff.

Prime Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.

Name:	***Dave Meadows***	**Key Personnel: (Yes/No)**	***YES***
Individual's Title:	***Executive Director & Sr. VP of State Health Programs***		
# of Years in Classification:	***4***	**# of Years with Firm:**	***4***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Over 35 years of top-level experience in Healthcare specializing in plans designed for government sponsored programs. 13 years as Vice President at Health Net overseeing the development and maintenance of product lines for some of California's largest benefit programs including Medi-Cal, Healthy Families, and Healthy Kids. Managed procurement, development, and oversight of Access Dental Plan's state contracts. Assessed market needs, and developed and implemented products for a national managed care company which offered a wide array of products including HMO, indemnity, life and health, and a number of specialty services including dental benefits.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2012 – Present LIBERTY Dental Plan Irvine, CA Sr. VP of State Health Programs

- Develops and implements competitive dental products;
- Negotiates contracts and agreements with clients and makes binding decisions;
- Develops, reviews, and reports on government business strategy and activity.

1999 – 2012 Health Net of California Rancho Cordova, CA VP, State Health Prog.

- Managed the performance of Health Net of California's state sponsored business unit which provided coverage to over 1.2 million medical and dental members.

1998 – 1999 DentiCare of California Inc. Rancho Cordova, CA VP, Prod. Dev. & Govt. Prog.

- Responsible for all aspects of the development and implementation of competitive dental and vision products;
- Responsible for monitoring corporate compliance activities;
- Obtained regulatory approvals for new products.

1998 - 1998 Access Dental Plan / Premier Access Insurance Company Sacramento, CA VP, Prod. Dev. & Govt. Prog.

- Responsible for all aspects of the development and implementation of competitive dental products;
- Responsible for the procurement, development, and oversight of government program business.

1992 – 1998 Foundation Health Corporation Rancho Cordova, CA VP, Prod. Dev.

- Assessed market needs for a multi-state, Fortune 500 managed care company;
- Successfully designed and implemented individual product portfolio and company's small group portfolio under small group reform (AB 1672);
- Prepared regulatory filings and obtained necessary regulatory approvals for products in various states.

1975 – 1992 California State Dept. of Corp. Sacramento, CA Supervising Examiner

- Reviewed, analyzed, and drafted rules and regulations;
- Was responsible for the financial aspects of regulation of Health Care Service Plans, including: licensing, compliance, and regulatory examinations.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

CA State University Northridge	Northridge, CA	B.S., Business Administration: Accounting	1975

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

CPA (currently inactive) 1981

Board Member of the California Department of Managed Healthcare
Financial Solvency Standards Board

Prior Board Member of the California Association of Dental Plans

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Scott Kelly	Sean O'Brien	Michael Daponde
COO	Vice President	Partner
Aspire Health Plan	Health Net of California	Daponde Szabo Rowe, Health Law
(P) 888.703.6999	(P) 818.543.9021	(P) 916.840.5609
(F)Unavailable	(F) Unavailable	(F) Unavailable
scott.kelly@aspirehealthplan.org	Sean.o'brien@healthnet.com	mdaponde@drshealthlaw.com

PROPOSED STAFF RESUME FOR RFP 3290

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***LIBERTY Dental Plan***

Check the appropriate box as to whether the proposed individual is prime contractor staff or subcontractor staff.

Prime Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.

Name:	***Maja Kapic***		**Key Personnel: (Yes/No)**	***YES***
Individual's Title:	***CFO***			
# of Years in Classification:	***12***	**# of Years with Firm:**		***12***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Integral part of the Executive Management team, who provides and develops strategic plans to meet the company's financial goals. Drives profitability improvements and cost containment leadership, thereby consistently improving financial operations and the cash flow of the Company. Keen knowledge and aptitude for an array of different business aspects including, but not limited to: financial analysis, IT systems utilization, customer accounts maintenance, human resources (recruiting and training new personnel), and database upkeep.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2004 – Present **LIBERTY Dental Plan** **Irvine, CA** **Chief Financial Officer**

- Develops and maintains the annual financial budget and forecasts, manages treasury functions and oversees operational finance, accounting and reporting of the Company;
- Provides financial analysis with recommendations and implementations of solutions.

2002 – 2003 **NORICOM Language Service Agency** **Bergen, Norway** **Business Management and Team Leadership**

- Implemented new IT system
- Conducted financial analysis
- Maintained customer accounts

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Norwegian School of Business and Economic Administration (NHH)	Bergen, Norway	M.S., Business & Economic Administration	2002

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

None

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Dr. Amir Neshat	John Carvelli	Randy Brecher
CEO	EVP	Sr. VP
LIBERTY Dental Plan	LIBERTY Dental Plan	LIBERTY Dental Plan
(P) 888.273.2997	(P) 949.270.0106	(P) 888.273.2997
(F) 888.830.7250	(F) 888.830.7250	(F) 888.830.7250
drn@libertydentalplan.com	jcarvelli@libertydentalplan.com	rbrecher@libertydentalplan.com

PROPOSED STAFF RESUME FOR RFP 3290

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***LIBERTY Dental Plan***

Check the appropriate box as to whether the proposed individual is prime contractor staff or subcontractor staff.

Prime Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.

Name:	***Melinda Fife***	**Key Personnel: (Yes/No)**	***YES***
Individual's Title:	***Director, Member Services***		
# of Years in Classification:	***1***	**# of Years with Firm:**	***1***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Over 23 years of experience within call center environments and managed healthcare. Possesses extensive Medicare, Medicaid, and Commercial dental knowledge which contributes to her ability to identify various needs within the dental industry. Profound knowledge of Medicaid compliance, and strong adeptness in the writing of policies and procedures. Successfully implemented the expansion of a call center from 40 employees to over 90 employees.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2016 – Present	**LIBERTY Dental Plan**	**Las Vegas, NV**	**Director, Member Services**
2000 – 2016	**United Health Care**	**Las Vegas, NV**	**Manager, Member Services, Gov't Programs**

- Managed a call center of 90+ employees;
- Drafted, reviewed and updated all department policies and procedures;
- Handled complex human resources issues;
- Implemented initiatives to improve employee performance, including productivity incentives, performance work plans, and inter-team development;
- Developed the process workflow for CTM issues ;
- Mentored and developed new employees on all aspects of their job functions.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Bonanza High School	Las Vegas, NV	High School Diploma	1989

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

None

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Rocio Gaska
Sr. Project Coordinator
United Health Care
(P) 702.443.4031
ezkieldavid@aol.com

Ann Stewart
Operations Manager
South West Medical
(P) 702.772.0811
(F) 702.304.7473
Akostelec25@gmail.com

Loralee Wood
Realtor
Coldwell Banker Premier Realty
(P) 702.419.3212
(F) 702.912-2941
Loralee.wood@cbvegas.com

PROPOSED STAFF RESUME FOR RFP 3290

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***LIBERTY Dental Plan***

Check the appropriate box as to whether the proposed individual is prime contractor staff or subcontractor staff.

Prime Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.

Name:	***Laurie Hargrave***	**Key Personnel: (Yes/No)**	***YES***
Individual's Title:	***Sr. Network Manager***		
# of Years in Classification:	***8***	**# of Years with Firm:**	***8***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Over 16 years of experience in the dental industry. Commenced dental career as a practice manager for a private dental office in Las Vegas. Gained thorough and valuable experience while managing the Claims and Customer Service Departments at Nevada Pacific Dental, a United Healthcare Dental Company. Oversaw the day to day operations of the departments, established, maintained and monitored goals for production, as well as accuracy, and ensured that turn-around times and service level agreements were met. Possesses a wealth of expert knowledge on provider network management and building business relationships with contracted dentists.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2008 – Present	**LIBERTY Dental Plan**	**Las Vegas, NV**	**Sr. Network Manager, Professional Relations**

- Responsible for recruiting, contracting, and maintaining Provider Networks in Nevada, Arizona, Colorado and Hawaii.

2005 – 2008	**Nevada Pacific Dental**	**Las Vegas, NV**	**Supervisor, Claims & Customer Service**
1999 – 2008	**R.D. Hargrave, D.D.S.**	**Las Vegas, NV**	**Practice Manager**

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of Nevada, Las Vegas	Las Vegas, NV	Master's in Administration	1999
University of Nevada, Las Vegas	Las Vegas, NV	B.S., Elementary Education	1995

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Fraud Waste and Abuse (FWA) and General Compliance Trainings	2016

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Brett Dyke, DMD
Dentist/Owner
Round Rock Dentists and Orthodontists
(P) (702) 300-9488
(F) Unavailable
brettdyke@yahoo.com

Lynda Bull
Vice President
Dental Insurance Industry (Retired)
(P) (702) 882-2644
(F) Unavailable
lyndabull@yahoo.com

David Ting, DMD
Dentist/Owner
Boston Dental Group
(P) (702) 882-4882
(F) Unavailable
davidtingdmd@bdgdentalservices.com

PROPOSED STAFF RESUME FOR RFP 3290

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***LIBERTY Dental Plan***

Check the appropriate box as to whether the proposed individual is prime contractor staff or subcontractor staff.

Prime Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.

Name:	***Meagan Peake***	**Key Personnel: (Yes/No)**	***YES***
Individual's Title:	***Supervisor, Grievances & Appeals***		
# of Years in Classification:	***1***	**# of Years with Firm:**	***2***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Over 20 years of experience in all aspects of the dental career field. Full understanding of dental terminology, knowledge of PPO/HMO and Government plans, with extensive experience in case presentation and financial arrangements. Proficiency in directing, motivating, and leading a successful team, with experience in the management and growth of general and all dental specialties. Exhibits exceptional skills in communicating, possesses knowledge of dental insurance claims processing, and is adept in Microsoft Word/ Excel/ PowerPoint. Qualified as a grievance and appeals analyst with a great understanding regarding plan benefits, coverage disputes, and addressing quality issues.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2016 – Present	**LIBERTY Dental Plan**	**Irvine, CA**	**Supervisor, Grievances & Appeals**
2014 – 2016	**LIBERTY Dental Plan**	**Irvine, CA**	**Grievance Analyst**
2011 – 2014	**West Coast Dental Services**	**Paramount, CA**	**Office Manager**

- Managed a dental practice with a staff of 10 people and consistently met monthly and yearly production goals.

2008 – 2010	**Delta Dental**	**Cerritos, CA**	**Claims Processor**

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Concorde Career College	San Bernardino, CA	Certified Dental Assistant	1998

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Dental Assisting	1998

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Stephanie Ford	Miranda Lent	Adrienne Barber
Manager	Assistant Manager	Supervisor
OptumCare	LIBERT Dental Plan	Martin Luther King Jr. Hospital
(P) 562.606.7059	(P) 888.703.6999 ext: 409	(P) 562.225.3665
(F) Unavailable	(F) 949.270.0109	(F) Unavailable
stephanieoford@yahoo.com	mlent@libertydentalplan.com	abarber@gmail.com

PROPOSED STAFF RESUME FOR RFP 3290

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***LIBERTY Dental Plan***

Check the appropriate box as to whether the proposed individual is prime contractor staff or subcontractor staff.

Prime Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.

Name:	***Beatriz Angulo***	**Key Personnel: (Yes/No)**	***YES***
Individual's Title:	***Claims Manager***		
# of Years in Classification:	***3***	**# of Years with Firm:**	***3***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Understands the business side of dental claim processing and is experienced with national dental plans including: Medicare, Medicaid, PPO, EPO and DHMO. Possesses experience in analyzing and reviewing team audits to ensure the highest quality and level of accuracy. Proficiency in reporting and troubleshooting, familiarity in partnering with dental consultants to ensure adherence to guidelines, ability to work interdepartmentally to ensure the meeting of standards, and adeptness in overseeing matters related to claims personnel.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

2013 – Present **LIBERTY Dental Plan** **Las Vegas, NV** **Claims Manager**

- Utilizes strong leadership skills in overseeing all personnel matters related to claims, runs daily reports, and problem-solves issues in order to achieve departmental goals.
- Actively works with claims, pre-estimates, referrals, and data entry departments in order to ensure that all standards are met within the organization.
- Partners with dental consultants and the grievance department to ensure guidelines are being followed.

2006 – 2012 **Red Rock Dental** **Las Vegas, NV** **Office Manager**

- In charge of all aspects of billing, collections, credentialing, and treatment coordination.

2005 – 2006 **Desert Springs Dental Care** **Las Vegas, NV** **Office Manager**

2002 – 2004 **Red Rock Dental** **Las Vegas, NV** **Office Manager**

1999 - 2002 **Children's Dental Group** **Las Vegas, NV** **Surgery Coordinator**

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Valley High School Las Vegas, NV High School Diploma 1995

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

None

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Beatrice Stark, DDS
Owner/Dentist
Enhance Dental
(P) 702.437.1007
(F) 702.304.1126
enhancedental1@aol.com

Ben Garagozloo, DDS
Endodontist
Independent Contractor
(P) 702.321.8602
(F) Unavailable
onsiteendo@yahoo.com

Gavi Morales
Defect Mgmt.
University of California
(P) 714.863.5388
(F) Unavailable
gavbenny@sbcglobal.net

POSITION DESCRIPTION			
Position Title:	Operations Manager	**Location:**	Nevada
Department:	Operations	**Reports To:**	VP, Member Government Programs
FLSA Status:	Exempt	**Union:** (Y/N)	No
Prepared by:	Vice President, Human Resources	**Last Updated:**	11/15/2016

Summary *(Including Minimum Essential Position Duties):*

Provide strategic and operational responsibility for Member Services, Claims, Mailroom and Facilities in Nevada. This position gives direction and leadership toward the achievement of the organization's philosophy, mission, strategy and its goals and objectives. Manage the daily activities of the Member Services and Claims departments while ensuring the highest level of customer satisfaction, accuracy and compliance with Nevada Department of Health and Human Services (DHHS) and Federal requirements.

- Oversee and monitor daily operations for Regional Member Services, Claims, Facilities and Mailroom.
- Confers with company leadership to discuss goals and objectives, implement and review progress, and to determine the needs to support departmental strategy.
- Balance productivity and quality requirements to ensure performance goals are met or exceeded.
- Ensure compliance to all DHHS and Federal requirements and guidelines.
- Identify and pursue needs for process improvements, quality auditing measures and system enhancements.

Education and/or Experience:

- Minimum requirements include a bachelor's degree in business administration, healthcare or related field, and/or,
- Minimum 7 years of experience in a managerial role in operations, administrative or related field.
- Minimum of 5 years Call Center Management Experience.

Specific Skills/Knowledge:

- Claims administration experience in dental, medical or related healthcare industry.
- Familiar with dental benefits, codes and nomenclature.
- Knowledge of call center operations.
- Strong leadership ability including the ability to foster a team environment and motivate staff to achieve success.
- Proven experience in managing multiple priorities and meeting deadlines/production goals.
- Working knowledge of Microsoft Office (Excel, Outlook, and Word).

Environment and/or Physical Factors:

Work is generally performed within an office environment, with standard office equipment available. Sedentary work involves extensive sitting, typing, close range vision most of the time.

Specific Skills/Knowledge:

- In-depth knowledge of commercial and managed care delivery systems, reimbursement mechanisms, State regulatory and legislative landscape and quality improvement initiatives.
- Knowledge of clinical dentistry procedure codes and generally accepted clinical and adjudication guidelines on medical necessity of proposed dental procedures.
- The Dental director must comply with applicable federal and state statutes and regulations.
- Working knowledge of Microsoft Office (Outlook, Excel and Word).

Environment and/or Physical Factors:

Work is generally performed within an office environment, with standard office equipment available. Sedentary work involves extensive sitting, typing, close range vision most of the time.

POSITION DESCRIPTION			
Position Title:	Dental Director	**Location:**	Nevada
Department:	Quality Management/Utilization	**Reports To:**	Chief Dental Officer
FLSA Status:	Exempt	**Union:** (Y/N)	No
Prepared by:	Human Resources	**Last Updated:**	12/12/2016

Summary *(Including Minimum Essential Position Duties):*

This position will be primarily responsible for the clinical review and medical necessity determinations for utilization of dental services, both pre-authorizations and claims. The Dental Director is responsible for the oversight of development, implementation and review of the Internal Quality Assurance Program (IQAP) including implementation of, and adherence to, any Plan of Correction involving clinical reviews, quality of care concerns and/or grievances.

- The Dental Director must be available Monday through Friday, between 8am and 5pm PST for Utilization Review decisions, and must be authorized and empowered to represent the Company to DHCFP regarding clinical issues, Utilization Review and quality of care inquiries.
- Directs and/or oversees the development and implementation of the IQAP, utilization management activities and monitoring the quality of care that plan members receive.
- Performs reviews emphasizing consistency with established clinical protocols, criteria and guidelines, and adjudication principles.
- Identifies potentially unnecessary services in relation to care delivery settings. Reviews all potential quality of care problems and oversees the development and implementation of, as well as adherence to, Plans of Correction.
- Identifies potential quality issues and trends in prospective and retrospective claims submissions.
- Examines clinical programs information to identify members for specific case management and/or disease management activities or interventions by utilizing established screening criteria, as needed.
- Oversees the referral process for specialty and out-of-network services.
- Serves as a liaison between the Company and providers, demonstrating frequent communication and oversight of provider orientations and ongoing education.
- Spearheads provider recruitment and credentialing activities.
- Represents the Company with regard to clinical issues, denials, grievances and problems.
- Ensures coordination of out-of-network services.

Education and/or Experience:

- The Dental Director must have a current and unencumbered dental license in the State of Nevada.
- Minimum of 5 years of experience in Dental industry/environment.
- Experience with Medicare/Medicaid.
- Experience reviewing pre-authorizations and/or claims preferred.

Specific Skills/Knowledge:

- In-depth knowledge of commercial and managed care delivery systems, reimbursement mechanisms, state regulatory and legislative landscape and quality improvement initiatives.
- Knowledge of clinical dentistry procedure codes and generally accepted clinical and adjudication guidelines on medical necessity of proposed dental procedures.
- The Dental director must comply with applicable federal and state statutes and regulations.
- Working knowledge of Microsoft Office (Outlook, Excel and Word).

Environment and/or Physical Factors:

Work is generally performed within an office environment, with standard office equipment available. Sedentary work involves extensive sitting, typing, close range vision most of the time.

PROPOSED STAFF RESUME FOR RFP 3290

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***OCDM***

Check the appropriate box as to whether the proposed individual is prime contractor staff or subcontractor staff.

Contractor:		**Subcontractor:**	***X***

The following information requested pertains to the individual being proposed for this project.

Name:	***David Johnson***		**Key Personnel: (Yes/No)**	***Yes***
Individual's Title:	***Senior Account Executive***			
# of Years in Classification:	***13***	**# of Years with Firm:**		***5***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

25 years of administrative, operations, and management including direct mail/marketing, freight transportation, and retail sales. Developed skill set in communicating, accuracy, teamwork, and project coordination.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

May 2011 – Present, OCDM Direct Marketing in Santa Ana, CA as Senior Account Executive

- Handling routine printing and distribution of identification card packets and other related projects for LIBERTY Dental Plan, Irvine, CA. Coordinate receiving data, ID card print production and lettershop fulfillment including qc and delivery to the post office.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Cal State Dominguez Hills, Compton, CA, earned and awarded a Bachelor's of Arts degree in Geography, 1995.

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Dave Rouse, Brand Manager, Alliance Printing Assoc., Inc.
P (562) 594-7975 F (562) 594-7985 Email: dave@apabrandu.com

Roger Anthony, Owner, Anthony & Associates
P (714) 972-8114 F (714) 972-8482 Email: rlanthony@prodigy.net

Kenn Gary, Sales Executive, Sapphire Printing Group, Inc.
P (714) 813-0363 F (480) 719-1597 Email: kenng@sapphireprinting.com

PROPOSED STAFF RESUME FOR RFP 3290

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***CreDENTALs Services, Inc. dba VerifPoint***

Check the appropriate box as to whether the proposed individual is prime contractor staff or subcontractor staff.

Contractor:		**Subcontractor:**	***X***

The following information requested pertains to the individual being proposed for this project.

Name:	***Joleen Thomas***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title:	***Director of Credentialing/Client Services***		
# of Years in Classification:	***18***	**# of Years with Firm:**	***18***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

- Over eighteen years of credentialing experience working at a VerifPoint.
- Expertise in coordinating credentialing process for initial appointments and reappointments.
- Solid knowledge of AAAHC, NCQA, URAC and Joint Commission credentialing standards.
- Proven ability to work independently and efficiently with superior results.
- Excellent organization skills
- Ability to maintain confidentiality, excellent composure and professional etiquette
- Proficient in word processing, spreadsheets and access database.
- Studying to take exam for Certified Provider Credentialing Specialist (CPCS).
- Responsible for all NCQA and URAC audits

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

11/1998 – 2/1999 – CreDENTALs, Mission Viejo, CA – Data Entry Processor
2/1999 – 9/2000 - CreDENTALs, Mission Viejo, CA – Client Services Assistant
9/2000 – present – CreDENTALs Services Inc. dba VerifPoint, Lake Forest, CA – Director of Credentialing/Client Services

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Jurupa Valley High School, Mira Loma, California – 1995 – High School Diploma

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

n/a

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Lori Calderone
Director, IPA of North Jersey
Seton Health Network
p- 973-754-2749
f- 973-754-2791
calderol@sjhmc.org

Tammy D Lord
United Concordia Companies, Inc.
Lead Business Analyst
P- 717-260-7503
tammy.lord@ucci.com

Rachel Coleman
Credentialing Analyst
Connection Dental
800-505-8880 Ext 4060
816-257-4438 Fax
Rachel.Coleman@GEHA.com

PROPOSED STAFF RESUME FOR RFP 3290

Company Name Submitting Proposal:	*LIBERTY DENTAL PLAN*

Check the appropriate box as to whether the proposed individual is prime contractor staff or subcontractor staff.

Contractor:		Subcontractor:	*X*

The following information requested pertains to the individual being proposed for this project.

Name:	*Richard Antoine, MIB/MBA*	Key Personnel: (Yes/No)	*yes*
Individual's Title:	*Founder, President & CEO*		
# of Years in Classification:	*23*	# of Years with Firm:	*23*

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

- Direct experience performing all tasks in the translation process including:
  - Content generation
  - Readability analysis and source-language editing for low literacy audiences
  - Translation and editing
  - Formatting of documents in multiple writing systems
  - Translation evaluation as a target audience reader
- In 2002, MAGNUS was one of 9 founders of the Association of Language Companies, the national trade group for language companies. Mr. Antoine was elected to be the association's first president and served from 2002 to 2004.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

- Consulting Experience
  - Los Angeles County Department of Mental Health – strategies and insights for understanding and communicating with underserved and minority language speakers in the US.
  - Project related consultations regarding project work flow optimization, quality enhancement and cost minimization strategies.

- Project Management Experience
  - Notable projects include work for high profile healthcare clients such as Anthem Blue Cross, Aetna, United Healthcare, TennCare and LA Care
  - Ongoing projects requiring translation under the auspices of research and accreditation organizations such as RAND, NCQA and others.
  - Emergency Readiness, Public Health and other communication materials in support of campaigns for government agencies nationwide at all levels of government.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Pepperdine University, Malibu, CA
Joint Master of International Business and MBA

Carnegie-Mellon University, Pittsburgh, PA
B.S. Managerial Economics and French

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Mark Maricich, CEO
Maricich Health (agency for LA Care)
18201 McDurmott W., Suite A
Irvine, CA 92614
Ph 949-223-6455
F 949-223-6451
mark@maricich.com

Marielle Weindorf
Datastat
3975 S. Research Park Drive
Ann Arbor MI 48108
Ph (734) 994-0540 x186
F (734) 972-5406
mweindorf@datastat.com

Lily Wendt
Alignment Healthcare
1100 W. Town and Country Road, #1600
Orange, CA 92868
Ph (657) 218-7430
F (323) 728-1460
LWendt@ahcusa.com

SECTION 3: TECHNICAL PROPOSAL – SCOPE OF WORK

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3.1 GENERAL

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3.1.1 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.

LIBERTY offers vast, specialized experience. We will utilize our experience, services, and programs, including those listed below, to meet DHCFP goals and requirements for a managed dental care model:

- ***Establishment and management of a Dental Provider Network.***
- ***Credentialing and contracting with providers.***
- ***Analytics to identify gaps in care for recipients and systematic outreach to facilitate and track access.***
- ***Authorization and utilization management.***
- ***Identification, investigation, and referral of suspected fraud cases to DHCFP.***
- ***Quality assurance and improvement.***
- ***Claims processing adjudication and payment.***
- ***Management of third party liability.***
- ***Education and other information sharing with beneficiaries and providers using modern technology as well as more traditional communication mechanisms.***
- ***Linkages to community support services.***
- ***Customer service.***

We offer Nevada a proven system for facilitating access to care for impoverished subgroups and achieving cost-effective outcomes – all done in a structure that is uniquely provider-friendly. We believe that dental care is more than just administration of a program. For LIBERTY, it's about coordinating care management, knowing that recipients have access to qualified providers, implementing outreach programs that encourage continuity of care, and proactively identifying and eliminating fraud, waste, and abuse. We believe in helping recipients to establish a dental home and in ensuring that each individual is matched to the right provider to receive the right care. In order to accomplish these goals, we offer progressive technology and operate our entire scope of services within a customized, single source platform that seamlessly integrates and synthesizes data.

These best practices—coupled with our established operations in Nevada and our comprehensive experience in Medicaid—uniquely position us as the ideal contracting partner for DHCFP.

LIBERTY has delivered dental care coordination in Nevada since 2008. We currently have 54 Nevada-based employees performing a variety of dental care coordination

functions. Our existing Nevada network – all contracted, credentialed, and actively serving our members – includes more than 1,300 dental providers.

We also currently administer a full array of dental benefits and services to approximately 3 million members in public and commercial programs in 50 states, including approximately 2 million Medicaid members—children and adults—in California, Florida, Illinois, New Jersey, New York and Texas. Over 85 percent of our total membership is enrolled in government sponsored programs.

We have direct experience working with a wide spectrum of Medicaid subgroups including children, young adults, pregnant women, older (but non-senior) adults, persons with disabilities, persons with Long Term Care needs, persons dually eligible for Medicaid and Medicare (including participation in Duals Demonstration programs). The health conditions of the Medicaid subgroups we serve range from relatively healthy individuals who primarily require access support for preventive services, to persons with a complex combination of physical health, mental health, and long term care needs requiring complicated treatment plans.

The chart in Table 3.1.1-1 conveys a list of our relevant Medicaid experience in the industry. Across all lines of business, we serve clients based in 27 states, with members enrolled in 50 states. Following this chart, we detail our most relevant experience in detail.

Staywell Health Plan (WellCare), Florida

On behalf of Staywell Health Plan (WellCare), we manage dental services for approximately 700,000 Medicaid members throughout the State of Florida. Over the past two years, we have been actively involved in efforts to improve HEDIS scores for overall utilization and we have achieved a 17 percent increase in the proportion of members utilizing dental services. This accomplishment was achieved in part by implementing the following initiatives:

- ***Establishing school based programs that partner with mobile van providers to administer programs.***
- ***Implementing government and community outreach programs with various stakeholder organizations.***
- ***Conducting outbound calls to schedule visits for those who have not seen a dentist in more than 9-12 months.***
- ***Developing partnerships with community based organizations.***

In Florida, we were also the dental plan selected to participate in a workgroup established by the Florida Agency for Health Care Administration to work with the Center for Medicare and Medicaid Services (CMS) as part of a CMS technical assistance grant to establish a State Oral Health Action Plan. This plan was targeted to improve utilization of preventive services and sealants. We also participate in the newly formed Florida Oral Health Alliance, which is a group of various stakeholders developing strategies to improve the oral health of Florida's most vulnerable children populations. We are also implementing a new initiative this year that reimburses Florida physicians (PCPs) for conducting dental assessments, making dental referrals, and providing fluoride varnish.

We have also been actively involved in identifying and correcting fraud, waste, and abuse. In February 2015, an outlier Florida provider was identified through an unusual amount of member grievances. An investigation ensued, revealing that in addition to over-utilization, the provider did not meet minimum treatment standards. The provider was terminated, reported to officials, and subsequently arrested for Medicaid fraud and allegations of child abuse. The provider was a long time Medicaid provider.

California Department of Health Care Services

Since 2005, we have been directly contracted with the California State Department of HealthCare Services for Medi-Cal (Medicaid) managed care in the counties of Los Angeles and Sacramento—Sacramento being the only mandatory geographic managed care dental program in California. Over the last ten years, we have increased

quality scores for our Medi-Cal membership despite budget rate reductions; the elimination, then reinstatement, of adult Medi-Cal dental services; and acquisition of two dental plans which did not meet program requirements.

Illinois Medicaid Managed Care

In June 2014, the State of Illinois Managed Care Program notified LIBERTY that we must be ready to assume the dental benefits administration of approximately 300,000 Medicaid members. The State was late in notifying the Medicaid managed care health plans that they would be assuming the responsibility for the provision of Medicaid child benefits and the newly enhanced adult Medicaid benefits to their members on July 1, 2014. As their dental partner to several health plans serving the Medicaid population, this gave us approximately two weeks to assume 160,000 members with Harmony Health Plan, and 40,000 members with Meridian Health Plan. We moved quickly and effectively to implement dental managed care to 300,000 Illinois Medicaid beneficiaries with minimal disruption and without gaps in timely access. Two examples of our accomplishments in Illinois are provided below – both demonstrating our ability to promptly identify and address fraudulent practices that had gone unnoticed by the existing dental payers in the market.

In September 2014, an Outlier Provider from the State of Illinois Medicaid program was identified within 2 months of the plan's transition. Upon investigation, it was found that the provider billed for services that were not rendered. By addressing aberrant patterns, it resulted in notification to authorities and the provider abandoning the office.

In April 2015, an Outlier Provider, also from the State of Illinois Medicaid program, demonstrated practices below the standard of care. The provider was deemed to be systematically undermining and defrauding the system. Children who obtained care had undetected caries, sealants were placed over fillings, fillings were placed over sealants, and overall treatment was below the standard of care. As a result of our findings, the provider's contract was terminated and reported to authorities.

Our experience will allow us to partner with the DHCFP in reaching its goal to provide quality dental care to the targeted populations in the State of Nevada.

3.1.2 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.

LIBERTY is fully authorized to operate as a certified vendor in the State of Nevada with the projected number of Medicaid and Nevada Check Up recipients under the DHCFP contract. As a Nevada licensed Prepaid Limited Health Service Organization in good standing, we have a valid certificate of authority (included in Figure 3.1.2-1) which we will submit to DHCFP prior to the contract readiness review. We currently provide dental benefits management services to more than 64,000 Nevada residents, have contracts with over 1,300 providers, and have operated a Nevada-based office and call center with 54 Nevada-based employees throughout the past eight years. We are in good standing with the State of Nevada, as evidenced by our certificate in Figure 3.1.2-2.

FIGURE 3.1.2-1. CERTIFICATE OF AUTHORITY

Certificate of Authority

STATE OF NEVADA
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INSURANCE
Carson City, Nevada

Nevada ID #:	**104054**
THE	**LIBERTY DENTAL PLAN OF NEVADA, INC.**
Incorporated in the State of	**NEVADA**
Home office at	**LAS VEGAS, NEVADA**

having duly qualified, is hereby licensed to transact:

**** PREPAID LIMITED HEALTH SERVICE ORGANIZATION ****
(Service Area – All Zip Codes Within the State of Nevada)

insurance business within the State of Nevada until terminated at the request of the insurer or suspended or revoked by the Commissioner of Insurance.

Original Dated at Carson City, Nevada

this 2nd day of October, 2008

Corrected this 29th day of July, 2013

Commissioner of Insurance

FIGURE 3.1.2-2. CERTIFICATE OF GOOD STANDING

SECRETARY OF STATE

STATE OF NEVADA

CERTIFICATE OF EXISTENCE WITH STATUS IN GOOD STANDING

I, BARBARA K. CEGAVSKE, the duly elected and qualified Nevada Secretary of State, do hereby certify that I am, by the laws of said State, the custodian of the records relating to filings by corporations, non-profit corporations, corporation soles, limited-liability companies, limited partnerships, limited-liability partnerships and business trusts pursuant to Title 7 of the Nevada Revised Statutes which are either presently in a status of good standing or were in good standing for a time period subsequent of 1976 and am the proper officer to execute this certificate.

I further certify that the records of the Nevada Secretary of State, at the date of this certificate, evidence, **LIBERTY DENTAL PLAN OF NEVADA, INC.**, as a corporation duly organized under the laws of Nevada and existing under and by virtue of the laws of the State of Nevada since June 8, 2007, and is in good standing in this state.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on September 22, 2016.

Barbara K. Cegavske

BARBARA K. CEGAVSKE
Secretary of State

Electronic Certificate
Certificate Number: C20160922-2379
You may verify this electronic certificate online at **http://www.nvsos.gov/**

3.1.3 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.

LIBERTY maintains a comprehensive Compliance Program led by our Compliance Officer and overseen by our Board of Directors. We have a demonstrated commitment to adhering to all authorities for the government programs we serve, including the Title XIX, Title XXI state plans and amendments, Code of Federal Regulations, and the Medicaid Services Manual. We will continue this commitment upon contract award.

3.1.4 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.

LIBERTY has operated dental benefits administration in Nevada since 2008. Our current network includes a total of 1,339 providers, with 1,210 providers in Clark and 111 providers in Washoe Counties, respectively. We will focus our provider recruitment efforts in geographic areas that have eligible individuals, including any additional counties the State includes in its DBA initiative. Nationwide, we have extensive experience serving Medicaid recipients residing in both rural and urban counties. As an example, we are currently serving over 58,000 Medicaid recipients in 33 rural counties in the State of Florida. We are well-positioned to identify and address all access to care challenges that exist and arise in each geographic area we serve. In addition to the policies and controls we have in place to ensure our network maintains a sufficient number of providers at all times within the required distances, we are adept at employing innovative solutions to provide all recipients access to quality services including:

- ***Multilingual telehealth services***
- ***Mobile dental Units***
- ***School based services***

We will work in various ways, delineated throughout our proposal, to ensure that recipients access dental services and receive high quality care including drawing upon our staff experience and expertise, our tailored processes, our information technology, and our provider and community partnerships.

3.1.5 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.

When situations arise such that Nevada providers are not best-positioned to provide services to Nevada Medicaid recipients, we will coordinate treatment with providers outside of Nevada, including in California, Arizona, Idaho and Utah. Our existing provider networks in several of these states facilitate our ability to link recipients with out of state services efficiently and effectively. In order for LIBERTY to enter into a single case agreement with a provider willing to treat Nevada Medicaid recipients outside of Nevada, the provider must be licensed in their home state of practice. Finally, in some areas, such as Reno, LIBERTY will include providers in states adjacent to Nevada in its network under the DHCFP contract.

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3.2 VENDOR DUTIES AND RESPONSIBILITIES

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3.2 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.

We understand and will comply with the requirements of Section 3.2.

Based on our experience with other Medicaid programs, we expect to build a strong partnership with DHCFP through active engagement at all organizational levels.

After we achieve successful implementation, our National and Local Account Executives will work together with the Nevada Operations Manager to assume responsibility for all support activities, including monthly reporting submissions, escalated issues, monthly reviews with DHCFP, and day-to-day communications to ensure that DHCFP receives outstanding responsiveness. In addition to these staff members, senior staff will participate, at a minimum, in monthly teleconferences and quarterly on-site professional meetings as scheduled by DHCFP. We will use these meetings as an opportunity to discuss contract compliance, audits, access to care, quality management, innovative services, and utilization management programs that seek to improve dental treatment methods, patient safety, and treatment outcomes.

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3.3 DENTAL SERVICES

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3.3 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.

We understand and will comply with the provisions of Section 3.3.

Benefit Package

LIBERTY's values are aligned with DHCP's mission to provide equal access to quality health care in the most cost-efficient manner possible for all eligible recipients. As such, we are committed to ensuring our benefit package will not be less in amount, duration and scope than those covered in the respective State Plans for Title XIX and XXI and the Nevada Medicaid Service Manual Chapter 1000. We acknowledge our

responsibility to provide all covered medically necessary dental services to eligible recipients.

Value Added Services

LIBERTY intends to provide the value-added codes delineated in Table 3.3-1, that are not included in the standard benefit schedule. The value-added codes that we will offer have proven efficacy – these have all been successfully administered by LIBERTY in one or more of the other markets we serve.

TABLE 3.3-1. VALUE ADDED SERVICES

Additional Benefit	*Description*
Additional Benefit #1: **Additional Fluoride Varnish Application at Primary Care Physician Office (D1206):**	***LIBERTY intends to add an additional fluoride varnish application applied specifically by PCPs or their clinical staff, or by mobile based providers, to facilitate both PCP Fluoride Varnish & School Based Sealant programs.***
Additional Benefit #2: **Caries risk assessment & documentation, low risk (D0601)**	***LIBERTY intends to add caries risk assessment codes to facilitate the collection of risk assessment data. This data will allow us to pinpoint specific members who require follow-up and additional treatment, as well as identify geographic areas that might require higher levels of outreach and engagement.***
Additional Benefit #3: **Caries risk assessment & documentation, moderate risk (D0602)**	
Additional Benefit #4: **Caries risk assessment & documentation, high risk (D0603)**	
Additional Benefit #5: **Screening of a patient (D0190)**	***LIBERTY intends to add patient screening and assessment, to be used specifically by PCPs or their clinical staff, or by mobile based providers, to facilitate both PCP Fluoride Varnish & School Based Sealant programs.***
Additional Benefit #6: **Assessment of a patient (D0191)**	***LIBERTY intends to add patient screening and assessment, to be used specifically by PCPs or their clinical staff, or by mobile based providers, to facilitate both PCP Fluoride Varnish & School Based Sealant programs.***
Additional Benefit #7	***LIBERTY intends to add an additional two prophylaxis***

Third and Fourth Adult Prophylaxis for Pregnant Women (D1110)	***treatments per year for pregnant women, in addition to the two they currently receive.***

Insurance Certificate or Evidence of Insurance

We will comply with DHCFP's requirement to refrain from issuing any insurance certificate or evidence of insurance to any Medicaid of Nevada Check Up recipient. Further, we acknowledge and agree that any insurance duty shall be construed to flow to the benefit of the DHCFP and not the Nevada Medicaid or Nevada Check Up enrolled recipient.

3.3.1 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.

3.3.1.1 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:

A. 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;

B. May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the recipient; and

C. 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.

We will provide medically necessary dental services covered under Title XIX, Title XXI, and MSM Chapter 1000 and conduct interperiodic screen as defined in MSM Chapter 1500. We have extensive experience in providing the full range of covered dental services to Medicaid recipients in multiple states (currently encompassing more than 3 million members), and we already coordinate and pay for a wide spectrum of dental services delivered to more than 64,000 Nevadans through our network of more than 1,300 Nevada dental providers.

We are deeply committed to and skilled at tracking and facilitating access to EPSDT and all other front-end preventive and routine services. While treatment of oral health

crises is of course also covered, we strive to avoid to the greatest possible extent the onset and exacerbation of such situations. With regard to EPSDT and the other preventive and routine services, we do not passively "cover" these benefits. Rather, we do everything we can to ensure that our members in fact utilize these benefits.

With regard to the specific subparts of requirement 3.3.1.1:

A) We understand the importance of ensuring the proper amount, duration, scope and clinical oversight of dental services. Our single source data system houses member eligibility, provider contracting and benefits, which ensures that all relevant information is systematically reviewed and applied to claims and pre-service requests.
B) Such systematic review assures all services provided are sufficient in amount, duration and/or scope to achieve the purpose for which they are furnished and that services are not arbitrarily denied or reduced.
C) Our claim system is flexible in its set up for benefit plan design, procedure code rules, potential fraud, waste, and abuse (PFWA) identifiers and clinical review requirements.

Our system functionality includes but is not limited to:

- ***Full scope of dental benefits, frequency limitations and exclusions, including specialized benefits such as school based dental, skilled nursing facilities and programs tailored for pregnant women.***

- ***Our system ties member eligibility, state specific dental benefits, frequency limitations, exclusions, member dental history, provider contracting status including any outlier or special processing rules that may apply to any single provider and/or his dental practice(s) and PFWA code identifiers.***

- ***We customize system adjudication rules for each group and/or plan design. This customization allows LIBERTY to adopt, create, monitor and adjust claims and pre-service requests subject to clinical review, administration review and/or auto adjudication, which ensures that the appropriate amount, duration, scope, and medical necessity benefits are applied to each claim and pre-service request.***

3.3.1.2 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).

We are proposing the following definition for "medical necessity":

DEFINITION OF MEDICAL NECESSITY

We approve care that is "medically necessary" or "needed"

This means:

- ***The treatment or supplies are needed to prevent, evaluate, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition and that meet accepted standards of dentistry;***
- ***Will prevent the onset of an illness, condition, or disability;***
- ***Will prevent the deterioration of a condition;***
- ***Will prevent or treat a condition that endangers life or causes suffering, pain or results in illness or infirmity;***
- ***Will follow accepted medical practices;***
- ***Services are patient-centered and take into account the individuals' needs, clinical and environmental factors, and personal values. These Criteria do not replace clinical judgment, and every treatment decision must allow for the consideration of the unique situation of the individual;***
- ***Services are provided in a safe, proper and cost-effective place, reflective of the services that can be safely provided consistent with the diagnosis;***
- ***Services are not performed for convenience only;***
- ***Services are provided as needed when there is no better or less costly covered care, service or place available; and***
- ***Services provided 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).***

LIBERTY's clinical utilization management team includes licensed dentists, who work under the supervision of our Dental Director. With guidance from the clinical guidelines delineated by the American Dental Association, American Academy of Periodontology, American Association of Oral and Maxillofacial Surgeons, American Academy of Pediatric Dentistry, American Association of Endodontics, American Association of Orthodontists and the American College of Prosthodontists, this team has developed the LIBERTY Dental Clinical Criteria manual which defines what constitutes medical necessity and medically necessary services. In addition to LIBERTY's Dental Clinical Criteria manual, LIBERTY has adopted Nevada specific clinical criteria. We have

ensured that our definition of medical necessity and medically necessary services will align with all Nevada and federal requirements and we will seek approval of this definition.

In making medical necessity determinations, LIBERTY relies on written guidelines and review criteria to ensure recipients obtain dental services:

- ***in a manner that considers the timeliness of care that meets their dental needs;***
- ***that are within professionally recognized standards of dental care; and***
- ***at a location appropriate for their condition.***

LIBERTY's Clinical Criteria and Guidelines are imperative components to the medical necessity decision-making process and ensure that decisions are based on sound clinical evidence.

Perhaps the most important benefit of our clinical review process is that in the course of evaluating requests for treatment against nationally accepted standards of dental care and our Clinical Criteria and Guidelines, we essentially partner with our providers in determining the most appropriate treatment and services for recipients. Our Utilization Review combined with our comprehensive Utilization Management program, enables us to eliminate unnecessary duplication of dental services while preventing against under-utilization and over-utilization of services. These efforts result in optimal health outcomes for our members in a quality, cost-effective, efficient manner.

Prior to implementation, any changes to our Clinical Criteria Guidelines and/or Medical Necessity definition are reviewed and approved by our Peer Review Committee, which meets on a quarterly basis.

State specific medical necessity rules are built into our system, and are consistent with the state Medicaid Services Manual. These rules identify dental procedure codes or a combination of dental codes that require claim and/or pre-authorization attachments, including, but not limited to, x-rays, periodontal charting, or clinical narratives. Procedures that require clinical review are systematically routed to the appropriate state licensed dental consultant for review. The dental consultant reviews each procedure for evidence of need and prognosis of the tooth or area in the mouth.

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

A. 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.

B. 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.

C. 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.

D. 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.

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

Policies and Procedures for Authorizations of Services

LIBERTY maintains written policies and procedures for the processing of requests for initial and continuing authorizations of services.

We have a proven IT platform to receive, process, and report prior authorization requests. We make the submission process easy for provider. For example, pre-authorizations can be submitted via paper, electronically, via an online portal, by telephone, fax, or email. Once received, authorization requests are date stamped, scanned, and inputted into our pre-authorization workflow application.

Our pre-authorization workflow (see Figure 3.3.1.3-1) tracks request inventory and directs each pre-authorization through a simplified step by step process until a final determination is made. Each step of the pre-authorization process is a tracked by user, date and time stamp for reporting purposes. On a daily basis, our pre-authorization review staff generates inventory reports (see Figure 3.3.1.3-2) which help identify where each pre-authorization request is in the workflow. Our trackable process and reviews ensure our timeliness goals are achieved.

FIGURE 3.3.1.3-1. PRE-AUTHORIZATION PROCESS WORKFLOW

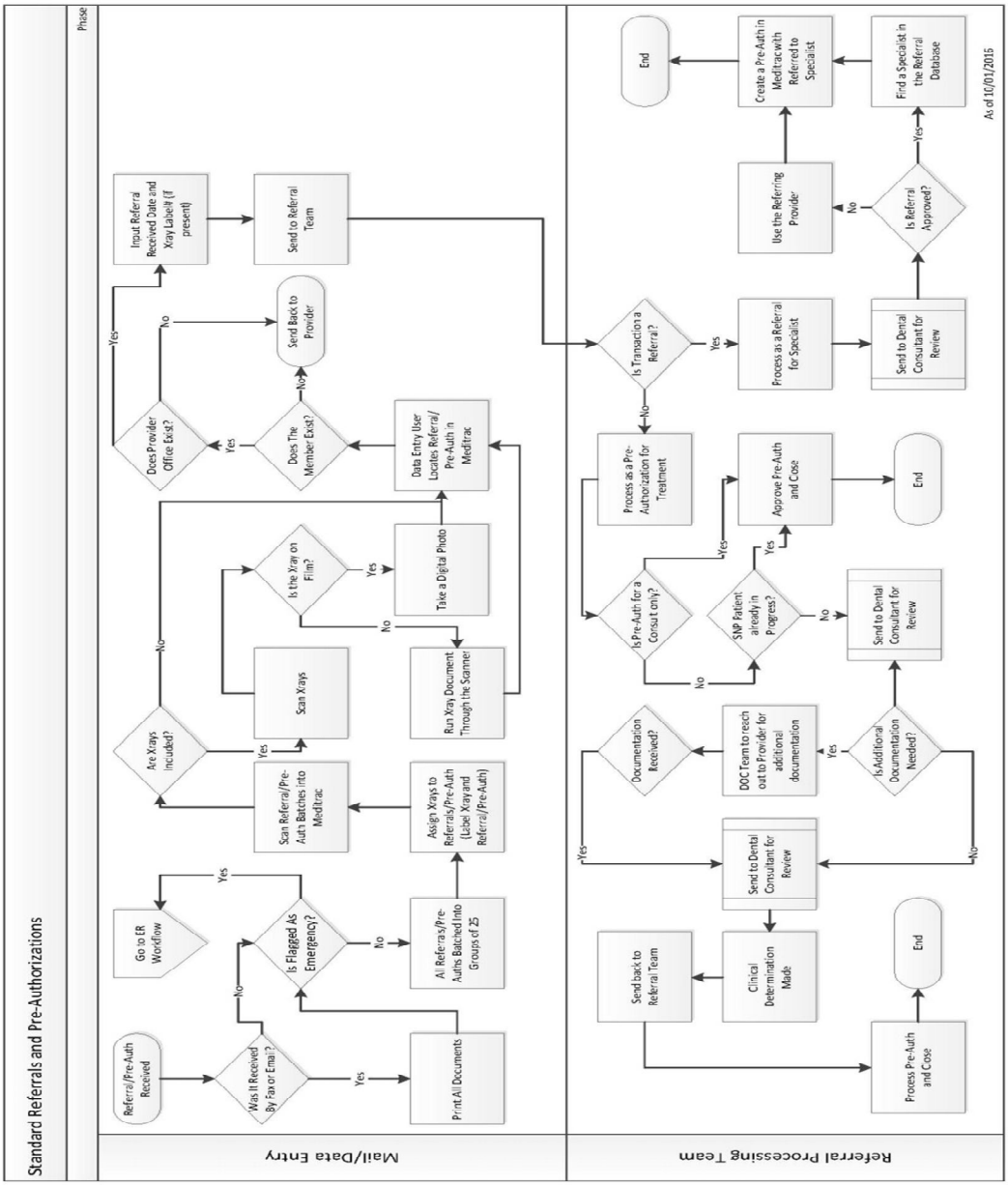

FIGURE 3.3.1.3-2. SAMPLE INVENTORY REPORT

Group Number	Group Name	PreAuth Number	Date Received	Days Aging	Office State	Highest Action Code Name	Work Group Name	Processing Status Name
MHCTX-020	HEALTH PLAN NAME	0008965893	11/10/2016	4	TX	Pre Estimate Claim	Pre Estimate Medicaid	OPEN
MHCTX-020	HEALTH PLAN NAME	0010777540	11/10/2016	4	TX	Coordination of Benefits	Pre Estimate Medicaid	OPEN
WCNJ1A07	HEALTH PLAN NAME	0010796026	11/10/2016	4	NJ	Crown Payable on Delivery Date	Pre Estimate Medicaid	OPEN
HNPHP1	HEALTH PLAN NAME	0010796058	11/10/2016	4	CA	Payable once per date of service	Pre Estimate Medicaid	OPEN
HNGMC820	HEALTH PLAN NAME	0010802607	11/10/2016	4	CA	Payable once per date of service	Pre Estimate Medicaid	OPEN
HNGMC21	HEALTH PLAN NAME	0010805283	11/10/2016	4	CA	Pre Estimate Claim	Pre Estimate Medicaid	OPEN
HNGMC21	HEALTH PLAN NAME	0010805388	11/10/2016	4	CA	Coordination of Benefits	Pre Estimate Medicaid	OPEN
HNPHP1	HEALTH PLAN NAME	0010805407	11/10/2016	4	CA	Coordination of Benefits	Pre Estimate Medicaid	OPEN
HNGMC21	HEALTH PLAN NAME	0010805454	11/10/2016	4	CA	Coordination of Benefits	Pre Estimate Medicaid	OPEN
HNGMC820	HEALTH PLAN NAME	0010812670	11/10/2016	4	CA	DDS Review Procedure - if paying more than $0/member age	Pre Estimate Medicaid	OPEN
HNPHP1	HEALTH PLAN NAME	0010813180	11/10/2016	4	CA	Pre Estimate Claim	Pre Estimate Medicaid	OPEN
HNGMC21	HEALTH PLAN NAME	0010813401	11/10/2016	4	CA	Pre Estimate Claim	Consultant Review	OPEN
HNPHP1	HEALTH PLAN NAME	0010813548	11/10/2016	4	CA	Pre Estimate Claim	Consultant Review	OPEN
HNPHP1	HEALTH PLAN NAME	0010813561	11/10/2016	4	CA	Pre Estimate Claim	Consultant Review	OPEN
HNGMC820	HEALTH PLAN NAME	0010814274	11/10/2016	4	CA	Pre Estimate Claim	Consultant Review	OPEN
HNGMC820	HEALTH PLAN NAME	0010814299	11/10/2016	4	CA	Pre Estimate Claim	Consultant Review	OPEN
HNGMC07	HEALTH PLAN NAME	0010814312	11/10/2016	4	CA	Pre Estimate Claim	Consultant Review	OPEN
HNPHP1	HEALTH PLAN NAME	0010814613	11/10/2016	4	CA	Pre Estimate Claim	Consultant Review	OPEN
MHTANFC5	HEALTH PLAN NAME	0010814765	11/10/2016	4	IL	Review for Ortho Benefits and Payment	Consultant Review	OPEN
HNGMC21	HEALTH PLAN NAME	0010821400	11/10/2016	4	CA	D9310 not payable same day as TX for HMO, CAP or EPO only.	Consultant Review	OPEN
HNPHP1	HEALTH PLAN NAME	0010845009	11/10/2016	4	CA	DDS Review Procedure - if paying more than $0/member age	Consultant Review	OPEN
HNPHP1	HEALTH PLAN NAME	0010845091	11/10/2016	4	CA	Pre Estimate Claim	Consultant Review	OPEN
HNPHP1	HEALTH PLAN NAME	0010851367	11/10/2016	4	CA	Pre Estimate Claim	Consultant Review	OPEN
HNGMC21	HEALTH PLAN NAME	0010854586	11/10/2016	4	CA	Pre Estimate Claim	Consultant Review	OPEN

LIBERTY's pre-authorization processors screen all requests to verify benefit eligibility, treatment plans, and plan exclusions and limitations. Our pre-authorization processor will also verify recipient history to see if similar or related treatment has either been rendered or pre-authorized previously and will provide this information to a Dental Consultant for review. Duplicate treatment requests automatically generate a duplicate request.

Review of Requests by Professionals with Clinical Expertise

All pre-authorization clinical determinations are made by licensed dentists who provide a clinical rationale on every prior-authorization request. That clinical rationale is printed and conveyed to the requesting provider and member on each Notice of Determination.

In instances where a clinical reviewer may not have the necessary information or documentation needed to render a decision, the pre-authorization is pended to the Dental Care Outreach unit. These staff members contact providers via telephone to obtain additional documentation requested by our clinical reviewers. By taking this additional step, LIBERTY increases our number of approvals and vastly decreases the need for the back and forth notification cycle that sometimes occurs between managed care administrators and providers. Once the documentation is received, the pended pre-authorization is then sent back to the clinical reviewer for final determination.

Once the clinical review has been completed on a pre-authorization request, the work item transaction is then sent via the application workflow back to the Pre-Authorization Processor for completion. The Pre-Authorization Processor will verify the clinical review determinations and apply the system reason codes assigned by the clinical reviewer to each line item on the pre-authorization request. Once finalized, the Processor will complete and close the work item, which then queues up the pre-authorization request to be printed and fulfilled.

Consistent Application of Criteria

In an effort to ensure consistent clinical review, our Chief Dental Officer, local Dental Directors, and clinical professionals collaborate on a monthly basis using case studies to keep a consistent clinical determination process across all lines of business.

Monitoring of Prior Authorization Requests

LIBERTY agrees to monitor all prior authorization requests and agrees to comply with all DHCFP requirements.

Coordination of Prior Authorizations and Edit Patterns

We agree to coordinate prior authorizations and edit patterns with those used in the FFS Service program.

3.3.1.4 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.

We have not encountered a situation where we rejected counseling or a referral service due to an objection on moral or religious grounds. Our goal, first and foremost, is to provide responsible, affordable, and quality dental care to all of our recipients. If such an occasion does arise, LIBERTY will provide written documentation supporting our stance (and conveying our rationale) to the DHCFP.

3.3.1.5 Must allow each recipient to choose his or her dental care professional, including the Primary Dental Provider (PDP) to the extent possible and appropriate.
A. Recipients will have an individual dentist, a clinic or a FQHC assigned as their PDP.
B. Vendor must allow for continued use of a recipient's provider(s) until the recipient can be transferred to an appropriate network provider(s).

The flexibility of our MIS allows recipients to choose any contracted provider or to be assigned a contracted provider within close proximity of a recipient's home address. Our welcome packets for Nevada recipients will provide instructions for the recipient to select a primary dental provider.

We offer multiple options to assist our recipients in selecting a primary dental provider. Through our website (www.libertydentalplan.com), recipients may search and select a provider close to their home and based on the provider's profile. Alternatively, recipients may call our Member Services Department to speak directly with a LIBERTY representative for assistance in selecting a primary dental provider. Our current Nevada network includes more than 1,300 dental providers and a broad range of independent dental offices, Dental Care Organizations (DCOs) and FQHCs. Our goal is to build upon this considerable baseline to maximize the Nevada Medicaid population's care access options.

Continuation of Coverage

During the transition of administration from DHCFP to LIBERTY, we will offer a Continuation of Coverage (COC) period of 120 days whereby a recipient can continue to seek covered services from his/her dental provider of choice. During this time period, if the provider is an out-of-network provider, LIBERTY will make every effort to contract with the provider for in-network services. If such an agreement cannot be made, LIBERTY will preserve the existing provider/patient relationship for up to 120 days. We will notify the recipient via telephone or mail of this temporary continuity feature, and we will also make available alternative in-network providers who meet geographic access standards and cultural needs.

3.3.1.6 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:

A. The anticipated DHCFP recipient DBA enrollment;
B. The numbers of network providers who currently are and are not accepting new Medicaid and Nevada Check Up recipients;
C. The expected utilization of services 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;
D. The numbers and types of providers required to furnish the contracted Medicaid covered services; and
E. 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.

We have extensive and proven experience in developing and maintaining robust provider networks that serve a culturally and geographically diverse membership. We also understand that having a large dental network "on paper" by no means ensures adequate access to our population.

Our utilization management system tracks utilization overall, by region, by county, by city, by zip code and for each Medicaid eligible child by name and Medicaid identification number. The system runs CMS-416 (measures 12a – 12f) and HEDIS® Annual Dental Visit (ADV) reports for custom specified timeframes to track utilization. CMS-416 data shows Nevada had a utilization rate of 43% for the Any Dental Services (12a) measure for calendar year 2013. That rate has since dropped and was most recently 38.6% in 2015. LIBERTY intends to increase utilization of services and will thus use an initial expected utilization rate of 45% as our guide for monitoring and maintaining access in the network.

We have successfully recruited, contracted, developed, and maintained Medicaid dental provider networks with over 51,000 points of access in multiple states. Additionally, we have over 1,300 points of access in our existing Nevada network as shown in Figure 3.3.6.1-1 below. Our goal is to provide the support and resources our network providers need to optimally care for Nevada recipients. In developing our network, we consider the anticipated recipient enrollment, the number of providers with open panels, the expected utilization of services, the number and type of providers, and geographic access standards.

FIGURE 3.3.1.6-1: ESTABLISHED NEVADA NETWORK

LIBERTY has an established Nevada network of more than 1,300 dental providers. This network provides us with an excellent baseline of contracted, credentialed dental providers who are actively serving our existing Nevada members. We will systematically work to recruit additional high-quality dental providers, to create as many excellent points of access as possible for Nevada's Medicaid recipients.

We identify potential providers using eligible provider network data from a third party vendor, NetMinder, which maintains competitor networks. In preparation to serve the Nevada Medicaid population, we have prepared NetMinder reports identifying 2,664 Medicaid dental points of access statewide, with 2,137 and 397 in Clark and Washoe Counties, respectively.

We will ascertain the degree to which DHCFP is willing and able to provide the contact information for each dental provider participating in the Nevada Medicaid program and the volume of Medicaid recipients each provider serves. This will allow us to prioritize and target the dental providers with the largest number of recipients. We will separately seek to obtain listings of all Nevada dental providers so that we can also recruit dental providers who do not currently accept Medicaid.

LIBERTY will target each of the provider types as indicated in Attachment M of the RFP. Using our strategies to identify additional providers for dental provider recruitment (such as competitors' networks, out of network providers, nomination requests and state website), we continuously recruit providers to ensure that we maintain our access standards, appointment standards, and recipient to provider ratios, and address changes in cultural and linguistic needs of the population.

We understand that a diverse provider network, which includes Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Indian Health Programs (IHCs) and Community Health Clinics, is a critical component of serving the Nevada Medicaid population. We recognize the level of access these facilities provide to our recipients, and we strive to support them in providing dental care to the Nevada Medicaid population. We have several years of experience in contracting with FQHCs, RHCs and IHCs. Our current national network consists of 672 FQHCs, IHCs, RHCs and other community clinics in 21 states. From our extensive experience with these types of facilities, we recognize that these centers will allow and encourage higher utilization for Nevada Medicaid membership.

In all the markets where we operate, LIBERTY continuously reviews and assesses our provider network through multiple mechanisms – all of which will be used in Nevada. We have policies in place to ensure our network maintains a sufficient number of providers at all times within the required distances.

- ***Monthly GeoAccess Reports. We generate GeoAccess reports to evaluate network access, and to identify and correct gaps. Our focus is to reduce disruption and improve continuity of care to our recipients. We plot the recipient census against existing provider locations and analyze the impact of provider changes we are aware of. This enables us to identify where additional contracting is needed to keep the network compliant with DHCFP requirements. We will monitor to ensure that recipients have access to a PDP or Primary Care Site within 25 miles of home for each provider type required to furnish the contracted Medicaid covered services as indicated in Attachment M of the RFP.***

- ***Review of recipient grievance and appeals. LIBERTY's ongoing review of recipient grievances and appeals provides insight into network access issues.***

- ***Recipient utilization trends and out-of-network utilization trends. LIBERTY reviews any changes in recipient utilization trends for a particular specialty or an increase in out-of-network utilization, which can indicate that there is an access issue for our recipients.***

- ***Change in Provider Status. When we are notified that a provider is no longer accepting new Medicaid and Nevada Check Up recipients, we will immediately "close" the provider in our MIS system. This action prevents the provider from appearing in our provider directory or our web search. In addition, our Member Services Department is able to view the "closed" status and will refer recipients to the next closest provider taking into consideration their age, special need and preferred languages. We monitor this closely to ensure that the status changes will not have an impact to access of care to the recipients.***

LIBERTY conducts regional monthly Provider Relations meetings, during which input from all of the above sources is reviewed. In attendance are all operational areas including the Member Services Department, the Claims Department, the Grievance and Appeals Department, Provider Relations Department, Network Managers, Dental Directors, and Dental Consultants. During these meetings, we collaboratively review information from all departments to identify where access may be limited. If an area is identified, we create a strategy to improve access to meet DHCFP requirements and run a NetMinder

report to identify any additional providers of the needed type within the area. We then begin our recruitment process to contract with these providers.

We continuously develop new recruitment strategies to ensure our membership has access to a superior network that meets their cultural, physical, and linguistic needs. We currently service a substantial population of special needs recipients, and are therefore well-versed in coordinating care for recipients with disabilities. We target providers that have specialized facilities and staff training to physically assist special needs recipients. Recruitment needs are initiated based on the following factors: growth of membership in a city or region, accessibility or appointment standards showing need for improvement, or changes in cultural, physical access or linguistic needs of the population. Once these needs are identified, we will proactively monitor and adjust our provider networks accordingly.

In order to meet the special needs of recipients with disabilities, each of our network providers must complete an accessibility survey as required by the Centers of Medicare and Medicaid Services (CMS). Network Managers document any specialized equipment or training that each office offers. We track this information in our system so we can easily identify providers accessible to recipients with disabilities, and publish this information in our online directory. Recipients can contact our Member Services Department for assistance in identifying providers that meet their needs. Please see Figure 3.3.1.6-2 for a sample of our directory.

FIGURE 3.3.1.6-2. SAMPLE PROVIDER NETWORK DIRECTORY

Member Services: (877) 550-3875

Dentists/Dentistas - LIBERTY GMC Adult
PROVIDER DIRECTORY

CARMICHAEL

#014668
Fonda Webber DDS Inc.
6600 Madison Ave, Ste 4A
Carmichael, CA 95608
(916) 961-5363
English
T 7am - 4pm
W-Th 7am-4pm
46803 Webber, Fonda
NPI: 1346387479 LIC: 46803

#009991
Marconi Family Dentistry & Specialty Group
5723 Marconi Ave, Ste A
Carmichael, CA 95608
(916) 489-9990
English, French, German, Hindi, Hmong; Mong, Hungarian, Japanese, Nepali, Portuguese, Russian, Spanish
M-F 8am - 5pm
61764 Dhawan, Pabina*
NPI: 1497003107 LIC: 61764
20350 Gabor, David*
NPI: 1164656906 LIC: 20350
36765 Hayashi, Randall*
NPI: 1598863961 LIC: 36765
61170 Tanabe, Renee*
NPI: 1578836706 LIC: 61170

#011678
Star Dental Practice
2447 Mission Ave Ste B
Carmichael, CA 95608
(916) 333-1875
English, Chinese, Hindi, Spanish
M-F 9am - 5pm
49441 Ahmed, Sameena*
NPI: 1699843219 LIC: 49441
55767 Chen, James*
NPI: 1588864417 LIC: 55767
61569 Chunduri, Rajesh*
NPI: 1497000848 LIC: 61569
47205 Wakode, Archana*
NPI: 1124247085 LIC: 47205

#012230
Star Dental Practice
5615 Manzanita Ave, Ste A
Carmichael, CA 95608
(916) 333-3700
English, Farsi, Hindi, Russian, Spanish, Vietnamese
M-F 9am - 5pm
47858 Chang, Chee Chiang*
NPI: 1730154394 LIC: 47858
55767 Chen, James*
NPI: 1588864417 LIC: 55767

CITRUS HEIGHTS

#004597
Coast Dental of California
6406 Sunrise Blvd, Ste Acd
Citrus Heights, CA 95610
(916) 727-1880
English
M-F 8am - 5pm
61098 Dhariwal, Raju*
NPI: 1265702906 LIC: 61098
54270 Kaur, Bipinjit*
NPI: 1871739011 LIC: 54270
100585 Luong, Elizabeth*
NPI: 1992250773 LIC: 100585
62152 Nguyen, Hanh*
NPI: 1508999400 LIC: 62152
47302 Ou-Yang, Fred*
NPI: 1316033285 LIC: 47302
50829 Tan, Maristela*
NPI: 1164569646 LIC: 50829
44272 Vardanian, Tigran*
NPI: 1043344591 LIC: 44272

CLOVIS

#004958
Coast Dental of California
1010 Shaw Ave Ste B
Clovis, CA 93612
(559) 777-6113
English, Arabic, Spanish, Tagalog
M-T 8am-5pm
Th-F 8am-5pm
64968 Mangat, Sabrina*
NPI: 1467829044 LIC: 64968

ELK GROVE

#005848
Archie Dental Group
8013 Laguna Blvd. #2
Elk Grove, CA 95758
(916) 691-6020
English
M-Th 9am - 5pm
30098 Archie, Thaddous*
NPI: 1992864011 LIC: 30098
60386 Lam, Lucille*
NPI: 1942598552 LIC: 60386

#004598
Coast Dental of California
9184 E Stockton Blvd
Elk Grove, CA 95624
(916) 686-1101
English, Arabic, French, Hindi, Spanish, Tagalog, Urdu
M-T 9am-6pm
W-Th 9am-6pm
61098 Dhariwal, Raju*
NPI: 1265702906 LIC: 61098
54270 Kaur, Bipinjit*
NPI: 1871739011 LIC: 54270
59621 Le, An*
NPI: 1265660211 LIC: 59621
47302 Ou-Yang, Fred*
NPI: 1316033285 LIC: 47302
50829 Tan, Maristela*
NPI: 1164569646 LIC: 50829
28248 Teal, James*
NPI: 1255474532 LIC: 28248

#011569
Grove Dental Group
9727 Elk Grove Florin Rd Ste 155
Elk Grove, CA 95624
(916) 714-7771
English, Korean, Lao, Russian, Vietnamese
M-F 8am - 5pm
52432 Mehrvarzi, Shahriar (Sean)
NPI: 1821159468 LIC: 52432
64909 Nguyen, Nancy
NPI: 1689050346 LIC: 64909
53724 Park, David
NPI: 1942410501 LIC: 53724
43387 Pereira, Sergio
NPI: 1679650360 LIC: 43387
49669 Shieh, Paul
NPI: 1912064361 LIC: 49669
57552 Woodson Mcgee, Erika
NPI: 1477700458 LIC: 57552

FOLSOM

#004599
Coast Dental of California
825 E. Bidwell, Ste 400
Folsom, CA 95630
(916) 984-4591
English, Hindi, Russian, Spanish
M-F 9am - 6pm
61098 Dhariwal, Raju
NPI: 1265702906 LIC: 61098
54270 Kaur, Bipinjit
NPI: 1871739011 LIC: 54270
62152 Nguyen, Hanh
NPI: 1508999400 LIC: 62152
47302 Ou-Yang, Fred
NPI: 1316033285 LIC: 47302
100668 Patel, Ravi
NPI: 1194279083 LIC: 100668
50829 Tan, Maristela
NPI: 1164569646 LIC: 50829

#009313
Western Dental Services, Inc
1016 Riley Street, Ste 1
Folsom, CA 95630
(916) 984-4127
Spanish, Farsi, Russian
M-T 9am-7pm
W 9am-7pm,
S 8am - 4pm
52577 Albik, Mohamad
NPI: 1396803342 LIC: 52577
65319 Mahdi, Amar
NPI: 1952766297 LIC: 65319

GALT

#010743
Galt Dental Group
1067 C St, Ste 125
Galt, CA 95632
(209) 744-0463
Vietnamese, English, Korean, Lao
M-F 9am - 5pm
47858 Chang, Chee Chiang
NPI: 1730154394 LIC: 47858
51260 Ho, Thanh
NPI: 1386780294 LIC: 51260
54782 Lee, James
NPI: 1548329311 LIC: 54782
64909 Nguyen, Nancy
NPI: 1689050346 LIC: 64909

The provider directory is subject to change without notice.
Languages spoken by the offices are self-reported and are not independently verified by LIBERTY Dental Plan.
If you need to access LIBERTY's free interpretation services please call the number listed on your ID card.
To view current providers, please visit our website, www.libertydentalplan.com

* Closed to new members. Wheelchair access.

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3.3.1.7 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.

We seek to contract with a broad and comprehensive dental health network to mitigate the need for our members to seek out-of-network care. During our most recent implementation of a Medicaid program, our out-of-network activity tapered off by 50% within the first 2 months after the continuation of care period. However, we understand that there are several instances in which our members may need dental care from an out-of-network provider, such as:

We value continuity of care and will provide 120 days of treatment continuity for new recipients whether or not their existing provider has joined our network.

- ***During the first 120 days of a recipient's enrollment with LIBERTY, we will allow the recipient to continue dental care with their out-of-network provider to ensure continuity of dental care. During this time period, we are able to constructively forge relationships with out-of-network providers and demonstrate our commitment to reducing their administrative burden. For example, by quickly turning around claims.***
- ***A recipient needs emergency services (e.g., after hours or when out of town) and seeks services from an out-of-network provider.***
- ***A recipient may have limited geographic access to a specific specialty provider and may be referred to an out-of-network provider.***
- ***A recipient needs access to care from a specialty dental provider and there is a shortage of that specific provider type.***

We will also cover out of network services for recipients when an in-network provider is not available within the required radius of twenty-five (25) miles of the recipient's home. In such instances our Member Services Department will work with the recipient to coordinate an approval of any licensed dentist that is reasonably accessible to allow the recipient to seek the necessary treatment. We do not reduce benefits to the recipients when treatment at an out-of-network provider is the result of an approved request. LIBERTY's priority will be contacting available out-of-network providers located

within 25 miles of the recipient's address before contacting out-of-network providers located over 25 miles from recipient's address.

Once an out-of-network provider is identified to treat the recipient, LIBERTY will attempt to negotiate a reimbursement rate starting with the Medicaid FFS rate then finalize a fee schedule that is agreed upon by both the provider and LIBERTY. As part of our ongoing provider monitoring, we track out-of-network providers in the system to identify when there is a need to refer recipients' out-of-network or if these trends could indicate a gap in our network. We will work with these providers to convert them to in-network status when possible. If there is a consistent complaint or an aberrant utilization pattern regarding an out-of-network provider, we will note this in our system to discontinue referring our recipients to that provider.

3.3.1.8 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.

We consider it a recipient's right to have access to a second opinion from an appropriately qualified dental provider. Members are advised of this right in their Member Handbook. LIBERTY's second opinion policy allows recipients (or their appointed representatives) to request a second opinion regarding treatment proposed by a network dentist (general dentist or specialist). The request may also be submitted by their treating dentist.

Second opinions are completed by contracted providers. If we cannot locate a qualified contracted provider within a reasonable distance of the recipient's residence or place of work, LIBERTY will authorize a second opinion outside of LIBERTY's provider network. All second opinions, whether in- or out-of-network, are available at no cost to the recipient.

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

Providers will be reimbursed in accordance with the agreed upon fee schedule. For non-emergency services, we coordinate and agree on the fee schedule ahead of the visit. For emergency services, we will coordinate following the treatment or visit. Our Member Services team will contact out-of-network providers to assist recipients in scheduling appointments, educating providers on how to submit claims, confirming eligibility, and discussing recipient benefits.

3.3.1.10 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;

Hours of Operation

We collect hours of operation from our network providers during the contracting period to ensure they offer the same hours of operation to all members, whether they have commercial, Medicaid, or Medicare coverage. We conduct secret shopper calls and review member grievances and appeals to identify any potential inconsistencies with the office hours in our directory and an office's actual hours of operation.

Appointment Availability Requirements

Our existing policies and procedures will ensure that providers meet Nevada appointment availability requirements for urgent care or emergency appointments within 24 hours, routine or preventive dental services within six (6) weeks and diagnostic care within fourteen (14) days. Additionally, wait time for appointments will be no more than one (1) hour from the scheduled time.

We have had an established network in Nevada since 2008. We are familiar with the importance of making sure that our network providers meet the standards for timely access to care and services. Our local Network Manager educates our providers on appointment availability standards and requirements during the contracting and onboarding process and during our new provider orientation sessions. Additionally, this information is available in the provider manual, orientation brochure, and online.

At each provider service call, the Network Manager confirms that the provider profile is current. This includes, but is not limited to confirming:

- ***wait times for periodic evaluations, non-urgent and urgent appointments***
- ***languages spoken***
- ***after hours availability***
- ***dentists participating at the practice; and***
- ***whether new patients are being accepted.***

3.3.1.11 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.

We understand and will comply with the requirements regarding emergency and urgently needed care outlined in 3.3.1.11.

Our policies and procedures require that emergency care be available twenty-four (24) hours per day, seven (7) days per week through our network of dental providers. However, if a recipient is unable to reach their dental provider after normal business hours and contacts LIBERTY, our afterhours recording instructs recipients on how to access a LIBERTY dental consultant, a qualified and licensed dentist, in emergency or urgent situations. The dental consultant will assess the needs of the recipient and provide guidance, which may include directing the recipient to the emergency room for care.

Our Member Services' internal response unit (IRU) will follow up with the recipient the following business day to ensure their concern was satisfactorily resolved. Additionally, we routinely monitor network providers, through secret shopper calls, to ensure compliance with contractual obligations regarding availability and after-hour emergency care procedures. We will track all such efforts in workflows and report outcomes to DHCFP.

3.3.1.12 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.

Delivery of Services in a Culturally Competent Manner

LIBERTY has a demonstrated, longstanding commitment to delivering dental services in a culturally and ethnically competent manner to all recipients, including those with limited English Proficiency ("LEP"), diverse cultural and ethnic backgrounds, and hearing or visual impairments or other disabilities. Similarly, we require our providers to

render services to all recipients in a non-discriminatory manner, in accordance with the same standards of care and with the same priority of their other patients, regardless of the recipient's race, color, creed, gender, disability, type of illness or condition, or any other prohibited basis.

We promote culturally and ethnically competent delivery of services through a variety of mechanisms, including:

- ***Assessing the needs of our recipients;***
- ***Providing high quality translation services;***
- ***Training providers and employees on culturally and linguistically appropriate services (CLAS) standards***
- ***Providing access to all vital documents in alternative formats; and***
- ***Educating our providers, subcontractors and recipients about the availability of these services and resources.***

We require staff who identify a LEP or visually or hearing impaired recipient to document this information in our MIS to facilitate future communication with the recipient. We make this information available to our providers and use it internally to ensure we always use the appropriate method to communicate with recipients. LIBERTY also requires our providers to document a recipient's language and requests for interpreter services in the recipient's dental record, as well as a recipient's refusal of interpreter services (when such services are offered).

Recipient Facing Materials

We facilitate the delivery of services to recipients with LEP, diverse cultural and ethical backgrounds, and hearing or visual impairments or other disabilities, by providing high quality oral and written translation materials and services, and by requiring providers to do the same. We produce all our written recipient-facing material at an eighth (8th) grade reading level or at a lower level when we determine it is necessary to do so. We also make alternate formats available to our recipients upon request, including in large print (14 point font or larger), audio and braille. In addition, our recipients have the right to make standing requests for written or translated materials.

Translation and Language Interpretation

LIBERTY is well versed in providing culturally and linguistically appropriate translated materials to recipients with LEP. We translate all recipient materials into Spanish, and if determined necessary based on our cultural and linguistic services needs assessment or if required by law or regulation, into other languages as well. Through a toll-free language line, we provide high quality interpreter services available to potential and current recipients in hundreds of languages. We also provide access to telephonic

interpreter services through bilingual Member Services Representatives and provide face-to-face interpreter services at the request of our providers. LIBERTY offers assistance to current and new providers and office staff to ensure their competence in accessing interpreter services and working with interpreters.

LIBERTY ensures that recipients and providers are made aware of the availability of interpreter services at no charge through:

- ***Signage posted at key dental points of contact;***
- ***Recipient and provider newsletters;***
- ***Provider manual;***
- ***LIBERTY's website; and***
- ***Notices of Language Assistance and Nondiscrimination included with all vital documents***

Interpretation Services for the Visually and/or Hearing Impaired

We make recipient materials available in large print and audio format and/or provide oral translation for those who may be visually impaired. LIBERTY also makes available for its recipients sign language interpreter services and arranges such services as necessary. In addition, we maintain a Telecommunications Device (TTY or TDD) line for assistance 24 hours a day seven days a week. Similarly, we require our providers to provide access to a TDD at no cost or inconvenience to the recipient wishing to use it.

As appropriate, we follow up with recipients to ensure that interpreter services or materials have been provided as requested. We review quarterly grievance reports for possible complaints related to visually or hearing impaired recipient's inability to receive necessary information due to their impairment, and immediately and appropriately act on any potential concerns.

Needs Assessment

As part of LIBERTY's commitment to promoting the delivery of care in a culturally competent and accessible manner, we conduct a health education cultural and linguistic services needs assessment to ensure that we are aware of the needs of our potential and current recipients. On at least an annual basis, we evaluate the cultural and ethnic backgrounds and disabilities of our current and prospective recipients. To perform this assessment, LIBERTY reviews:

- ***demographic data from government agencies;***
- ***published reports on oral health;***
- ***internal reports regarding recipient demographics, health care utilization and health status; and***
- ***recipient and provider surveys.***

The results of this assessment are used to evaluate our current efforts to promote delivery of services in a culturally and ethnically competent manner. Based on the results, we may modify or add to the activities described above.

LIBERTY Employees

We coordinate and facilitate the integration of cultural competency guidelines by conducting language proficiency testing; working with the information systems department to establish a system for identifying and profiling language and ethnic specific data; encouraging community input on relevant issues; and participating in key committees and task forces related to best practices in cultural and ethical competency.

We incorporate cultural and ethnic competency information through various communication tools. For example, we inform employees of ongoing cultural and ethnic competency trainings and interpretation workshops, we maintain records of employees who have attended such trainings, and assess their effectiveness. All our employees complete cultural competency training at least annually.

LIBERTY Providers

We assess providers' bilingual capabilities upon contracting and at least annually thereafter to ensure that the racial, ethnic, cultural, and linguistic needs of our recipients are being met. We give providers information on how to access language assistance services upon contracting and during orientation and additional details are provided in various provider communications (newsletters, annual training, etc.) on an ongoing basis.

Through our contracts and provider manuals, LIBERTY requires our providers to agree to provide services to all recipients, including those with LEP, visual or hearing impairments or with diverse ethnic and cultural backgrounds, in the same manner, in accordance with the same standards and with the same priority as their other patients. We also require that providers assist all of our recipients with obtaining or accessing services, and to have policies prohibiting making improper inquiries regarding a person's race, color, national origin, religion, sex, age or disability.

In short, LIBERTY's proven track record in promoting culturally competent services comes from our own values and our Medicaid experience. We are confident applying this experience in Nevada will prove similarly successful in improving access to front-end preventive and routine services for the State's Medicaid population – and substantially reducing the volume of required oral health crises and related treatments.

3.3.2 Vendor Covered Services

3.3.2.1 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:

A. General Dentists
B. Pediatric Dentists
C. Oral Surgeon
D. Oral and Maxillofacial Surgeon
E. Endodontists
F. Periodontists
G. Prostodontists
H. 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.

At a minimum, LIBERTY will directly pay for all covered medically necessary dental services as defined in the Medicaid Services Manual (MSM) Chapter 1000 – Dental to include services provided by the provider types listed above, as well as all non-covered medically necessary dental services in accordance with EPSDT federal regulations.

We currently ensure that EPSDT federal regulations regarding medical necessity are met in all the other Medicaid programs we administer and will ensure that all services are reviewed for medical necessity prior to denial, whether or not such services are covered under the DHCFP's state plan and without regard to any service limitations otherwise established in the MSM.

For treatment not covered under the DHCFP's state plan and outside of the scope of LIBERTY, but found to be needed as a result of conditions disclosed during screening and diagnosis, we will assist in referring members to appropriate providers including those who have expressed a willingness to furnish uncovered services at little or no expense to the family, in accordance with 42 CFR 441.61. We will work with providers

and parents/guardians to ensure that utilization for pediatric dental services are in accordance with the AAPD clinical guideline on periodicity of examination, preventive dental services, anticipatory guidance, oral treatment for children and EPSDT guidelines for dental.

3.3.2.2 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.

LIBERTY understands the need to allow appropriate medically necessary dental treatment for persons over the age of 21. Our MIS system is customizable and, at a minimum, allows for no prior authorization for medically necessary:

- ***diagnostic services needed for emergency extractions;***
- ***palliative care; and***
- ***the treatment of extractions.***

Additional services such as partial or full dentures, palliative periodontal treatment, adjunctive non-emergency services, amalgam or plastic fillings and stainless steel crowns may be provided when prior authorization is submitted with evidence of medical necessity consistent with the Nevada Medicaid service manual criteria.

Medical necessity may include evidence of:

- ***Extractions or palliative treatment for tooth or area demonstrating pain, swelling, infection or bleeding***
- ***Filling for crown for a tooth adjacent to a partial denture and is the abutment tooth for the partial***
- ***Denture or partial denture where it is necessary to prevent the progression of weight loss and promote adequate mastication***

3.3.2.3 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.

We understand and will comply with offering expanded dental services in addition to the adult services for Medicaid eligible pregnant women for periodontal scaling and root planning.

LIBERTY will offer a value-added benefit, which includes a third and fourth cleaning per year for pregnant women. Reports have shown possible links between periodontal disease and pre-term, low birth weight babies. Ensuring that pregnant members understand this possible correlation is of the utmost importance to us, thus, we have implemented outbound call programs specific to pregnant women in our Texas Medicaid program in an effort to increase the initial low utilization rates.

We identify pregnant recipients in a number of ways, including, but not limited to: identifiers on the 834 file; working with the state directly; via outbound call programs; and by working with our provider network to ensure they check the appropriate box on their ADA claim forms when one of their patients is pregnant. Once identified, we send oral health information to pregnant recipients at least monthly and collaborate with MCOs, providers and other stakeholders to create a comprehensive pregnant woman outreach program. An example of an outreach communication for pregnancy and oral health is included to the right.

3.3.2.4 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.

Upon contract award, we will request the appropriate contacts to coordinate access to facilities from DHCFP. Upon contracting, LIBERTY identifies providers who have hospital and/or surgical center access and privileges, and at which locations. We maintain a current list of these providers by verifying their status during our routine service visits and calls.

Once a case is identified as one in which a Medicaid or CHIP recipient requires a hospital or surgical center setting for general anesthesia or intravenous sedation, we immediately route the case through our Internal Response Unit (IRU) for coordination. In these situations, prior-authorizations are escalated to our dental consultants for immediate review. Our IRU team works with the dental provider, the member's MCO, and the hospital to obtain access to facilities and physician services necessary to complete treatment. LIBERTY will not hesitate to reach out to the DHCFP for assistance if the MCO is uncooperative in expediting approval.

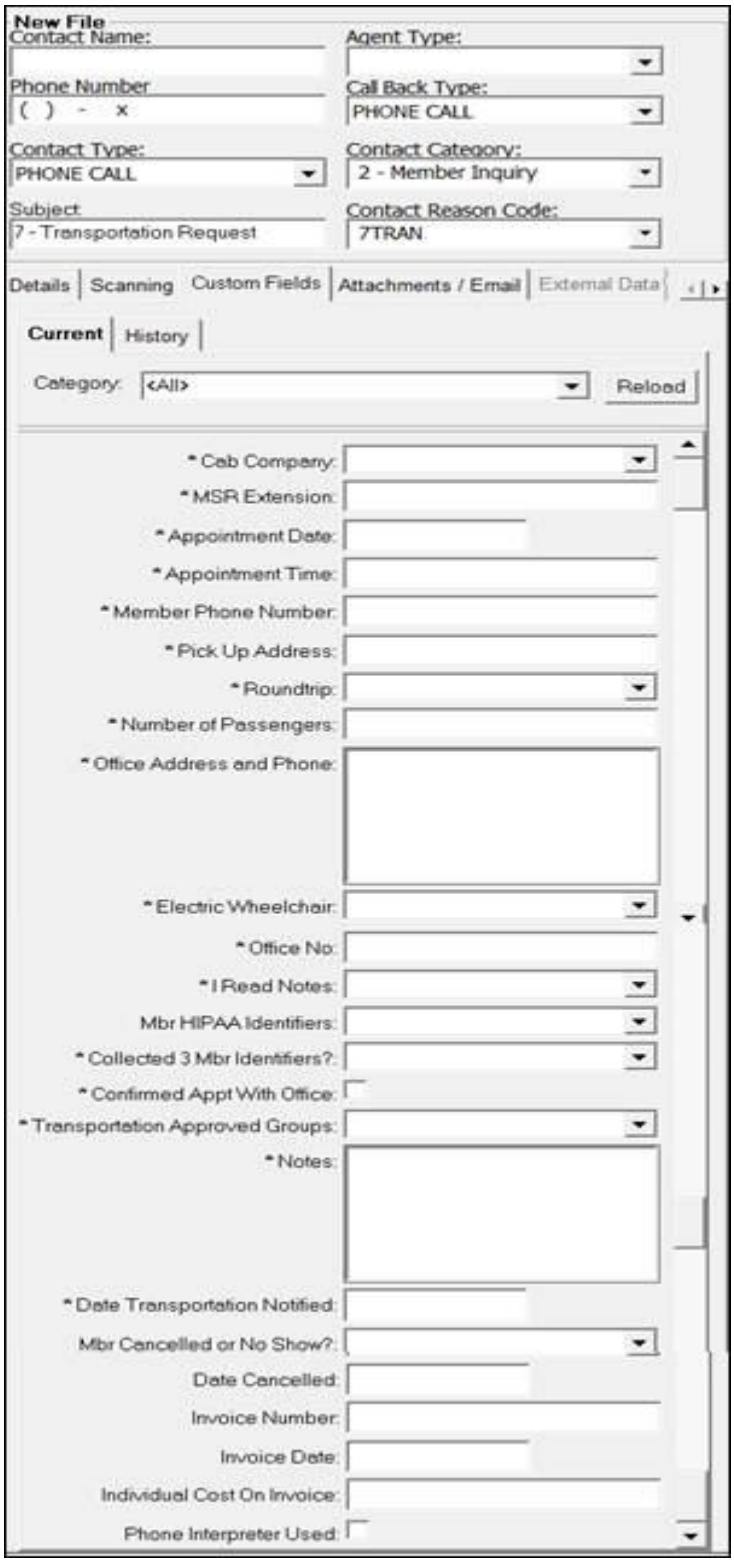
3.3.2.5 Non-Emergency Transportation (NET)

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.

We will work collaboratively with DHCFP, its NET Broker, and the recipient, to provide non-emergency transportation. Because of our existing relationships with our healthcare partners, we are familiar with this process and already have policies and procedures in place to coordinate transportation services for recipients.

As part of our established policy, we verify appointments prior to making transportation arrangements. Our workflows will be customized to meet the needs of the DHCFP contract and the NET broker. *Figure 3.3.2.5-1* provides an example of the workflow we use to capture pertinent data related to transportation services.

FIGURE 3.3.2.5-1. TRANSPORTATION WORKFLOW



3.3.2.6 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.

We understand the complexity and effort that goes into coordinating services for orthodontic treatment and, to address this, we created a distinct orthodontic workflow within our processes employing staff specialized in coordination of orthodontic cases.

LIBERTY handled over 10,000 orthodontic treatment cases for Medicaid enrollees in 2015.

The guidelines set forth in the MSM Chapter 1,000 are very similar to the guidelines that we follow today for orthodontic treatment, which are listed below. We understand the additional component specific to Nevada Medicaid is a completed Client Treatment History Form outlining the recipient's commitment and history of complying with dental care treatment. We will gladly facilitate this requirement.

- ***Board certified and/or board eligible orthodontist provides orthodontic services.***
- ***Requests for recipient orthodontic treatment must be pre-authorized and include the following***
    - ***Examination***
    - ***Orthodontic records (panoramic x-ray, diagnostic films, study models)***
    - ***A completed HLD form***
    - ***A narrative outlining the treatment plan***

Our Dental Outreach Care representatives will coordinate with orthodontic offices to obtain all of the above information if not initially received with a prior authorization request. If this information is not received in a timely manner, we may request an extension if it is in the best interest of the recipient, and will notify the recipient accordingly.

When all required information has been received, our specialized orthodontic staff will submit the pre-authorization request to a licensed Orthodontist for clinical review. Our Orthodontic Consultants will review the pre-authorization package and render a decision based on the guidelines set forth by the state of Nevada Medicaid and the MSM Chapter 1000 (e.g. medical necessity and a HLD Index score of 26 or higher). Today, we successfully execute a very similar protocol for thousands of Medicaid orthodontic cases in California, Florida, New Jersey, Texas and Illinois.

Within our orthodontic workflow, we can determine what codes are approved and for what length of time, allowing us to create an orthodontic case. We can also coordinate

the EPSDT services at each six month interval, as required under the Nevada contract. If EPSDT services are not completed within six months, an exception report can be generated and an outreach call can be made to the recipient and provider to help facilitate EPSDT services.

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

3.3.3.1 The 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.

3.3.3.2 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.

LIBERTY will ensure all medically necessary services identified in an EPSDT Healthy Kids periodic or interperiodic screening are available to all eligible Medicaid beneficiaries under the age of 21 years, if those services are listed in 42 U.S.C. 1396 d (a). LIBERTY currently operates under the same guidelines in our other Medicaid programs and medical necessity code rules are built into our MIS system specific to the state Medicaid Services Manual. For Title XIX children, system code rules identify dental procedure codes or a combination of dental codes that require review. Procedures that require clinical review are systematically routed to the appropriate state licensed dental consultant for review. The dental consultant will review each EPSDT procedure for evidence of need and prognosis of the tooth or area in the mouth, ensuring all medically necessary EPSDT services are covered. All services are reviewed for medical necessity prior to denial, whether or not such services are covered under the DHCFP's state plan and without regard to any service limitations otherwise established in the MSM.

We understand and agree that we are responsible for reimbursement of all dental services under EPSDT which are considered medically necessary, and will ensure that

all services are reviewed for medical necessity prior to denial, whether or not such services are covered under the DHCFP's state plan and without regard to any service limits otherwise established in the MSM, for Title XIX (Medicaid) recipients.

As noted in our responses to prior questions, LIBERTY has proven success in not merely covering EPSDT services, but in significantly increasing utilization of these services among the Medicaid children we serve.

We agree to coordinate care to ensure all medically necessary services are provided under EPSDT guidelines, and currently do so in the other Medicaid programs that we administer. For those services that are outside of the scope of LIBERTY Dental Plan, but found to be needed as a result of conditions disclosed during screening and diagnosis, we will assist in referring recipients to appropriate providers including those who have expressed a willingness to furnish uncovered services at little or no expense to the family, in accordance with 42 CFR 441.61.

3.3.3.3 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.

We will comply with the requirement that EPSDT screenings and Well baby/Well child screenings for Nevada Medicaid and Nevada Check Up (NCU) recipients are to be billed using the same codes with the same reimbursements. We will ensure that all providers are aware of this requirement through regular outreach and education efforts.

LIBERTY understands and agrees that if awarded the contract we will not be required to pay for any treatment outside of the Title XXI state plan for the NCU recipients as the NCU program is Nevada's version of the federal Children's Health Insurance Program (CHIP).

3.3.3.4 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.

We understand and comply with the requirement regarding provision of services determined to be unsafe or ineffective, or which are considered experimental. In the

case of peer-reviewed studies, we agree to comply as stated, and understand that limits may be put in place based on medical necessity.

3.3.3.5 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.

We agree to provide information and perform broad outreach and educational activities to eligible enrolled children for EPSDT services, as detailed in section 3.3.4 below, and agree to have the information and activities reviewed and approved by DHCFP or its designee prior to implementation. LIBERTY has a proven track record in increasing usage of preventive services for Medicaid-covered children, as outlined in our responses to previous questions.

3.3.4 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:

We fully understand that both member engagement and a healthy, ongoing relationship with a Dental Home provider will result in continuously accessible, comprehensive, family-centered, and culturally effective coordination of dental health care for Nevada's Medicaid and NCU recipients.

Beyond establishing the optimal Dental Home for recipients, we believe in engaging in ongoing recipient outreach initiatives that emphasize the importance and availability of routine and preventive services. We also understand there is no cookie-cutter approach to outreach, education, and engagement, and that oral health issues, including barriers to access, vary by locality. Therefore, we will work with DHCFP, local

advocates, government agencies, community groups and other stakeholders to complete an evidence-based needs assessment, and we will implement culturally appropriate programs to address the specific barriers, needs and issues of Nevada's Medicaid and NCU recipients we identify.

We agree to comply with all applicable State and federal statues, regulations and protocols, and will submit a written description of all planned promotional and educational activities to the Nevada Division of Public and Behavioral Health, Chronic Disease Prevention and Health promotion for approval prior to implementation.

Additional information regarding our Health Promotion, Education and Outreach programs are detailed in subsections 3.3.4.1 and 3.3.4.2 below.

3.3.4.1 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.

To ensure our outreach efforts have the greatest positive impact for Nevada Medicaid recipients, we look forward to working collaboratively with DHCFP, local advocates and other stakeholders to develop regionally based oral health improvement programs.

Our outreach begins during the enrollment process. We reach out to recipients upon enrollment to encourage placement in a Dental Home, as well as to establish the importance of routine and preventive dental care. Nevada Medicaid and NCU recipients will receive our welcome enrollment packet as part of our initial outreach to them. We then use a combination of outbound calls and home mailing campaigns, among other efforts, to support our outreach initiatives.

Our local team of experts, dedicated to the overall success of the Nevada program, will play a key role in these campaigns. They will leverage a blend of outbound calling, mailing initiatives, data analysis, and local representative support in order to:

- ***partner with providers on outreach and education;***
- ***source local mobile vendors for school based dental programs; and***
- ***identify specific areas for utilization improvement.***

Collaborative Partnerships with Community Organizations

Our experience has taught us that collaborative partnerships with community organizations are imperative to understanding our recipients from a holistic perspective

that accounts for dental, health, and socioeconomic needs. It also provides us direct and immediate information regarding local barriers to access or other concerns recipients may encounter navigating the program or services. This holistic approach is critical to impacting recipients' lives, helping them adopt healthier lifestyles, and promoting overall wellness. In Nevada, we will seek to partner with community organizations throughout the State including but not limited to the Las Vegas Urban League, Nevada's Community Health Centers, neighborhood community recreation centers such as Searchlight and Walnut, and all members of the Nevada Community Action Association (NCAA), in order to connect with members of the community and provide educational events that support healthy lifestyle changes.

Recent Community Events in other Programs:

- ***Multicultural Family Festival:*** ***With 15,000 attendees, LIBERTY provided two translators from each of the following languages -Russian, Spanish, Arabic, Vietnamese, Chinese and Hmong– to help canvas the event, handing out information on how to utilize the local Medicaid plan, and distributing over 8,000 toothbrushes and oral hygiene kits.***

- ***California Pan-Ethnic Health Network (CPEHN):*** ***LIBERTY sponsored three CPEHN events on oral health inequities in communities of color. The program brought together hundreds of local advocates, stakeholders, and county health representatives to exchange ideas and conversations about how to better support these communities.***

- ***Elementary School Dental Presentations:*** ***LIBERTY conducts dozens of dental presentations in individual classrooms.***

- ***Sacramento Healthy Kids Day & Del Paso Heights Harvest Festival:*** ***LIBERTY participates in numerous community events like these, year round. We typically staff an informational table and distribute toothbrushes. We also coordinate with Early Smiles to provide onsite dental screenings.***

- ***Family Fridays at the Crocker Art Museum (special attendees from Robertson Community Center).***

- ***Community Event Sponsorships:*** ***LIBERTY has sponsored several community events recently including of Run for a Safe Haven to benefit My Sister's House (a local domestic violence, sexual assault, and human trafficking shelter and***

program), Vision y Compromiso (annual state conference promotors, leaders, and community workers).

- ***Community Advocacy:*** ***LIBERTY provides input and support at community advocacy meetings for groups such as the Medi-Cal Dental Advisory Committee and Healthy Sacramento Coalition.***

Outreach Programs

We have implemented several outreach projects in the other Medicaid and CHIP programs that we administer, with the goal of increasing preventive services for our members. Each client we serve prioritizes the types of services they wish to improve upon differently, and we customize our outreach focus depending on which programs are most important to them.

Once we have a better understanding of DHCFP's core utilization concerns, we will develop specific outreach initiatives for recipients that reflect those goals. Below are examples of some of the outreach campaigns we have conducted in other states that we plan to implement in Nevada.

Additional details on each of the following programs are conveyed below:

- ***1st Tooth 1st Birthday Programs***
- ***Fluoride Initiatives for Children***
- ***School Based Dental Programs***
- ***Sealant Utilization - Provider Engagement & Pay for Performance Programs.***

1st Tooth 1st Birthday Initiative

We have worked alongside states, numerous advocates, and other stakeholders over several years to identify ways and means to improve quality within our Medicaid programs. Recently, through analysis of utilization trends and discussions with numerous member advocates, we identified a barrier to access issue for members between the ages of zero to one.

CASE STUDY: FIRST TOOTH

To examine access issues for the youngest children in Sacramento County, we asked dentists at what age they first start seeing children in their practice. Approximately one-half of all dentist respondents and one-half of all general dentist respondents (49% and 51.9%, respectively) reported they start seeing children by age 1 or the first tooth. In contrast, a representative sample of dentists statewide showed only 18% of general dentists started seeing children at age 1; 82.2% of pediatric dentists reported they saw children at the recommended age 1. This finding suggests that a concerted effort has been made in Sacramento County to follow the recommendation for "the first dental visit at the first tooth or first birthday." Not unexpectedly, of the pediatric dentists 100% reported they saw children at the recommended age 1.

Specifically, some providers were refusing to treat members at this age and parents/guardians did not understand the importance of having their children seen by a dentist at such a young age. We immediately launched a 1st Tooth 1st Birthday campaign in conjunction with our network providers to ensure our youngest members receive routine preventive, diagnostic, and specialty dental care. Our mission was to promote awareness of the American Academy of Pediatric Dentistry's (AAPD) recommendation to "Get it Done in Year One".

We called the parents/guardians of each of our recipients aged one year and younger to encourage and assist them in selecting a Dental Home in order to foster their relationship with a general or pediatric dentist. We also reached out to our provider network, and reminded them of the importance of seeing children by their first tooth/first birthday. While this campaign was specifically focused on children aged one and younger, we routinely perform similar campaigns for children of all ages within Medicaid Managed Care Dental programs.

Fluoride Initiative for Children

In analyzing utilization trend analysis, LIBERTY identified that many of our members were not receiving a high percentage of fluoride treatments during their office visits. Research shows that a simple fluoride swab may be critical to eliminating or diminishing dental disease. Visiting a dental provider at an early age for oral health examinations and preventive services significantly decreases or eliminates a child's anxiety about dental treatment. Therefore, we developed the Fluoride Initiative in California to increase early fluoride application in children three years of age and younger, and to strengthen the Recipient/Dental Home relationship. Our initiative focused on a combination of outreach and education by reaching out to providers and recipients through mailings and flyers.

We worked with several providers chosen specifically for their ability to work with and effectively treat young children. These providers were paid an additional supplemental fee to perform child visits and apply fluoride varnish to children between the ages of zero and three years old. For this particular outreach program, we contacted the parents and guardians of the zero to three populations via an outbound phone call campaign, and helped these recipients make dental appointments with the identified providers.

Additionally, we designed and implemented a successful outbound call campaign, in which our Member Service Representatives (MSR) called parents (or guardians) to

inform them about the program. If the parent agreed to participate, the MSR would warm transfer the parent to the provider office to make an appointment. The outbound campaign resulted in thousands of appointments made by parents of young children for their child's first dental visit.

To measure our progress and success, we used claims data to determine the number of eligible children between the ages of zero and three years old who received fluoride treatments prior to the initiative and again following the initiative. This program resulted in the improvement of fluoride treatment utilization rates in the California Medicaid Managed Care Program by 31% for our members.

Table 3.3.4.1-1 demonstrates the significant utilization improvement of 31 percentage points for fluoride treatments for the California Medicaid Managed Care Program due to our fluoride initiative.

TABLE 3.3.4.1-1 FLUORIDE TREATMENTS IN CHILDREN 0-3

	Prior	After
Eligible Members Age 0-3	4,298	5,040
Members Who Received Fluoride Treatments	828	2,515
Percentage of Member Who Received Fluoride Treatment	19%	50%

School Based Dental Programs

Understanding that the most effective way to improve sealant rates is to go to where the children are, as opposed to waiting for them to come to us, we work with mobile dental providers to create and expand current school based dental programs. For example, in Florida, we are contracted statewide with mobile dental providers and pay them on a fee-for-service basis for services they perform in schools. We track their progress and work closely with them on outreach efforts in coordination with our health plan and dental provider partners. Similarly, in California, we are contracted with mobile providers and recently developed a proprietary mobile unit program with The Centers for Oral Health (COH) in Sacramento County. We are targeting an increase in sealant and preventive utilization in Sacramento County by 10% in 2016.

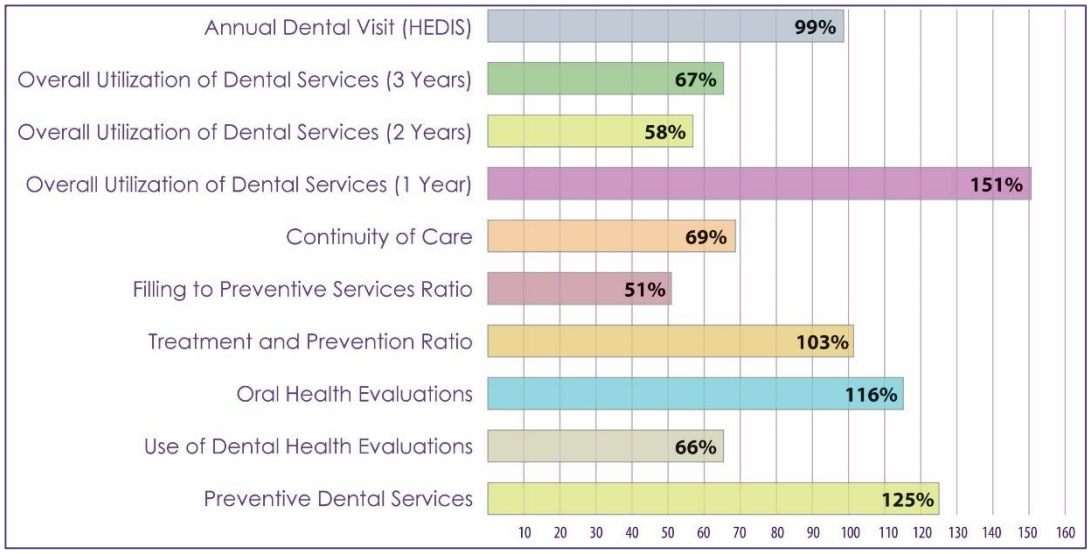
Sealant Utilization - Provider Engagement & Pay for Performance Programs

Provider engagement in the process of increasing sealant utilization is paramount, and we approach this need from numerous directions. By identifying providers who currently provide a high rate of sealants, we can guide more members to these providers through our Dental Home efforts and provider location services, both within member services and through our online portals. Partnering with providers and creating Pay for

Performance programs has proven effective in increasing sealant rates. As an example, we most recently partnered with numerous providers in the Florida Medical Management Assistance (MMA) program to improve usage which resulted in increases of pediatric sealant utilization at individual provider offices by as much as 200%. LIBERTY will work with DHCFP providers to develop similar programs, should we determine that sealant utilization is a target area for improvement.

After taking over a CHIP program in California from another dental carrier, we made significant improvements in utilization between 2009 and 2011. Figure 3.3.4.1-3 shows that overall use of dental services over a one-year period increased by 151%, while preventive dental services, including sealants, among the same population increased by 125%, as a result of our focused improvement program.

FIGURE **3.3.4.1-3 PERCENTAGE INCREASE IN UTILIZATION OF DENTAL SERVICES 2009-2011**



Methods of Communication

We employ a combination of outbound calls and recipient mailings as part of our outreach methods. Below, we describe each in detail, including our process, scheduling, and methods of delivery.

Outbound Call & Text Campaign

Our Member Services staff conducts outbound phone calls to recipients to inform them of their benefits, to encourage routine dental visits, and to assist in establishing a Dental Home. We contact newly enrolled recipients within the first 90 days of their enrollment and provide them with oral health education information, answer any questions they may have, and offer assistance with scheduling an initial appointment at their Dental Home. Our Recall Visit program targets recipients who have not had an appointment at

their Dental Home within the past six months. During these calls we take time to review the information discussed in our initial calls.

We conduct various standard outbound call programs on an ongoing basis, and perform additional ad-hoc campaigns tailored to address specific barriers to access or other issues we identify.

FIGURE 3.3.4.1-4 AD-HOC OUTBOUND CALL CAMPAIGN EXAMPLE

An example of a successful ad-hoc outbound call campaign we conducted involved reaching out to the parents/guardians of all recipients of kindergarten or first grade age to remind them to take their children to the dentist before the school year began. In order to achieve the highest contact rate, we made calls during and after standard business hours and on weekends. We "warm transferred" parents to providers or conducted three-way conference calls to assist with making appointments.

LIBERTY is currently implementing a texting outreach program for members in our California Medicaid market. The program has been carefully vetted to meet FCC requirements and has been approved by California. Since over 90% of the recipient phone numbers in our records are for cellular phones with texting capabilities, we expect the texting campaign to yield a high success rate. LIBERTY looks forward to working with DHCFP to build on this anticipated success, by developing a texting outreach program for Nevada Medicaid and NCU recipients.

Recipient Mailing Campaign

In conjunction with our "Outbound Call & Text Campaign," we mail flyers and letters to recipients encouraging plan participation and underscoring the importance of establishing a dental home. Some examples of these materials are included to the right. The timing and frequency with which we implement these campaigns will be coordinated to meet DHCFP's needs, and all materials will be customized and submitted for DHCFP approval prior to use.

Initial Dental Health Assessment & Recall Visit Program

Upon implementation of the program, we will launch our Initial Dental Health Assessment (IDHA) campaign, which will involve mailing out our NCU-approved recipient enrollment packets, as well as performing initial outbound phone calls and sending welcome texts to recipients within 90 days of the go-live date. If a recipient cannot be reached by phone after three attempts, we will send a postcard alerting

them that we have attempted to reach them by phone, and advising them on how we can be reached if they have any questions. Once we contact a recipient, our outbound call team updates the recipient's record in our system and schedules an automated task for any follow-up that may be requested or required. These automated tasks prompt our representatives to place future call(s) to the recipient and, in doing so, we increase rapport and strengthen relationships with recipients.

In addition, as part of our initial and ongoing outreach efforts, we analyze utilization data to determine which recipients have not had routine service visits within six months, and include them in our Recall Visit program. We call each of recipient and offer to assist them with making an appointment and provide any oral health, or other information the s/he may need. If we cannot reach the recipient after three attempts, we send a postcard to their home. All efforts are noted in the recipient's profile. In addition, we run monthly reports for our providers which list recipients who are overdue for a visit. These reports empower providers to directly and appropriately improve utilization of services, thereby reinforcing the Dental Home model.

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

A. How the dental program operates;
B. Medically Necessary Covered Dental Services, benefit limitations, and any Value-Added services offered by the vendor;
C. Dental Exams and preventive care;
D. The importance of oral health, proper nutrition and including the relationship between oral health and systemic/overall health;
E. Oral health literacy; and
F. 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.

All of LIBERTY's outreach efforts, from outbound calls and text campaigns to the initial handbook recipients receive, provide an opportunity to educate recipients on how the dental program works including information regarding:

- ***Dental Homes;***
- ***Recipient rights and responsibilities;***
- ***Covered dental services including EPSDT, medically necessary services, and the value-added services we offer; and***

- ***Transportation services.***

All of our campaigns are built around educating members on the importance of proper oral health, the relationship between oral health and a recipient's overall health, and the importance of visiting their dental home according to the AAPD clinical guidelines on periodicity of examinations, preventive dental services, anticipatory guidance and oral treatment for children.

The onboarding and enrollment process for recipients provides LIBERTY with the opportunity to interact with and educate them on their dental benefits. LIBERTY is prepared to welcome and educate our members on a large-scale basis during the implementation of the managed dental care program in Nevada, as well as on an ongoing basis as members are enrolled in our plan. In this response, we outline our ongoing welcoming process, followed by our member welcoming efforts during the implementation of the program. We will seek approval for all member welcoming activities and materials from DHCFP.

Initial Member Education - Member Welcome Packets

When LIBERTY receives the Member File, we provide the file to our Fulfillment, which is responsible for ensuring that new members receive a welcome packet within 10 days of becoming a member. The member welcome packet, a sample of which is provided as Attachment 5, in accordance with DHCFP requirements, includes information such as a welcome letter, Member Handbook, our provider directory, a member identification card for all eligible members, explanation of benefits, description of the member's rights and protections, and information on alternative methods or formats for communicating with visually and hearing-impaired members and non-English speaking members. The member identification cards will include the member's name, the member's Medicaid ID number, LIBERTY's contact information, emergency instructions, and dental home assignment. We will also include information on our website welcoming new members.

Initial Dental Health Assessment: Outreach and Welcome Calls

Our Member Services Representatives (MSRs) conduct outreach calls to each new member within 90 days of enrollment to advise our members on their dental home, how to change their dental home preference if desired by the member, obtain an initial dental health assessment, and utilize their dental benefits. MSRs will educate members on the benefits available, search for a dental provider, and offer to assist with making a dental appointment. In order to achieve the highest contact rate, we make calls during and after standard business hours and on weekends. Additionally, MSRs routinely conduct "warm transfers" of members to providers or facilitate three-way conference calls with providers to assist the member in scheduling appointments.

Welcome Text Messages

As part of LIBERTY's ongoing communication with members, we will send an initial text message welcoming new members to the program if approved by DHCFP. The text will include relevant information for contacting us, as well as the required option to opt out of text messages completely. This initial text message will be followed by additional texts on a weekly or monthly basis, which will contain relevant information for new members, such as a reminder to obtain an initial dental health assessment, how they can contact us if needed, and crucial oral health education information.

Initial Program Member Welcoming Efforts

Upon contract award and program implementation, LIBERTY is prepared to welcome and educate the large influx of members, such as by conducting large educational campaigns welcoming members to the program. This campaign will include a blitz on local radio and television commercial tailored toward the local populations that will introduce members to LIBERTY and provide our contact information. We will also work with the local departments of parks and recreation to engage neighborhood community centers to host events or join established events to orient new members and provide continuing education. Our team will visit faith-based organizations, schools, and providers throughout the State to welcome, educate and engage with members "where they are."

LIBERTY also firmly believes that since some of our new members will be actively engaged with their health plans, we should work closely with the health plans on mutual welcome messaging. For example, in Florida, we worked with Staywell Health Plan to develop a flyer reminding members to make a dental appointment and to call us if they have any questions or concerns. We intend to work with the health plans in Nevada in the same medical-dental collaboration capacity to develop mutual welcome messaging for members who are new to Medicaid and for members who are new to our care coordination organization and model.

Our local Nevada team will work with the state and DHCFP to develop region-specific welcoming materials and programs to ensure we are reaching all members effectively and efficiently.

Ongoing Member Education - Member Portal

Our secured member portal, Member iTransact, provides our members with direct access to information about their care and allows them to engage with their dental health. All access points are HIPAA-compliant and include standard requirements for identifiers and secure credentialed logins. Our web portal allows members to:

- ***Access educational material***

- ***View their personal information.***
- ***View their benefit plan(s).***
- ***Locate providers based on specific search criteria (The Provider Search is also available without logging in as a member, but it has fewer search criteria).***
- ***View claim/pre-estimate/referral status and information in real time.***
- ***View their utilized benefits – accumulators.***
- ***Print or request an ID Card.***
- ***Contact Member Services in real time.***
- ***See additional materials related to their dental benefits.***

Mobile Application

LIBERTY developed a smart phone application designed to increase member participation and reduce administrative burdens. We are one of the first in the dental industry to offer a mobile smart phone application that dramatically enhances member services and communications. Members can access their member account information, view their digital ID card, view dental benefits and co-pays, find a dentist, and get answers to Frequently Asked Questions right from their mobile phone. They also can check their benefit utilization and check the types of treatment or limitations available to them. Our mobile application is fully HIPAA compliant and is available on both the iPhone and Android platforms.

LIBERTY understands that oral health is directly related to members' overall health, and we strive to educate and encourage our members to adopt healthier lifestyles. We have a comprehensive approach to helping our members achieve better health outcomes. We partner with our members, our providers, state managed care organizations (MCO), health providers, and community organizations to influence member behavior. Below we describe our programs, outreach, provider support, and community collaboration in effort to provide high-quality care for our members.

LIBERTY's Education Programs to Encourage Healthier Lifestyles for Members

PCP Collaboration

Our experience has shown that member compliance with attending dental appointments increases when the member is referred by a pediatrician or family doctor. We have directly funded and/or participated in several Primary Care Physician training programs in collaboration with local stakeholders and our Managed Care Organization (MCO) partners, to integrate oral services with physical health. Our Primary Care Physician training programs are designed to increase the number of doctors performing oral health screenings and fluoride varnish applications and to equip them with the information necessary to effectively provide referrals to dental professionals.

Dental Care for Pregnant Women

We developed enhanced benefits for pregnant women for some of our MCO's, which included additional cleanings. Several reports have shown possible links between periodontal disease and pre-term, low birth weight babies. Ensuring that pregnant members understand this possible correlation is of the utmost importance to us; thus, we have implemented outbound call programs specific to pregnant women in our Texas Medicaid program in an effort to increase low utilization rates.

We identify pregnant members via numerous avenues, including but not limited to: identifiers on the 834 file; working with the state directly to identify pregnant members; via outbound call program; and by working with our provider network to ensure they check the appropriate box on their ADA claim forms when one of their patients is pregnant. Once identified, we mail all pregnant members oral health information at least monthly and will collaborate with MCO's, providers and other stakeholders to create a comprehensive pregnant woman outreach program.

Dental Disease Management for Members with Diabetes

LIBERTY has partnered with managed care organizations (MCO's) to identify members diagnosed with diabetes and have referred them to Dental Disease Management programs. We run baseline utilization data on these members, and we mail an education flyer to members with low utilization rates to educate them on the importance of oral health. Our team then called the members and assisted them with scheduling appointments. Our team would then make reminder calls before the appointment and follow-up calls once the appointment was completed. We also worked with the member's MCO care manager to ensure dental care was being included in their care plans. We will seek to work with the Nevada Medicaid MCOs to implement this collaborative program.

Establishing Dental Presence at a Patient-Centered Medical Home Locations

We are currently working with two of our MCO partners in establishing a dental presence at their Patient-Centered Medical Home (PCMH) locations. These locations are designed to have a comprehensive, coordinated care approach that normally encompasses numerous areas of medical care, coordinated by an Inter-Disciplinary Care Team (IDCT). LIBERTY and our MCO partners believe dental should be included not only as a service at the PCMH locations, but that the dentist should be involved in the IDCT as well.

"I work for LIBERTY Dental Plan because the company culture is to do the right thing for the member. LIBERTY goes the extra mile to ensure our members are treated with respect, do not get caught up in a trail of computer automated phone lines, and we ensure that the treatment being requested and performed is the right treatment for the right reasons. LIBERTY cares!" -- Matthew Vitier, LIBERTY Employee

LIBERTYs ongoing education efforts will include outreach activities noted in section 3.3.4.1.

3.3.5 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.

3.3.5.1 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:

A. Coordinate the care with out-of-network providers;

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

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

Nevada Medicaid recipients will be permitted to use an out-of-network provider for as long as the in-network providers are not able to offer the required services. If we do not have a provider who can provide the necessary dental services to a recipient, or if there is not an available dentist within the required radius of the recipient's home, we will assist the member in finding an out-of-network provider. Care is coordinated through our Internal Response Unit (IRU).

The IRU unit is made up of, Customer Care Specialists (CCS) in the Member Services department and handles and coordinates all out-of-network (OON) cases where a recipient has an access to care issue due to either a provider coverage gap or access and availability. Whether it is an emergency or standard case, the CCS representatives are responsible for coordination with the member and provider to obtain medically necessary dental services.

IRU case coordination also includes:

- ***Immediate handling of emergency cases and/or standard cases through coordination with the member, provider, and on-site dental consultant when needed.***

- ***Working closely with the provider and Provider Relations department to ensure that members have access to care within the access standards.***

- ***Coordinating out-of-network (OON) care when provider access/availability are not met and medically necessary treatment is needed and appropriate.***

- ***Reviewing and confirming treatment plans for appropriate benefit application and treatment options through discussions and coordination with providers, Network Managers and on-site dental consultants (DC).***

Once the CCS Representative determines the type of request, ER or standard, and type of provider, general dentist or specialist, and type of service requested, the following steps occur:

- ***A courtesy call is made to the member to provide the timeframe for resolution; Emergencies are resolved within 24 hours.***

- ***A DC reviews the case for a clinical determination of dental necessity. Based on the findings, the DC will provide recommended treatment including CDT codes.***

- ***We engage our provider relations team in a final attempt to assist in locating an in-network general dentist or specialist.***

- ***The CCS coordinates the OON approval with the DC and assists the member with scheduling an appointment with the OON treating provider.***

- ***Once a provider has been identified, we will contact the provider and send a referral request to them for confirmation. We will agree to pay the out-of-network provider for the service(s) performed according to the agreed upon fee. The referral confirmation will include our payment in full, and the provider is instructed to not seek any payment from the member for covered services.***

Recruitment of OON Providers

The IRU works in cooperation with Provider Relations (PR) when access and availability issues occur ensuring their awareness of the situation and allowing for resolution. During PR recruitment, there are non-contracted providers that will accept recipients on a case-by-case basis at a negotiated Medicaid FFS rate. Provider relations will continue to engage each non-contracted provider and offer the opportunity to become part of the contracted provider network. Unless we become aware of a quality or other issue with the out-of-network provider, we will attempt to recruit the provider to join the Nevada Medicaid network.

OON Provider Reimbursement

We will attempt to negotiate a reimbursement rate starting with Medicaid FFS first then finalize a fee schedule that is agreed upon by both the provider and LIBERTY. We agree to negotiate a contract with the out-of-network-provider to determine the rate prior to services being rendered or no more than the Medicaid FFS rate.

A detailed explanation regarding the use out-of-network providers is described in detail in 3.3.1.7

We will provide 120 days of continuity of care coverage for new Nevada enrollees regardless as to whether an in-network or out-of-network provider is used, unless we become aware of a quality or other issue with the provider.

3.3.5.2 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.

When there is not a provider in Nevada who is able to provide services to Nevada Medicaid recipients, we will coordinate treatment with providers outside of Nevada..

We will attempt to negotiate a reimbursement rate starting at Medicaid FFS then finalize a fee schedule that is agreed upon by both the provider and LIBERTY. During our discussion, we will ensure that providers understand that the negotiated fee schedule is considered payment in full and that they must not bill, accept or retain payments from Medicaid or Nevada Check Up recipients. We understand that the only exception is for Third Party Liability (TPL).

3.3.6 Emergency Dental Services

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

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

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

A. Require prior authorization for emergency dental services and care.
B. Indicate that emergencies are covered only if care is secured within a certain period of time.
C. Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered.
D. 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.

3.3.6.4 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.

3.3.6.5 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.

3.3.6.6 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.

3.3.6.7 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.

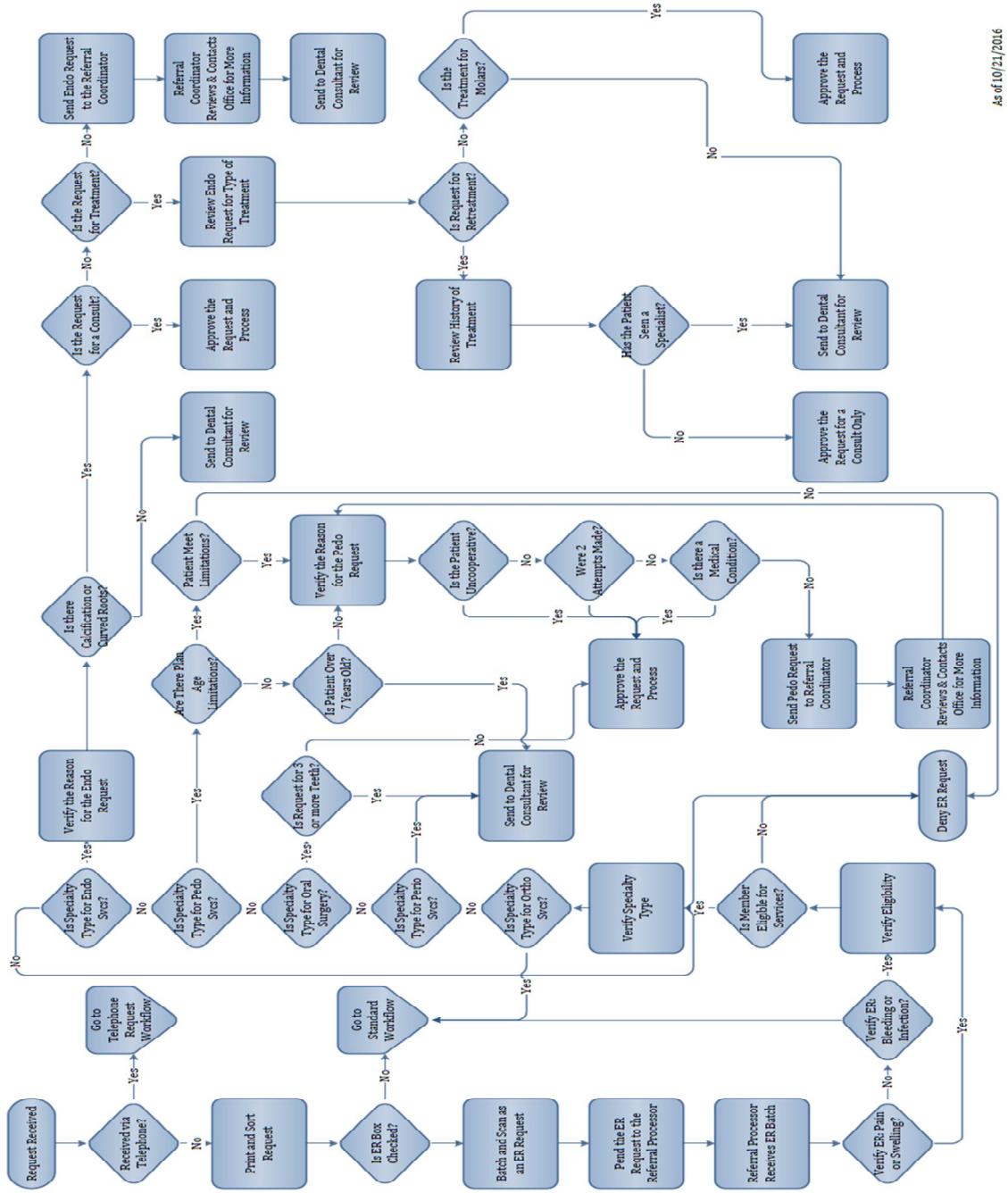
3.3.6.8 Non-emergent services provided in an emergency room are a covered service. Providers are expected to follow national coding guidelines by billing at the most appropriate level for any services provided in an emergency room setting.

We understand and will comply with the requirements set forth in 3.3.6 (3.3.6.1 -3.3.6.8) regarding Emergency Dental Services.

We receive and process requests for emergency services on a daily basis. In 2015, we processed 32,623 requests for emergency services. In 2016, we are at pace to complete 35,000 requests for our approximately 2 million Medicaid members. We have a specific processing team who receives, validates, and processes requests for

emergency services. The workflow in Figure 3.3.6-1 illustrates the process that we have in place today to handle emergency requests.

FIGURE 3.3.6-1 EMERGENCY REFERRALS WORKFLOW



We will not deny any claim or request for emergency services that are when it is notated on the member's profile is notated that a request was made and a LIBERTY representative instructed the recipient to seek emergency services. We will commit to not requiring a pre-authorization for emergency services, putting a window of time around when emergency services can be rendered or billed as long as claims are submitting within the timely filing limits, or use specific terminology or key words to explain or define the emergency services rendered. We will not deny payment based on the member's failure to notify us in advance or within a certain period of time after the emergency care is rendered unless it is rendered under the medical payment.

Pre Service Requests

Pre-authorization for emergency dental services is not necessary, but we do have staff ready to receive pre-authorization requests and expedite processing within 24 to 48 hours. Requests for emergency services can be received either by telephone, fax, email, or web portal submission.

Upon receipt of a pre-service request, our emergency services staff will review the request to ensure member eligibility and benefit plan. These requests are input into our adjudication application and forwarded through our workflow to a dental consultant for expedited clinical review. Requests for emergency services are not denied if deemed medically necessary by a licensed dental consultant. If the pre-service request is not deemed an emergency by a licensed dental consultant, the request is forwarded to our Dental Care Outreach unit who will contact the requesting provider for verification of treatment plan and emergency status. If additional supporting documentation is received, the Dental Care Outreach unit will resubmit the request to the licensed dental consultant for re-review.

Once the request is approved, the Claims Processor adjudicates the requests, prints the provider notification and faxes the notification to the submitting provider office. In addition, as a courtesy a telephone call is made to the recipient within 72 hours of receipt of request to notify the recipient of the outcome of the request.

Post-Service Submission

Claims for emergency services are handled by the same emergency services team. Claims can be received via paper, EDI, web portal submission, fax, or email. Claims for emergency services must clearly be flagged as emergency services with either a narrative, claim entry note or a place of service code 20 – 24. These triggers will notify the Claims Processor that services were or could be emergency related and require further review. Once identified, the claims are forwarded through the adjudication application workflow to the emergency services team. Claims that are not clearly

identified will be treated as standard claims and be subject to standard claims processing guidelines and benefit limitations.

All claims received for emergency services will not be denied but will be clinically reviewed by a dental consultant for necessity. In instances where a consultant questions medical necessity, the provider may be contacted by our Dental Director to discuss the treatment rendered. This practice will not affect the payment outcome of the claim but will help LIBERTY profile the treatment patterns of providers. Claims for both in-network and out-of-network providers are covered under emergency services treatment.

Emergency services rendered in a hospital or ambulatory surgery center will be reviewed for dental necessity. Services that qualify as dental will be paid by LIBERTY as such. More complex services that involve medical related conditions such as a trauma to the mouth and/or teeth will be pended while we contact DHCFP for direction. If required, LIBERTY can process dental related treatment initially and forward the remaining portion of the claim along with a copy of the explanation of benefit to the appropriate Nevada Medicaid medical vendor for payment.

3.3.6.9 Post-Stabilization Services

The vendor is financially responsible for:

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

B. Post-stabilization services obtained within or outside the network that are not pre-approved by a network provider or other organization representative, but administered to maintain the recipient's stabilized condition within one (1) hour of a request to the vendor for pre-approval of further post-stabilization care services;

C. Post-stabilization care services obtained within or outside the network that are not pre-approved by a network provider or other organization representative, but are administered to maintain, improve, or resolve the 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;

D. 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

E. 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.

We will treat post-stabilization services similar to the emergency related services. We understand that post-stabilization services are medically necessary and in the best interests of the recipient. Therefore, similar to covering emergency services for both in-network and out-of-network providers, LIBERTY will treat the stabilization of a recipient in the same manner. We understand the requirements as outlined and will comply with the requirements as we currently do today.

When a claim for post-stabilization is received, Claims Processors will forward that claim to our Care Coordinators for review. Our Care Coordinators are responsible with coordinating treatment requests with extenuating circumstances such as patients with

special needs or serious medical conditions or patients who need stabilization services prior to being treated by a more permanent provider.

Upon receipt of the case, the Care Coordinator will contact the submitting provider who stabilized the recipient, verify their network affiliation with LIBERTY, and if not affiliated, will coordinate the transfer of the recipient's case to a local in-network provider who can immediately assume responsibility of care for the recipient. The Care Coordinator will facilitate discussion between the in-network provider the treating provider to ensure all clinical information is transferred. Once the recipient is under the care of the in-network provider, the Care Coordinator will authorize payment to the provider who performed stabilization. Their claims will not be denied.

3.3.6.10 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)].

A. 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.

B. 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.

We have an established process to coordinate services with other vendors and providers to ensure continuity of care. We currently provide this service to our Medicaid plans in the states of California, Florida, New Jersey, Texas, and Illinois according to Title 42 CFR 438.208.

During the welcoming process, we will provide multiple mediums for a recipient to select a Primary Dental Provider (PDP). Our welcome packet outlines the process to the

recipient on how to select a PDP and our website (www.libertydentalplan.com) also provides easy access to select a provider. LIBERTY will conduct outreach calls to all new members to educate them on selecting a PDP and will send out a postcard reminder to recipients who have not selected a provider after 30 days of enrollment in an effort to initiate provider selection. Ultimately, if no contracted provider is selected, we will assign a provider within the geographical area of the recipient's home address.

Services rendered by non-contracted providers during the first 120 days will be covered as part of our Continuity of Care process for all new members. During this time period, we will identify these out-of-network providers and work diligently to try and contract them. If unable to contract the providers after 90 days, we will reach out to the recipients either through the mail or outreach telephone campaign to reassign the member to an in-network provider for continuing treatment plans in progress after the 120 day period.

Any transition between providers or referrals from a general dentist to a specialist will include electronic access to patient history and records to ensure continuous treatment and avoid duplication of services. These records are made available online through LIBERTY's Provider Portal. Recipient records can also be provided electronically using multiple mediums such as 837 transactions, .csv files, or other proprietary formats as requested.

Recipients Receiving Orthodontic Services

Recipients receiving orthodontic services will have a carved-out workflow. Orthodontic transition of care is managed by a small group of specialized Claims Processors who work with both the recipient, the previous Orthodontist office, and the new assigned Orthodontist office to ensure uninterrupted treatment visits continue to occur timely as scheduled. Upon receipt of a claim for an Orthodontic visit, the Claims Processor will contact the provider via telephone to request the Orthodontic treatment history including banding date and number of treatments completed. Once received, the historical treatment information is input into our adjudication system which ensures the length of the treatment plan will continue without interruption and ensure the proper amount of treatment due to the recipient is completed.

Recipients with Special Needs

Recipients with special needs are managed through a separate workflow and are coordinated by Specialists who manage a treatment plan from start to finish. Notification of special needs individuals is received by LIBERTY and updated in the recipient's member profile. Upon request for treatment, a workflow transaction is created which gets routed to a Special Needs Coordinator. This individual manages requests for recipients who have specific needs that need to be accounted for during

treatment. Examples of what LIBERTY coordinates are children or adults with mental or physical disabilities, recipients with severe medical conditions, or individuals in nursing homes or convalescent homes.

The Special Needs Coordinator locates a provider who has the ability or equipment needed to support the treatment of the member or a provider who has privileges to hospital or surgery center that can assist with such treatment. Once the provider is located and briefed on the case by the Special Needs Coordinator, a telephone call to the recipient is made to brief them on who the provider is, where they are located and discuss the need for a consultation with the provider. In past cases for Medicaid recipients, the Special Needs Coordinator works with the recipient's primary care dental provider, a specialist, the medical physician, and the MCO to help in coordinating dental services for recipients. Upon completion of a case, the Special Needs Coordinator will reach out to the primary care provider to make them aware of the treatment completed and recommendations, if any, from the provider who treated the special need.

3.3.11 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.

LIBERTY has a history building relationships with local FQHCs to support the needs of Medicaid populations. LIBERTY has contracts with hundreds of FQHC providers in the states of Illinois, Florida, New Jersey and New York to support our Medicaid populations. Our existing dental network in Nevada includes contracts with eight FQHCs as listed in Figure 3.3.11-1.

FIGURE 3.3.11-1. LIBERTY NEVADA NETWORK FQHC's

Office Name	Office City	Office State	Office County
Elko Family Medical & Dental Center	ELKO	NV	ELKO
Eastern Family Medical & Dental Center	LAS VEGAS	NV	CLARK
Community Health Alliance	RENO	NV	WASHOE
Community Health Alliance Adult "Mobile" Outreach	RENO	NV	WASHOE
Las Vegas Paiute Dental Dept.	LAS VEGAS	NV	CLARK
Fallon Tribal Health Center	FALLON	NV	CHURCHILL
Pyramid Lake Tribal Health Clinic	NIXON	NV	WASHOE
Walker River Tribal Dental Clinic	SCHURZ	NV	MINERAL

Our goal, and what we have been successful at, is to contract with the FQHC as a whole instead of providers within the FQHC. This provides us access to multiple specialties within the same location making it easy for recipients. We do not just contract with these FQHCs, we partner with them to develop a process that ensures our providers are meeting state and federal requirements for wrap around dollars. In Florida for example, we work closely with the Florida Department of Health (DOH) clinics.

FIGURE 3.3.11-2 EDUCATION FOR SUCCESS

LIBERTY outlined what services were required to qualify as a billable dental encounter and helped educate over 100 clinics statewide on how to submit their claims for proper payment and qualify for wrap dollars. By performing this exercise with the DOH clinics and continuing to partner with them on new initiatives such as mobile dentistry in schools for the child Medicaid population, we have built a strong relationship that continues to grow to this day.

LIBERTY currently has encounter reporting processes developed and in place for the FQHCs we are contracted with in other states. Reporting is done on a quarterly and annual basis, but timelines can be adjusted accordingly based on federal, state and provider needs. We will also provide FQHC reporting to DHCFP per the requirements, which are in line with what we currently do with our Medicaid programs in Illinois, Florida, New Jersey and New York.

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3.4 ENROLLMENT REQUIREMENTS AND LIMITATIONS

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3.4.1 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.

3.4.2 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.

Our database allows membership data to be available on a real-time basis to all operational areas, including Member Services for eligibility verification, call center activities, and claims processing, as well as our provider web portal. We will accept all recipients appearing in DHCFP's data file as eligible based on coverage dates and parameters as specified by Nevada Check Up.

We do not delay or deny enrollment of members based on their health status or their need for immediate services; rather, we work extensively to preserve access to and continuity of care during the contract start-up phase (as well as for all Nevadans who newly obtain Medicaid coverage during the course of our contract).

We are highly committed to avoiding and preventing all forms of discrimination by our staff and our providers – including the subgroups listed in this requirement (race, color, and national origin) but also individuals who are vulnerable to discrimination due to their impoverishment, physical appearance, education level, language, disability, age, gender, and sexual orientation.

We will accept recipient eligibility and enrollment data every business day via standard electronic file transactions. We will confirm all inbound eligibility data as submitted by DHCFP through an established secure transfer method. We will commence file retrieval and upload within six hours of file availability. Enrollment staff will process each file

using LIBERTY's Member Load Protocol. We will customize the Member load screen with applicable parameters and interfaces according to established protocol DHCFP. If corrupt data renders the file unloadable, we will notify DHCFP immediately. Upon successful loading, all files leave an electronic time stamp that includes the operator name, date and time. Each affected member record is updated with these data elements for tracking and auditing purposes.

Although data pre-scrubbing is described in detail in 3.17, examples of controlling mechanisms include a filter to validate member age, USPS address validation, or standardization of a numeric or date field. The Member Load Protocol is designed to facilitate the standardization of inbound data into the ideal format for our processing system, while allowing the client to exert maximum control of the outcome. Once pre-scrubbing is complete, data is electronically compared to current membership in our database. Records that fail to load are exported to an error report, along with other data-specific errors and duplicate records, and submitted to staff for correction. We will bring any errors that are unresolvable to DHCFP's attention and resolve them according to their direction.

Our system assigns our own unique identification number to each enrolled individual. This allows us to recognize recipients who are simultaneously enrolled in more than one plan or have multiple coverages based on various eligibility factors, such as "dual eligibles" enrolled in both Medicaid and Medicare. Our system is flexible enough to allow the same person to be enrolled with more than one member number, yet sophisticated enough to recognize and track such members as the same individual. Our system can store and cross-reference multiple member-identifiers to ensure smooth interfaces between inbound and outbound file processes. We recognize and plan for various state agency and CMS reporting requirements that necessitate storage of data elements at the member level for retrieval and inclusion in various outbound regulatory reports.

Our system will capture all standard member demographic data, Medicaid or other unique membership numbers, language and ethnicity data, and any other data elements DHCFP and we deem necessary to administer benefits accurately. Specific examples of our data collection and usage capabilities include the following:

- ***Aid Codes for Medicaid recipients with specific ailments. These codes enable the segregation of members with specific or special needs, such as pregnancy, to facilitate dental disease management and the delivery of specialized healthcare benefits;***

- ***Responsible Party's address to facilitate communications with non-enrolled parents of child members, even when residing at a different address;***
- ***Written and spoken language preferences to ensure we are providing members with the most appropriate material and ongoing communication supports;***
- ***Head-of-household identifiers to recognize when multiple recipients belong to the same family, facilitating both a unified "dental home" assignment as well as realizing a cost-savings for mailings;***
- ***Reinstatement protocol to ensure recipients who become eligible after a break in coverage are assigned to the same dental home provider if desired;***
- ***Coverage alignment to ensure recipients with multiple coverages are assigned to the same dental home for each product, thereby maximizing the coordination of their care.***

3.4.3 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.

LIBERTY has policies and procedures in place to correct eligibility errors and data anomalies that result in unintentional denial of benefits. Our system can be programmed to allow a specified amount of retroactivity, e.g. 180 days, without intervention. Therefore, once the corrections are received, the system will re-adjudicate any claims that were received during the time of inactivation. Payment will be made in the amounts that would have been paid at the time services were rendered and are based on negotiated or contracted fees. We also provide 120 days of continuity of care from the point of enrollment forward, without regard to whether the new enrollee's dental provider participates in our network. This feature, coupled with our coverage of retrospective eligibility timeframes, avoids disruptions in care and/or provider payment that could otherwise occur at the outset of program implementation. If an enrollment

request exceeds the retroactivity period allowed by contract, it will be denied and can be subsequently reviewed with DHCFP.

3.4.4 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:

A. Determine the number of recipients each enrolled PDP will accept as new patients; and
B. Transmit recipient elections regarding PDP assignment for the forthcoming month.

LIBERTY confirms that all members receive a valid PDP assignment upon enrollment or reinstatement. Every effort is made to solicit the member's preference, but when this is not possible our auto-assignment system will assign the member and take into account factors such as spoken language and distance between member and provider. If an established member-to-provider assignment is disrupted for any reason (most commonly due to an "on-off-on" pattern of Medicaid eligibility), every attempt is made to reconnect the member with the same provider.

In addition to consideration of member preferences, providers must also meet certain criteria to be available for selection in the auto-assignment process. The provider must have available openings for new members based on the office's membership capacity. Each provider and office has a system designation of panel size versus member allotment, known as "provider to member ratio," which is designed to monitor and report an error if the ratio is exceeded by more than 2%.

We will ensure (1) full-time equivalent (FTE) dentist per one thousand five hundred (1,500) recipients per geographic service area. We will also comply with obtaining authorization from DHCFP for dental clinics where a dentist provides direct supervision of dental residents who have a temporary permit from the State Board of Dentistry, should the capacity need to be increased to allow for one (1) dental resident per one thousand (1,000) recipients.

3.4.5 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.

LIBERTY provides multiple ways for dental providers to verify and confirm both new and existing member office assignments and coverage dates. In addition to traditional paper rosters each month (an excerpt of which is shown in Figure 3.4.5-1), we offer dental providers the option to receive e-rosters, access to our online portal, a 24-hour telephonic IVR system, as well as a team of professional Member Service Representatives available during extended business hours. While paper rosters offer a complete list on a monthly basis, other options are best used when new members enter the system mid-month and require services before the next roster cycle. Our Member Services team is ideal for members experiencing emergencies, new providers, and situations that require customer service above the routine. Our use of a single-source database enables membership data to be available on a real-time basis and all members to be assigned to a primary dental provider within 3 business days after receipt of eligibility data.

FIGURE 3.4.5-1. MONTHLY ELIGIBILITY ROSTER

Monthly Eligibility Roster
November 2016

OFFICE: **002060 - Clelen Tanner, D.D.S., Inc.**
21911 Foothill Blvd., HAYWARD, CA 94541-2118

TOTAL NO. OF MEMBERS: **7**

Subscriber Member Name	Member Number	Home Phone	Date of Birth	Effective Date	Tier Name	Benefit Plan
[redacted]	[redacted]		[redacted]	02/01/2014	Employee Only	Humana LS100 Plan
				02/01/2014	Emp+Fam (Spouse + Child(ren))	Humana LS100 Plan
				10/01/2016	Employee Only	LDP-100 (Ortho 175)
				05/01/2016	Employee Only	Humana LS100 Plan
				10/01/2016	Employee + Spouse	LDP-100 (Ortho 175)
				02/01/2014	Employee Only	Humana LS100 Plan
				05/01/2016	Employee Only	Humana LS200 Plan

3.4.6 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.

LIBERTY understands that it is sometimes necessary to transfer a recipient from one health plan to another or to Nevada's FFS Medicaid program for a variety of reasons such as the recipient's decision to receive services from another provider or enroll in another health plan. Accordingly, we have formal protocols in place to facilitate a seamless, and HIPAA compliant transfer of relevant patient information, dental records and other pertinent materials to another plan, FFS provider or dentist, as expeditiously as possible. Our process to accomplish this has proven effective in other Medicaid markets, and includes the following:

1. ***Upon receipt of a request to transfer a recipient's information from LIBERTY to another health plan, FFS provider, or dentist, we document the request in our member tracking system.***

2. ***We promptly reach out to the recipient to request a HIPAA-compliant authorization which specifically authorizes us to furnish copies of the recipient's information, including dental records in LIBERTY's possession, to the specific health plan, FFS provider, or dentist indicated in the authorization. If the recipient has already been transferred, the other health plan, FFS provider, or dentist may furnish a copy of the recipient's completed HIPAA-compliant authorization to LIBERTY, and we will accept such request as though the recipient made it him or herself.***

3. ***We document receipt of the recipient's authorization in our member tracking system, including an original or electronic copy of the authorization.***

4. ***Within five (5) business days of receipt of the completed HIPAA-compliant authorization, we issue a copy of the recipient's information, including dental records, to the requested health plan, FFS provider, and/or dentist.***

5. ***If applicable, we will also direct our contracted providers to forward all dental records in their possession to a new provider within five (5) business days of the request from LIBERTY or the recipient.***

We provide recipients with any needed assistance as they transition to another plan, such as walking them through the above process, providing authorization forms or other related materials in the recipient's preferred language, or in alternate, accessible formats (e.g., large font), etc. This recipient-friendly, proven approach will serve our Nevada members well as they transition into and out of Medicaid coverage and/or LIBERTY's care coordination program.

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3.5 RECIPIENT SERVICES

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3.5 RECIPIENT SERVICES

3.5.1 Information Requirements

3.5.1.1 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.

We understand and agree to comply with the requirements of Section 3.5.1.1.

Our experience with Medicaid and CHIP programs nationwide allow us to fully understand, comply, and provide educational material based on the diverse needs and cultural backgrounds of our recipients while adhering to National Standards for Culturally and Linguistically Appropriate Services.

Our proposed recipient education and communication material for Nevada will be written at level which is developmentally and culturally appropriate (at or below eighth 8th grade reading level) in order to ensure the needs, expectations and preferences of our recipients and potential recipients are met. We also offer free oral interpretation services to each recipient and potential recipient.

Our Member Handbook is the primary source of written information regarding available services and how recipients can access these services. Recipients are provided with LIBERTY's contact information, such as our toll-free phone number, for assistance regarding dental benefit inquiries, how to locate a participating provider, assistance obtaining a dental appointment, and coordinating oral interpretation services.

Our Member Handbook will be mailed to each recipient within 5 days of enrollment. The Member Handbook and information on interpretation and language assistance services can also be found on our website and on our online member portal.

3.5.1.2 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.

We understand and agree to comply with the requirements of Section 3.5.1.2.

Recipients and potential recipients can request a Member Handbook, which will include a section on the procedures for accessing and utilizing oral interpretation services at no cost. The details will include that oral interpretations are available for any language and written information will be available in prevalent languages. This information can also be found on our website.

We are committed to training all staff and providers to inform members on recipients' right to request language assistance services (written and oral).

3.5.1.3 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.

Understanding the multi-cultural nature of our recipient populations, our written communications will respond to special core language needs. We will work with DHCFP to ensure all materials are at the required reading level by utilizing an 8th grade level, in the proper font sizes, translated into all required threshold languages (including both English and Spanish), and in formats for the visually and/or hearing impaired.

We ensure that all recipient materials are accessible to all populations, including recipients who are visually or hearing impaired. All recipient insurance cards and written information include a TTY/TDD toll-free telephone number for hearing impaired callers. These callers are routed through a computer application that enables direct written communication with a Member Services Representative. Visually impaired recipients may request materials in braille, which are translated and made available by our fulfillment team. All written materials are translated by a certified translator and made available in both English and Spanish. Spanish-speaking recipients may request materials in Spanish; these are fulfilled onsite within two business days of request. Written materials will also be available in other prevalent languages.

When contacted by recipients and when potential recipients contact LIBERTY, we will notify them that oral interpretation is available for any language and that written information is available in prevalent languages at no expense to the recipients and instruct them on how to access those services. We agree to translate, and make available, all written recipient materials in Spanish and for each Limited English Proficiency group (defined as constituting five percent or more of recipients or 1,000 or

more recipients in the statewide service area, whichever is less). Furthermore, we agree to make all recipient materials available in alternative formats for recipients with special needs within forty-five calendar days of a request at no expense to the recipient. We will also provide written notice of changes in policies or procedures to recipients at least thirty calendar days before the effective date of the changes.

We maintain the ability to communicate with deaf and hearing-impaired callers through dedicated toll free TDD/TTY telephone lines. Additionally, we utilize a third party language assistance vendor, with TDD/TTY capability when needed, for languages not supported internally. We also have experience handling calls through the national and state relay systems.

3.5.2 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."

We understand and agree to comply with the requirements of Section 3.5.2.

Within five days of receiving notice of the recipient's enrollment, we will provide each recipient with a Member Handbook that has been reviewed and approved by the DHCFP prior to distribution. The information contained in the handbook will outline all the information and elements required by DHCFP. Member Handbooks will be mailed to the head of the household at the address on file.

In the event the address on file is outdated or incorrect, and the Member Handbook is returned to sender, we will make every effort to contact the recipient by calling to confirm the address on the State file or by any other means provided. We will also post updated versions online for member access. The Member Handbook will be written at a level that which is developmentally and culturally appropriate (at or below eighth grade reading level). Recipients have the right to request and obtain the Member Handbook at least once per year or upon request.

Each Member Handbook will include the following language in a way which is clearly visible to the recipient in bold lettering:

"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."

A sample of our Member Handbook has been provided as Attachment 5.

3.5.2.1 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.

We agree to comply with the requirements of Section 3.5.2.1.

LIBERTY's Member Handbook is the primary source of written information regarding available services and how recipients can access these services. We understand the Member Handbook must be submitted for review and approval to the DHCFP prior to distribution. Modifications to the Member Handbook will be made as directed by DHCHP and will be documented at least once a year as updates are made.

3.5.2.2 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:

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

B. Role of the primary care dentist;

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

D. The address and telephone number of the vendor's office or facility;

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

F. 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;

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

H. 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;

I. The provider list located on the vendor's website shall be updated by the vendor monthly;

J. Any restrictions on the recipient's freedom of choice among network providers;

K. Procedures for changing a PDP;

L. 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;

M. Procedures for enrollment and disenrollment;

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

O. 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;

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

Q. How to access Non-Emergency Transportation;

R. 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);

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

T. The risk, benefits, and consequences of treatment and non-treatment;

U. 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;

V. 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;

W. Notification of the recipient's responsibility to report any third-party payment

service to the vendor and the importance of doing so; and

X. 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.

We understand and agree to comply with the requirements of Section 3.5.2.2.

The items A-W above will be included in the Member Handbook. A draft handbook and welcome packet has been included as Attachment 5.

3.5.2.3 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.

We understand and agree to comply with the requirements of Section 3.5.2.3.

We will provide written notice to each recipient should the Member Handbook require significant changes as described in 42 CFR 438.10(f)(4) 30-days before the intended effective date. The notification will be mailed semi-annually to each recipient's household. This notification of changes will also be available to recipients online. We will issue the Member Handbook no later than 30-days prior to the effective date of such changes. We will send updated Member Handbooks to all recipients. Members will be able to access updated Member Handbooks via the web or by calling Member Services.

3.5.2.4 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.

We understand and agree to comply with the requirements of Section 3.5.2.4.

As soon as we decide to terminate a provider or become aware that a network provider is leaving the plan, the Network Manager assigned to that provider will submit a termination form. Upon receipt of the form, our Professional Services department enters the information in our system, creating an action that flags when letters need to

be generated so that we meet the required timeframe. We then generate a report identifying recipients who received services from the terminated provider.

Within 15 business days of the termination notice, we send written notice to each of the recipients that his/her provider is no longer available and provide them with a new assigned provider currently accepting new patients. The notification letter contains the contact information for the new provider (address and telephone number) and effective date. If the recipient would like a different provider than the one assigned, the letter also provides instruction on how to search for a new provider of their choice and conveys our call center's Member Services toll-free phone number and hours of operation.

3.5.3 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.

3.5.3.1 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.

Our Member Services department will exceed DHCFP's requirements and be available to recipients, providers, and DHCFP personnel 60 hours a week. The specific hours of availability are Monday through Friday between 5:00 a.m. and 5:00 p.m. Pacific Time.

3.5.3.2 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.

Our toll-free telephone number will be available to recipients, providers and DHCFP personnel throughout the same 60 hour timeframe described above: Monday through Friday between 5:00 a.m. and 5:00 p.m. Pacific Time.

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

A. Explaining the operation of the vendor;

B. Explaining covered benefits;

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

D. Responding to recipient inquiries;

E. Providing Concierge Services; and

F. 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:

1. 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;
2. 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;
3. Assisting recipient in obtaining out-of-area and out-of-network care; and
4. 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.

Customer service is at the heart of our operations. Our Las Vegas call center features Concierge-Style "Live" Member Services, whereby live representatives answer every phone call (excluding after hours calls).

Direct access to a live Member Services Representative (MSR) enhances the service experience and avoids delays caused by numerous telephone menus and prompts. Our highly-qualified multi-lingual representatives are empowered to handle all aspects of a recipient's inquiry from general assistance to complete case management and capturing grievances for triaging.

We also operate call centers in Irvine, California (Corporate office) and Tampa, Florida. These call centers will provide back-up support if needed. All locations work collaboratively to ensure timely and seamless interactions for all callers, ensuring no disruption to service.

Staffing and Recruitment

We typically maintain a staffing ratio of 1 MSR per 25,000 recipients. However, staffing levels are monitored by the Call Center Analyst and management team through real-time views and daily, weekly, and monthly reports. This review ensures immediate adjustments for peak levels. Extensive resource analyses are performed at least monthly to ensure on-going staffing levels are achieved and performance goals are met or exceeded.

Our recruitment practices include procuring bilingual professionals with an emphasis on customer service and dental industry experience where possible. Currently, 52% of our MSRs speak Spanish. Member Services works closely with Account Management to identify specific language needs and with Human Resources to recruit bilingual representatives to meet those needs.

Recipient Services

Our MSRs will assist with inquiries related to: covered benefits, eligibility, claims/referrals, finding a provider or dental home, orchestrating provider transfers, assisting with scheduling appointments, providing information about a provider (e.g., hours of operation, languages spoken, and handicap accessibility), assisting with special needs, requesting materials, and tracking and reporting on exempt grievance, grievances, second opinions and appeals. LIBERTY will report PDP and Primary Dental Care Sites changes electronically to DHCFP at a frequency established by DHCFP.

In addition to the above, our MSRs are typically the first point of contact for receiving recipient grievances. When this occurs, there may be two outcomes as indicated below:

- ***The recipient expresses dissatisfaction but is willing to allow the MSR to attempt to resolve their concern. This is done by capturing the details from the recipient, reaching out to the dental office for their interpretation of the circumstances, and offering solutions to either party within 24 hours. If unable to reach a satisfactory resolution, the recipient is offered the formal grievance process and the case is forwarded to our Grievance and Appeals department for handling.***

- ***There may be times that a recipient may decline the MSR's assistance and requests to file a formal grievance. In this scenario, the case is automatically forwarded once the details have been captured.***

After-Hour and Holiday Access

Our policies and procedures ensure that emergency care is available 24 hours per day, 7seven days per week through our network of dental providers. However, if the recipient is unable to reach their dental provider after normal business hours, our closed message (on the toll free number) instructs them to contact our after-hours partner, Tunstall Americas. Tunstall provides immediate phone access to a qualified LIBERTY dental consultant in emergency or urgent situations. Our dental consultants are licensed dentists who will assess the needs of the recipient and provide guidance which may include directing them to the emergency room for care.

Our Member Services' internal response unit (IRU) will follow up with the recipient the following business day to ensure their concern was resolved and inquire on their satisfaction. All efforts are tracked in workflows that allow for reporting to DHCFP.

Access for the Deaf and Hearing Impaired and Multilingual Services

We maintain the ability to communicate with deaf and hearing-impaired callers through dedicated toll free TDD/TTY telephone lines. Additionally, we have the ability to utilize a third-party language assistance vendor, with TDD/TTY capability when needed, for languages not supported internally. We also have experience handling calls through the national and state relay systems.

We contract with telephonic and face-to-face language assistance vendors to provide interpretation services for recipients with limited English proficiency. These services are provided at no cost to the recipients. Telephonic inquiries are handled through a 3-way call between the caller, LIBERTY, and the language assistance vendor. We also contract with a back-up language assistance vendor to ensure continued coverage should the primary vendor experience technical difficulties. We coordinate all on-site interpretation requests with our vendors.

Recipients and providers can request on-site interpretive services at the dental office, including sign language. These requests are coordinated through a contracted language vendor at no cost to the recipient. Member Services will verify appointment times prior to scheduling a face-to-face interpreter. Details of the request are captured in workflows and can be reported on at any time.

Internal Response Unit and Case Coordination

We have an established and dedicated Internal Response Unit (IRU) in the Member Services department to coordinate out-of-area and out-of-network care. Our IRU staff support our executives, account managers and recipients in resolving escalated cases and ensuring continuity of care. The IRU is staffed by Customer Care Specialists who are trained in all aspects of the call center and possess the skills required to perform case coordination activities. They are responsible for researching each case and working with our dental director and dental consultants to expedite review and approval of treatment.

Training and Employee Development

Training is the most critical phase in developing a successful and professional MSR. All new employees receive training from the Corporate Employee Development department (CEDD) which includes an overview of LIBERTY and required compliance training on HIPPA and fraud, waste, and abuse.

Following CEDD training, new employees transition to their hiring department for department-specific training. Member Services trainers from all locations collaborate for consistency and uniformity across the enterprise. The training duration is a minimum of three weeks and is separated into modules so the new employee does not become overwhelmed. Students are required to sign-in to each class and pass the corresponding assessment test before advancing to answering calls independently. All training efforts are tracked in a database for auditing and reporting purposes.

Member Services training is conducted in a classroom setting, and the curriculum includes lecture, hands on experience with real case scenarios, interactive exercises, role playing, and peer-to-peer shadowing. Much of the focus is on our customer service philosophy, core values, customer service principles, and cultural and special needs awareness.

Following is a high-level list of the training topics covered:

- ***LIBERTY's customer service philosophy.***
- ***Member Services Core Values.***
- ***HIPAA compliance.***
- ***Cultural linguistics, diversity, and sensitivity.***
- ***Department policies and procedures.***
- ***Soft skills boot camp, emphasizing that MSRs are to be professional, courteous, responsive, and empathetic.***
- ***Dental terminology.***
- ***Customized recipient specific training, such as, demographics, special needs and programs, regulatory and State specific guidelines, etc.***

- ***Medicaid-specific training, such as instructions on dentally necessary covered dental services.***
- ***Benefit plan details specific to DHCFP, including, limitations, exclusions, frequencies, etc.***
- ***Provider networks.***
- ***and referrals.***
- ***Grievances, appeals and second opinions.***
- ***Call escalation.***
- ***Telecom and host system operations.***

In addition to new hire training, ongoing and refresher training is conducted to reinforce information on subjects previously taught, provide information about updated policies and procedures, and introduce new requirements. The training sessions provide an opportunity to discuss real-case scenarios experienced by MSRs while assisting customers. Trainers lead these sessions. Training opportunities are identified through call monitoring, help desk feedback, on-floor observations, and monthly one-on-one sessions with supervisors. Employees are encouraged to do a self-assessment of their training needs and to communicate them to their supervisor who will coordinate the training.

3.5.4 Dental Provider Requirements

3.5.4.1 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.

We confirm that all enrolled recipients will have the freedom to choose from participating PDPs and change their PDP upon request. Recipients will be assigned to a valid PDP immediately, within five days, upon enrollment or reinstatement. The preference of the member is given the highest consideration, as well as factors such as spoken language and distance between member and provider. If an established member-to-provider assignment is disrupted for any reason, every attempt is made to

reconnect the member to the same provider upon reinstatement. Enrollees have the freedom to change their PDP upon request as frequently as once per month.

3.5.4.2 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.

In consideration of distance between the dental provider's office and residence of member, standards may be different between urban and rural settings. Generally, the rule for urban areas would ideally limit the distance to 15 miles. However, in more sparsely populated areas, this may be extended to 25 miles. For members in extreme rural locations, we will outreach to the member if their preference is not initially available.

3.5.4.3 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:

A. Assigning enrolled recipients to a provider from whom they have previously received services, if the information is available;
B. Designating a PDP or Primary Dental Care Site who is geographically accessible to the enrolled recipient per NAC 695C.160 (25 Mile Rule); and
C. Assigning all children within a single family to the same PDP.

Although every effort is made to solicit the enrollee's preference, when this is not possible our auto-assignment system will ensure the new assignment is valid and appropriate. Once the auto-assignment feature is engaged, the system follows a method known as "inheritance protocol" to determine if a previous member-to-provider assignment has existed and can be reassigned again. This is ideal for members who experience a Medicaid coverage gap, and for assigning members of the same family to the same provider if they enroll at different times. Inheritance protocol will follow these steps, in this order, to make the best PDP determination:

- ***Identify if member has had a previous provider assignment in system;***
- ***Identify if member has other family members with an active assignment;***

- ***If neither of the above apply, the system uses a combination of member's spoken language and zip code to match to the closest provider who can accommodate member's language;***
- ***If no providers are available that match member language needs within 15 miles, the language requirement is lifted and a match is then made strictly by zip code to the closest available provider.***

3.5.4.4 Changing a PDP or Primary Dental Care Site

C. 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.

Recipients are free to change their PDP assignment upon request and for any reason, as frequently as once per month. There are multiple methods for recipients to initiate a provider change, including contacting our Member Services team by telephone, by use of our iTransact member portal, or by written request via email or regular mail. Instructions on this procedure are provided in the new member packet.

B. 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.

In cases where a PDP has been terminated, LIBERTY will reach out within 15 days to send written notice to each recipient that their provider is no longer available and provide them with network providers that are currently accepting new patients in the area. Recipients are informed of their option to select another Primary Dental Provider before one will ultimately be auto-assigned. In addition, our network providers are required under contract to complete all services started prior to the effective date of termination, consistent with professionally recognized standards of dental practice.

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

1. 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;
2. The PDP ceases to participate in the vendor's network; or
3. 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.

We understand and will comply with the above requirements. All the above circumstances will trigger a new PDP assignment effort on our part. All situations creating PDP changes will be tracked. We will report the mix and volume of changes to DHCFP, and will conduct our own analyses of these data to identify operational improvement opportunities.

3.5.4.5 Use of Dental Homes

A. The vendor is encouraged to use existing patient-centered Dental homes/health homes, when available and appropriate.
B. Vendor should use supportive provider services and contracting to support the expansion of patient-centered dental homes/health homes.
C. Vendor is encouraged to use other innovative models, when available and appropriate.

Using Existing Patient-centered Dental homes/health homes

We will work with DHCFP to gain access to data that will allow us to identify members' current Dental Home, including encounter data or any other data available. We will draw upon this information (as made available) in our dental home assignment process and provider recruitment and outreach efforts. Members who have utilized at a specific office or who are identified as having a specific Dental Home which is already in our contracted network will be assigned to that office as their Dental Home going forward.

Establishing a Dental Home

All members will be empowered to select a "Dental Home"—an environment that encourages families to establish a relationship with a dental provider to access comprehensive and preventive dental care, as well as to maintain positive oral hygiene practices in their own home. Member engagement/outreach and a healthy, ongoing relationship with a Dental Home provider, promotes continuously accessible, comprehensive, family-centered, and culturally effective coordination of dental health care. We collect provider information, such as languages spoken within the office and hours of operation, to identify providers that meet the geographic, linguistic and cultural needs of the members within their local community. We utilize the data to ensure that our members are able to select or are assigned to providers that meet their specific

cultural and linguistic needs within time and distance standards to promote a proper Member/Dental Home relationship.

Assignment of Dental Homes

Our Dental Home proposed approach is to match each of our members to the most appropriate Dental Home possible, considering factors such as member/caregiver preferences, continuity of care, distance, spoken language, ethnicity, and other family members within the same household.

Upon receiving the eligibility file from the State, our MIS system conducts an automatic assignment process to assign members to dental homes. The MIS takes into account time and distance to the members, as well as preferred linguistic and cultural needs. LIBERTY also has designated providers who have been identified through our provider profiling tool as Centers of Excellence—those providers who have met all of our practice patterns, grievance and appeals, access, and availability standards. In addition to the assignments provided by our MIS, we manually review the assignments to identify opportunities to assign members to our Centers of Excellence providers. We offer an established Centers of Excellence network in Nevada for our existing commercial enrollees, which will be extended to our Medicaid and Nevada Check UP enrollees.

By gathering demographic information from 834 enrollment files, as well as from member self-identification during phone calls, we compare that data with demographic information about our network providers. Manually assigning members to our Nevada-identified Centers of Excellence also ensures members within specific age groups have an assigned dental home that is near their home, meets their cultural and linguistic needs, and provides the highest level of satisfaction possible. Although much effort is placed in how carefully we assign members to providers, freedom of choice is promoted by allowing members to change their dental home to any contracted provider within the network.

Once a Dental Home is assigned, we send a member identification card to the member with the assignment and the Member Services toll-free number in the event that the member wants to change the Dental Home assignment. When a member calls in to change their Dental Home assignment, our Member Service Representative (MSR) assists the member and logs their choice. Our system will automatically generate and mail a new member identification card to the member whenever a new Dental Home is selected.

Provider Support and Education

To ensure a successful Dental Home model, we support our providers with resources and education to enable them to provide preventive and comprehensive care to our members. During provider orientation and through our Provider Handbook, we train providers and staff on their roles and responsibilities of being a Dental Home provider.

On a monthly basis, our Provider Relations staff sends a list of assigned members to our providers via mail, email or fax, whichever is their preference. The lists are also available online through our provider portal. Providers have access to all of their assigned members' dental visit history with LIBERTY through our provider portal and are able to determine which members are due for a check-up. Provider Relations staff also proactively reach out to our providers with members who are under-utilizing service on quarterly basis. Provider Relations staff will assist our providers in encouraging those members to come in through our calling campaigns, described above, or through other communication methods. For example, the reminder postcard in Figure 3.5.4.5-1 was created and sent out by our providers to remind members to schedule an appointment.

FIGURE 3.5.4.5-1 PROVIDER REMINDER POSTCARD

Fluoride Initiative for Children

In analyzing utilization trend analysis, LIBERTT identified that many of our members were not receiving a high percentage of fluoride treatments during their office visits. Research shows that a simple fluoride swab may be critical to eliminating or diminishing

dental disease. Visiting a dental provider at an early age for oral health examinations and preventive services significantly decreases or eliminates a child's anxiety about dental treatment. Therefore, we developed the Fluoride Initiative in California to increase early fluoride application on children three years and younger and strengthen the Member/Dental Home relationship. Our initiative focused on a combination of outreach and education by reaching out to providers and members through mailings and flyers.

We worked with several providers chosen specifically for their ability to work with and effectively treat young children. These providers were paid an additional supplemental payment to perform child visits and apply fluoride varnish to children between the ages of zero and three years old. For this particular outreach program, we contacted the parents and guardians of the zero to three populations via an outbound phone call campaign, and helped those members set dental appointments at the identified providers.

Additionally, we designed and implemented a successful outbound call campaign, in which our Member Service Representatives (MSR) would call parents to inform them about the program. If the parent agreed to participate, the MSR would warm transfer the member to the provider office to make an appointment, where thousands of calls resulting appointments were made with parents of young children for their first dental visit. To measure our progress and success, we used claims data to determine the number of eligible children between the ages of zero and three years old, who received fluoride treatments prior to the initiative and again following the initiative. This program resulted in the improvement of fluoride treatment utilization rates in the California Medicaid Managed Care Program by 31% for our members.

Examples of successful strategies and lessons learned in encouraging Dental Home participation

LIBERTY's experience with the Dental Home model throughout the states we operate in has enabled us to implement and refine several programs to support the model. As described below, our Provider Centers of Excellence program encourages members to seek care from our recommended providers based on the assumption that our members utilize more services when they are seeking care from a provider they enjoy visiting. Also described below are our member outreach programs that support the Dental Home model.

For example, in the Florida MMA Medicaid program, we utilized our proprietary provider profiling tool and identified 37 offices that were providing excellent services to our members in their geographic areas. After careful review of each office's practice

patterns, grievance/appeal data, member satisfaction and loyalty indicators and other relevant criteria, we deemed these offices our Centers of Excellence (COE). We then began considering them our preferred offices when suggesting Dental Homes to our members. As a result, more members are utilizing services at these COEs as noted below:

- ***16 (43%) treated more members since becoming a COE.***
- ***20 (54%) treated more members than the same period in prior year.***
- ***12 (32%) treated more members since becoming a COE and more than the same period in the prior year.***

Additionally, after further review, all 37 offices remain on our Centers of Excellence list and continue to provide higher than average service to those members that utilize them as their Dental Home.

FIGURE 3.5.4.5-2 CREATING AN ACCOUNTABLE CARE ENVIRONMENT

Creating an Accountable Care Environment

Our Centers of Excellence model allows designated providers to generate more revenue over the long term, while facilitating continuity of care to our members.

This model is also designed to discipline low performing providers or eliminate them altogether. Penalties may include closing the office to new enrollment, increasing requirements for pre-authorizations and claim submissions, reducing fees, and/or reporting them to the state dental board or authorities, if merited.

By putting programs in place that hold our providers accountable, we can continue to ensure that members receive the best care from the most qualified providers. In keeping with our member-centric care model, we train our providers on the importance of ensuring that all members are seen on a timely basis and that they receive the services they need and deserve within a Dental Home setting.

Establishing Dental Presence at Patient-Centered Medical Home Locations

We are currently working with two of our MCO partners in establishing a dental presence at their Patient-Centered Medical Home (PCMH) locations. These locations are designed to have a comprehensive, coordinated care approach that normally encompasses numerous areas of medical care, coordinated by an Inter-Disciplinary Care Team (IDCT). LIBERTY and our MCO partners believe dental should be included not only as a service at the PCMH locations, but that the dentist should be involved in the

IDCT as well. We also facilitate the use of portable equipment or mobile vans at PCMH locations.

Member Outreach and Education

During our interactions with our members, we will take the opportunity (where appropriate) remind our members of the importance of preventive and comprehensive dental care through a Dental Home and attempt to schedule an appointment with them, beginning with our initial welcome call and text messages. Additionally, our member services staff conducts outbound calling campaigns to our members on a regular basis. For example, through our Recall Visit program, our MSRs identify and call a member who have not had an appointment at their Dental Home within the past six months and assists them with scheduling an appointment. When a member calls our toll-free line, the MSR, in addition to addressing the issue the member is calling about, will review the member's profile to determine the date of their last preventive check-up. If it is almost time or past time for another check-up, the MSR will conduct a three-way call with the assigned dental office to schedule the member's next appointment.

We will partner with community organizations, faith-based organizations, and schools, to participate in health fairs and other events to reach out to members "where they are." During these events, we provide educational information to our members to promote Dental Home participation. All of this information is available online and in multiple languages.

Other Innovative Models

LIBERTY, in conjunction with other organizations, funded a partnership with the Center for Oral Health's school-based program to provide dental screenings, fluoride varnish, and oral hygiene instruction by dental hygienists on-site in the Sacramento, California area schools. The hygienist provides a "ranking" to the member's oral health to indicate the member's need to see a dentist (for example, is there a dental emergency or is there only a need for preventive care). The Center for Oral Health identifies which students are LIBERTY members and sends their information to us. Member Services then contacts the parent or guardian of the child and helps them schedule an appointment with their Dental Home. We follow up with the parent after each visit to ensure they understand what the next step is in their child's dental health, whether it is another restorative appointment or the next 6-month checkup.

3.5.5 Children with Special Health Care Needs (CSHCN)

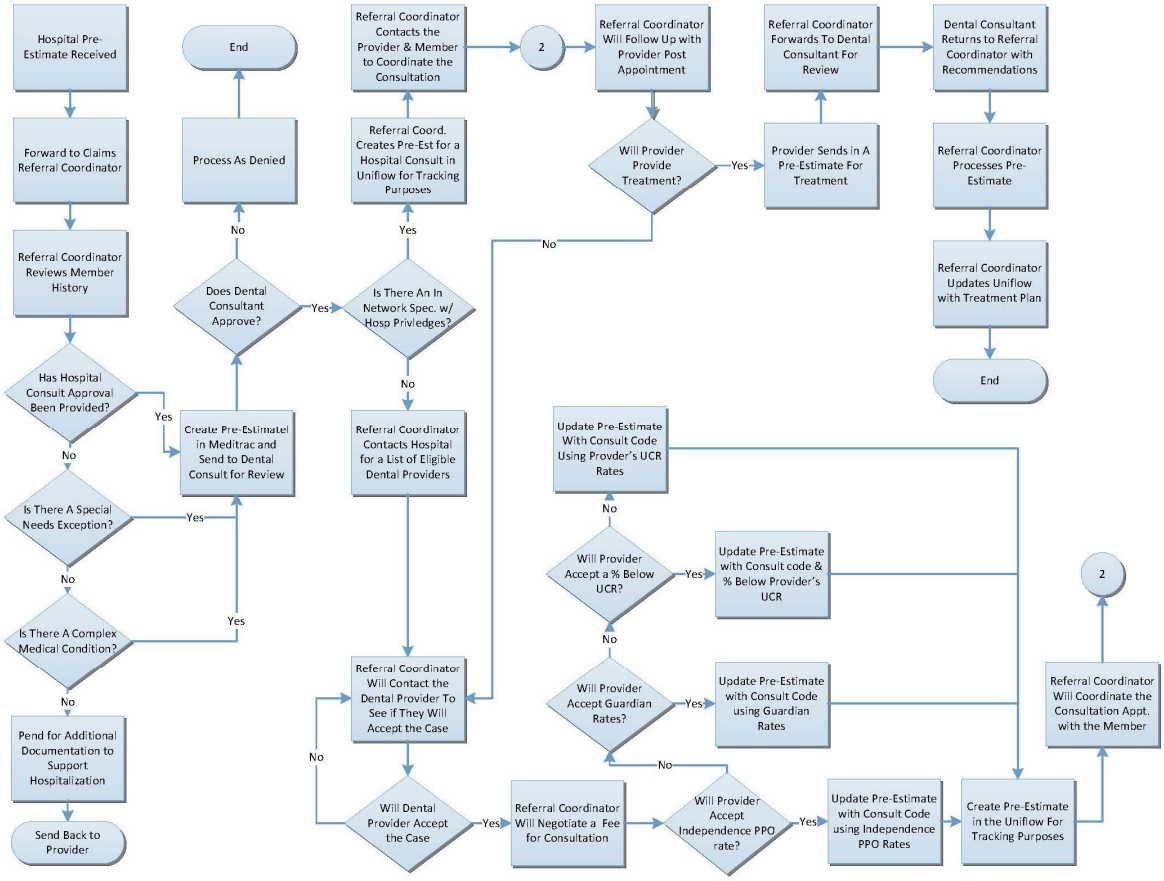
3.5.5.1 The vendor must produce a treatment plan for recipients with special health care needs who are determined through an assessment by appropriately qualified health care professionals to need a course of treatment or regular care monitoring. The treatment plan must be:

A. Developed by the recipient's primary dental provider with recipient participation, and in consultation with any specialists caring for the recipient;
B. Approved by the vendor in a timely manner, if approval is required by the vendor; and
C. In accordance with any applicable State quality assurance and utilization review standards.

3.5.5.2 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.

We have a process in place (see Figure 3.5.5.2-1) to address Children with Special Health Care Needs.

FIGURE 3.5.5.2-1. WORKFLOW OF HOSPITAL CASES



Requests for this population are received and triaged to our Special Needs Coordinator. The Special Needs Coordinator works in conjunction with the Dental Director to evaluate the case and condition of the recipient and develop a course of action to get preventive care and treatment for the individual. The Special Needs Coordinator will reach out to the recipient or recipient's legal guardian to introduce themselves as the point of contact for LIBERTY Dental Plan and to discuss the needs of the child and treatment being requested. The Special Needs Coordinator will work with the primary dental provider, and the recipient or their guardian to develop a treatment plan. The treatment plan will be reviewed and approved in a timely manner if necessary and will follow all State and federal guidelines.

Our Special Needs Coordinator will share the recommendations made by the Dental Director in an effort to make the recipient or recipient's legal guardian feel more at ease with the process from beginning to end.

Once the provider is located, the Special Needs Coordinator will review the case with the provider, schedule a tentative appointment and contact the recipient or recipient's legal guardian to share the provider information, tentative appointment date and time and outline the next steps in receiving treatment. In some cases, a recipient's treatment plan includes multiple providers and coordination between a primary dental provider, a specialist, a medical physician and the Group or Health Plan. In these more complex cases, the goal is to keep all parties engaged in the treatment and progress of the recipient and to make sure records are shared and there is limited or no cost to the recipient.

Upon completion of the treatment, the Special Needs Coordinator will conduct a follow up telephone call with the recipient or recipient's guardian. The purpose of the call is to ensure treatment was completed as requested and the needs of the recipient were achieved. If further treatment is necessary, the Special Needs Coordinator will facilitate further treatment coordination until case completion and recipient satisfaction has been achieved.

We will also update our MIS to ensure our recipients have direct access to a specialist through a standing referral. We make the treatment plan available to the recipient and provider through our portals, and in hard copy upon request.

All coordination of treatment for Children with Special Health Care Needs is tracked from start to finish and can be reported on if requested by the DHCFP.

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3.6 NETWORK

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3.6 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.

We understand and will comply with the requirements of section 3.6

We have experience in establishing and managing appropriate provider networks in multiple States across the country. We understand the importance of maintaining a sufficient network to ensure that Nevada Medicaid recipients can access to the quality of dental services that are available to them. We are committed to provide a Medicaid network which includes General Dentists, Pediatric Dentists, Endodontists, Oral Surgeons, Oral and Maxillofacial Surgeon, Periodontists, Orthodontists, Dental Hygienists and essential community providers. During our contracting process, we first target providers with high utilization in order to minimize disruption and geographic areas of existing and potential recipients to ensure access standards are met.

We recognize the importance of ensuring that Nevada Medicaid recipients receive timely access to quality care from a contracted provider. We will utilize provider contract requirements, written policies and procedures, provider education and communication strategies, and monitoring and enforcement systems to ensure that our network providers comply with DHCFP's access and appointment availability standards so that the Nevada Medicaid recipients receive the access of care they are entitled.

We generate GEO access reports on a monthly basis to evaluate adequacy of our network; this includes but not limited to monitoring FTE requirements for accepting eligible recipients per service area and changes to the network. Quality assurance and commitment to recipient care begins with up-to-date, accurate policies and procedures that reflect current processes and changes in federal and/or, state regulations (including DHCFP requirements), and any LIBERTY or client requirements.

We understand the importance of adhering to compliance regulations at all times, and diligently maintain our information and processes to reflect industry standards and regulatory requirements.

3.6.1 The vendor must adopt practice guidelines and protocols which:

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

3.6.1.2 Are adopted in consultation with contracting dental professionals; and

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

Clinical Dentistry Criteria and Practice Guidelines

LIBERTY's Clinical Criteria Guidelines and Practice Parameters (CCGs) were developed in 2005 and are subject to periodic revisions and an annual review by the Peer Review Committee. The CCGs were developed internally by our Dental Directors with oversight from the Chief Dental Officer and input from participating network general dentists and specialists to ensure sound dental clinical principles, processes, and evidence to consistently evaluate the appropriateness of dental services.

LIBERTY understands that there are multiple treatment alternatives for many dental conditions and therefore, single source clinical guidelines are not readily available. LIBERTY's CCGs are derived from publications of organized dentistry and education from United States based dental schools. References Include:

1. ***Knox-Keene Dental Guidelines. Department of Corporations Health Care Service Plan Division, Sacramento, Calif; December 1985:26.***
2. ***ADA Clinical Practice Guidelines Handbook – a guide to creating clinical guidelines (http://ebd.ada.org/~/media/EBD/Files/ADA_Clinical_Practice_Guidelines_Handbook-2013.pdf?la=en).***
3. ***California Dental Association Guidelines for the Assessment of Clinical Quality & Professional Performance; 1995-2010 (http://www.cda.org).***

Our CCGs are an essential component of Utilization Management and Dental Care Management programs. The CCG and Practice Parameters, and are based on sound clinical dentistry and the professionally recognized standards of care. Clinical staff, including, but not limited to, members of the Peer Review Committee and the QMI Committee, conduct an annual review of the CCGs and recommend revisions as appropriate; such revisions are reported to the Board of Directors quarterly and/or annually.

Our CCGs are currently undergoing the annual review; we anticipate updated criteria will be finalized in early 2017.

3.6.2 The Vendor must:

3.6.2.1 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;

Quality assurance and commitment to recipient care begins with up-to-date, accurate policies and procedures that reflect current processes and changes in federal and/or, state regulations (including DHCFP requirements), and any LIBERTY or client requirements. We understand the importance of adhering to compliance regulations at all times, and diligently maintain our information and processes to reflect industry standards and regulatory requirements.

A copy of our current Medicaid policies and procedures manual ("Provider Manual") is provided as Attachment 7. We are aware of, and can comply with, the RFP requirements, and will amend the Provider Manual as necessary to reflect DHCFP requirements. Before distributing the Provider Manual to our network providers, we will submit the document to DHCFP for review and approval.

During our orientation with providers and before the contract start date, Network Managers thoroughly review our Provider Manual and Provider Contract with providers and their staff which includes but is not limited to prior authorization guidelines, grievances and appeals, access standards, language assistance program and other policies that are required to administer the Medicaid program. Providers can access our Provider Manual online at any time or request a hard copy. Our policies and procedures are also available to recipients or potential recipients since the Provider Manual is online and sign on is not required.

When policies and procedures need to be revised, whether initiated by LIBERTY or DHCFP, we will make necessary updates to our Provider Manual and submit to DHCFP for review and acceptance. Upon final acceptance by DHCFP, we will notify network providers and staff via fax blast within five (5) business days of its completion and prior to implementation and/or the effective date of the revisions, as required by DHCFP.

By maintaining an updated Provider Manual, we ensure that our providers remain aware of compliance requirements and will adhere to the expectations set forth by the Nevada Medicaid and the Nevada Check Up programs. This level of training helps provide recipients with the quality of service they are entitled to.

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

Our utilization management (UM) system is customizable at the plan, procedure, provider and/or provider office level. We will adopt the Nevada guidelines to ensure that our utilization management, recipients' education, and covered services are consistent with the states guidelines. Prior authorization requests are adjudicated by the UM system and then systematically routed to the appropriate clinical or administrative staff for review and processing.

System adjudication edits include, but are not limited to, recipients' eligibility, benefits including any applicable limitations and exclusions, recipients claim history, provider status, and a series of PFWA coding rules. These system rules ensure that appropriate benefits and clinical reviews are applied to each request in a timely manner. Our clinical UM team includes multiple licensed dentists that work under the supervision of the Dental Director. Working in conjunction with the guidelines established by the American Dental Association and various dental specialty associations, including but not limited to the American Academy of Periodontology, American Academy of Pediatric Dentists, and American Association of Orthodontists, our clinical UM team has developed the LIBERTY Dental Clinical Criteria manual which is used to clearly define what constitutes medical necessity. In addition to this manual, we adopt state-specific clinical criteria as it applies to the State's Medicaid Service Manual. To ensure that all guidelines are applied consistently, each member of our clinical UM team is trained and routinely calibrated using the approved clinical criteria.

3.6.2.3 Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services;

We recognize the importance of ensuring that our recipients receive timely access to quality care from a contracted provider. We will utilize provider contract requirements, written policies and procedures, provider education and communication strategies, and monitoring and enforcement systems to ensure that our network providers comply with DHCFP's access and appointment availability standards so that the Nevada Medicaid recipients receive the access of care they are entitled to.

We are able to comply with DHCFP's timeframes for maximum appointment wait times, which vary by degree of urgency. They include the following:

- ***Routine and preventive appointments – within six (6) weeks***
- ***Therapeutic or diagnostic appointments – within fourteen (14) days***

- ***Urgent/emergency appointments – twenty-four (24) hours***
- ***Referrals to specialty care – within thirty (30) days***

All of these standards will be incorporated into our Nevada provider agreements, provider manual, communications to providers (i.e., newsletters, fax-blasts, and service calls), and provider training materials.

3.6.2.4 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;

3.6.2.5 Mechanisms to ensure compliance by providers;

3.6.2.6 Monitor providers regularly to determine compliance;

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

During our initial training, we will educate and ensure that providers and their staff understand the importance of offering the same hours of operation to Nevada Medicaid recipients (and Nevada Check Up recipients) as to commercial recipients. This parity requirement also applies to appointment wait times for periodic evaluations and urgent care (requiring immediate attention), and to new membership acceptance status. Our provider education materials will reinforce these requirements.

Network Managers produce monthly reports on appointment wait times. Additionally, on a quarterly basis, we generate appointment standard reports for our Quality Management and Improvement Committee to review, analyze, and provide recommendations to staff.

We determine compliance and monitors providers access and availability by multiple methods, including "secret shopper" calls, identification of access and availability related issues from Member Services Reports, Grievances & Appeals Trends and QM and/or Operations meetings.

If issues are identified with specific providers, assigned Network Managers discuss these deficiencies with the providers, counselling the providers on availability and wait time standards. All discussions are documented in our Provider Service Report (PSR). The Network Manager notifies the Member Services Department to follow up with a "secret shopper" call to the provider within the next 30 days. If we learn from the "secret shopper" call that the provider continues to violate access standards, we will develop a Corrective Action Plan and/or exercise our contractual remedies against the provider,

which include suspending further assignments of recipients to the provider. If there is no improvement, we ultimately terminate our agreement with the provider.

Servicing Offices

During each service call or visit, our Network Managers confirm that the provider profile is current. This includes, but is not limited to: wait time for periodic evaluations; non-urgent and urgent appointments; languages spoken; office hours and after hours; dentists participating at the practice; and whether providers are accepting new recipients. Each service call or visit is documented using our Provider Service Report (PSR) summarizing the discussion and findings. If there are changes with the provider profile, such as whether or not they are accepting new recipients, we update the information in our system accordingly. PSRs are scanned and stored in our profile file for future reference.

Secret Shopper Calls

We will conduct annual "secret shopper" calls to our network providers to determine the actual times that our recipients are waiting to get an appointment and validate hours of operations for Nevada Medicaid recipients versus commercial members. We utilize a subset of our Member Services Representatives who are trained specifically in the skills necessary to administer successful "secret shopper" call surveys.

Acting as a recipient's parent/guardian who is requesting an appointment, the secret shopper caller inquires as to appointment accessibility for initial examinations, preventive dental care appointments, hygiene treatment, routine care, and emergency care. The caller also inquires as to appointment wait times for both general dentistry and specialist appointments. A quarterly report summarizing the results of the calls is prepared under the direction of the Access and Availability Committee, which then determines any necessary corrective actions. If the need for corrective action is identified, the Committee forwards the information to our Provider Relations Department for immediate feedback to the provider.

Member Services Reports and Grievances & Appeals Trends

We also monitor complaints from recipients to assess whether network providers are meeting availability and wait time standards. If we find a consistent trend from recipients about a specific provider, our Grievance and Appeals or Member Service Department notifies the provider's assigned Network Manager. The Network Manager then schedules a counseling session with the provider to discuss the specific complaint. During the counseling, the Network Manager asks the provider to verify the issue, provides education on the importance of meeting those standards, and describes the consequences if the provider continues to be non-compliant. A summary of the meeting is documented in our PSR.

A follow-up service call or visit is scheduled with the provider within 60 or 90 days after the counseling session (depends on the severity of the concern) to evaluate whether the provider has improved their performance. If the provider has made little or no improvement in meeting the access standards, we may suspend assignment of new recipients to the provider. If further monitoring shows that the provider continues to violate our access standards, our next step is to begin the process to terminate our relationship with the provider.

Operations Meeting

We conduct regional monthly Provider Relations meetings, which are joined by all operations areas including the Member Services Department, the Claims Department, the Grievance and Appeals Department, Provider Relations Department, Network Managers, Dental Directors, and Dental Consultants. During these monthly meetings, we collaborate to review information from all the departments to identify where appointment availability and wait times may be an issue and determine a strategy to improve on those issues.

If providers do not comply with access and appointment standards, an education plan will be initiated to educate the provider and staff on the appointment availability guidelines. Further actions with these offices may include:

- ***Verbal re-education.***
- ***Halt referrals to office and, resurvey in specified timeframe (e.g. 1 month, 3 months, 6 months).***
- ***Corrective Action Plan (CAP). A CAP letter to be sent to office and written response requested. Corrective action plans can include such items as:***
    - ***Staff education on appointment availability requirements,***
    - ***Posting the requirements in the office,***
    - ***Modifying emergency protocols of office,***
    - ***Hiring additional staff/hygienist, etc.***

During our review of appointment times, we may identify issues in our network. For example, if a provider office phone number is disconnected or the phone is not answered, this may indicate the provider changed office hours or providers may have changed. After investigation into such a matter, the Network Manager will attempt to confirm any or updated information by calling or visiting the office, sending a letter, etc., or if appropriate, will recommend that LIBERTY terminate a provider.

During our review of appointment times, we may identify issues in our network. For example, if a provider office phone number is disconnected or the phone is not answered, this may indicate the provider changed office hours or providers may have

changed. After some investigation into these matters, the Network Manager may visit the office, mail a letter, or recommend terminating a provider if necessary.

3.6.2.8 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;

We have vast experience in working with recipients of various language and cultural backgrounds. We understand the importance of ensuring our providers are culturally competent in environment in which they provide care. We, also support our providers by educating our recipients about the importance of adherence to dental care and treatment plans.

Our Network Managers provide cultural competency training to offices; this training is also available on our website for dental providers and their office staff to access at any time. We strive to provide specific cultural and linguistic competency training to meet the changing needs of the diverse populations in the communities that we serve. The goal of this training is to provide the tools to communicate successfully across social boundaries, to build understanding and trust between provider and patient, and to work with patients to develop treatment plans that are effective and culturally relevant.

91% of our current network in Nevada has staff or a provider who is bilingual.

Languages spoken by the dentist and office staff are collected during the contracting process and updated/confirmed during the orientations and service calls/visits as well as during the random surveys conducted annually. We strive to recruit providers that meet the cultural and linguistic needs of our recipient.

In addition to providing cultural competency training, we ensure that our providers are equipped with the resources they need to communicate with recipients. We provide telephonic translation services (and occasionally in-person translation services) when requested by providers. We highlight these resources to our providers through our provider website, trainings, Provider Manual and newsletters. Figure 3.6.8.2-1 conveys the cover page of a recent provider newsletter.

FIGURE 3.6.8.2-1 – SAMPLE PROVIDER NEWSLETTER

3.6.2.9 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

LIBERTY is committed to contract with Medicaid network providers who truly understand the importance of ensuring that recipients receive the quality of care that they deserve. We do not discriminate against particular providers if they are acting within the scope of their license under the applicable State law.

In the event that a provider requests reimbursement amounts that are above what we offer to other providers in the same geographic area, we may decline to contract in order to control costs and be consistent with our responsibilities to recipients and the State. As soon as we make our decision not to contract, we provide a written notice to providers of our decision and the reason that we decline to contract. Our ultimate goal is to ensure that recipients have access to quality care while we deliver a cost effective program.

3.6.2.10 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:

A. Changes in the vendor's services, benefits, geographic service area or payments; or

B. Enrollment of a new population in the network.

We generate GeoAccess reports monthly or as often as needed when there are changes to the provider network, new enrollment in an area or the inclusion of additional service areas, to evaluate network access and to identify and correct gaps. Our focus is to reduce disruption and improve continuity of care to Nevada Medicaid recipients.

We plot the member census against existing provider locations and analyze the impact of changes. This enables us to identify where additional contracting is needed to keep the network compliant with DHCFP requirements.

We will provide DHCFP documentation, in a format approved by DHCFP, our compliant provider network before the contract effective date and any time there is a significant change thereafter. Our documentation will demonstrate an appropriate range of network providers which include general dentists, endodontists, oral surgeons,

periodontists, pediatric dentists, prosthodontists, and essential community providers. Our goal is to meet the needs of anticipated number of recipients in the service area and provide them with access to quality of care.

3.6.3 Network Management

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

A. 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:

1. Delivery of covered medically necessary, dental services and preventive services, including EPSDT screening services;
2. Referrals for specialty care and other covered medically necessary services in the vendor benefit package;
3. Continuity and coordination of the enrolled recipient's dental care; and
4. 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.

We understand and agree to comply with section 3.6.3.

Our Provider Agreement and Provider Manual require that PDPs are responsible to deliver dental services that are consistent with professionally recognized standards of dental care and which accurately reflect the covered services available through the recipient's benefit plan. We will ensure delivery of covered medically necessary services, including EPDST, continuity of care and maintenance of dental records.

Figure 3.6.3.1-1 is an excerpt of our provider agreement and provider manual in sections to address the above topics. Upon award of contract, we will update our provider agreement to reflect applicable DHCFP requirements.

FIGURE 3.6.3.1-1. PROVIDER CONTRACT EXCERPT DELIVERY OF DENTAL SERVICES

Standard of Care. Dental Office shall maintain the dentist/patient relationship with Members and shall be solely responsible for the provision of dental services. Dental Office shall render services in a timely manner and in a manner consistent with all applicable state and/or federal laws and regulations, professionally recognized standards of dental practice, and the professional and ethical standards and guidelines issued by LIBERTY (including any standards or guidelines set forth in the Provider Manual or otherwise issued by LIBERTY). In addition, Dental Office shall conduct its relationship with LIBERTY and Members in a professional and positive manner.

Referrals for Specialty Care

Figure 3.6.3.1-2 "REFERRALS TO SPECIALISTS BY THE GENERAL DENTIST" below is an excerpt from our Medicaid process in other States; however, once awarded, we will adjust our Provider Manual to meet DHCFP requirements. We are committed to ensure that providers follow DHCFP requirements and guidelines.

FIGURE 3.6.3.1-2. PROVIDER CONTRACT EXCERPT REFERRALS TO SPECIALISTS BY THE GENERAL DENTIST

LIBERTY expects contracted general dentists to provide the wide array of services and procedures such as endodontic, periodontal and oral surgical procedures that are often within the scope of general dentists. LIBERTY expects to refer to specialists only services that are beyond the scope of services of the training and experience of most general dentists such as complex endodontic or oral surgical procedures.

The Medicaid Program has a Direct Referral provision, which does not require the use of a specific form. You may refer to any participating Specialist for specialty services.

You should provide notification to the specialist as to what services or conditions you want evaluated and treated and any recommended procedure involved. You should provide any narrative or radiographic materials to assist the specialist. If you cannot locate a participating specialist, please contact Member Services for assistance.

In some cases, LIBERTY may arrange for an out-of-network ("non-participating") specialist when in-network specialists are not available. In some cases, LIBERTY may re-direct a member to another general dentist that may be able to provide the specialty services. Confirm the need for a referral and that the Referral Criteria listed below are met.

Inform the member that:

- ***Referral is only for Medicaid covered services listed.***
- ***The Specialist will evaluate their necessary services and the services will be subject to pre-authorization by LIBERTY unless emergency or urgent in nature.***
- ***The member will be financially responsible for non-covered services provided by the Specialist***

Continuity of Care

Our provider contract requires that our providers deliver continuity and coordination of the enrolled recipient's dental care. In the event of the termination of this Agreement, and unless prohibited by applicable law, PDP's shall complete all services started prior to the effective date of termination, consistent with professionally recognized standards of dental practice and LIBERTY's policies and procedures.

Below are excerpts from our Provider Contract and Provider Manual to ensure that our providers comply:

***Figure 3.6.3.1-3* is an excerpt from our Medicaid Provider Manual regarding continuity and coordination of care.**

FIGURE 3.6.3.1-3 CONTINUITY AND COORDINATION OF CARE EXCERPT

CONTINUITY AND COORDINATION OF CARE

A panel of network dentists shall be available in currently assigned counties from which members may select a provider to coordinate all of their dental care.

Continuity of care between the primary care general dentist and any specialty care dentist must be available and properly documented. Communication between the primary care general dentist and dental specialist shall occur when members are referred for specialty dental care. LIBERTY expects General Dentistry providers to follow up with the Member and with the Specialist to ensure that referrals are occurring as per the best interest of the Member. Specialist providers are encouraged to send treatment reports back to the referring General Dentist providers to ensure that continuity of care occurs as per generally accepted clinical criteria.

The General Dentist provider is responsible for evaluating the need for specialty care, the need for any follow-up care after specialty care services have been rendered and should schedule the member for any appropriate follow-up care. LIBERTY expects general dentists to provide the array of services and reserve specialty referrals only for procedures beyond the scope or training of the general dentist.

Maintenance of Dental Record

LIBERTY requires that providers maintain dental records according to the applicable governmental agencies. Figure 3.6.3.1-4 is an excerpt from our Provider Agreement. Upon award of the contract, we will update our Provider Agreement to include additional elements to meet DHCFP requirements.

FIGURE 3.6.3.1-4 PROVIDER CONTRACT EXCERPT

a) Access to Records. Dental Office shall permit LIBERTY, upon advance written notice, and all applicable governmental agencies or divisions (and/or the designees of LIBERTY or such governmental agency/division) to inspect, evaluate and audit any physical facilities and equipment, books, contracts, documents, papers, records, including dental records and documentation of the Dental Office that pertain to Members, any aspect of Covered Services performed, reconciliation of benefits and determination of amounts payable (the "Records"). Dental Office shall cooperate and assist with, and provide the Records to, LIBERTY and any applicable governmental agency/division (and/or their designees) for purposes of the above inspections, evaluations, and/or audits, or as otherwise requested by LIBERTY from time to time. Dental Office shall notify LIBERTY of any disclosure of Records it is required to make to a governmental agency or division. Dental Office may not make the access or the provision of Records described in this Section 2.6(a) contingent upon a confidentiality statement or agreement. The above-described rights to inspect, evaluate, and audit will extend through the period during which Dental Office is required to maintain the Records as set forth in Section 2.6(b) below.

(b) Retention Period. Dental Office shall maintain the Records for ten (10) years from the termination or expiration of the Agreement or the completion date of any audit conducted pursuant to Section 2.6(a) (whichever is later), unless otherwise required by law.

3.6.3.2 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.

We understand that a diverse provider network, which includes essential community providers, is a critical component of serving the Nevada Medicaid population. We recognize the level of access these facilities provide to our recipients, and we strive to support them in providing dental care to the Nevada Medicaid population. From our extensive experience with these types of facilities in other states, we recognize that these centers will allow and encourage higher utilization for Nevada Medicaid membership.

We require that essential community providers follow the same guidelines, policies, and procedures as other providers. This includes but not limited to treating all patients the same regardless whether the patients have commercial, Medicaid or Medicare plans. Below as Figure 3.6.3.2-1 is an excerpt from our Provider Contract in regards to non-discrimination.

FIGURE 3.6.3.2-1. PROVIDER CONTRACT EXCERPT

(d) Compliance.

i. Non-discrimination. Dental Office shall not, and shall ensure that Dentists and other Dental Office Agents do not, in any way discriminate against Members on the basis of race, color, national origin, ancestry, place of origin or residence, sex, age, religion, sexual orientation, disability, medical condition or health status, marital status, membership in a Dental Plan or program, source of payment, or any other class or status protected by applicable federal and/or state discrimination laws.

3.6.3.3 The vendor is required to negotiate in good faith with all of the following essential community providers if they provide covered dental services:

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

B. The University Medical Center of Southern Nevada;

C. The University of Nevada School of Medicine (UNSOM);

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

E. Division of Public and Behavioral Health (DPBH);

F. Division of Child and Family Services (DCFS);

G. Community Centered Behavioral Health Clinics (CCBHC);

H. County Child Welfare Agencies;

I. 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.

We have several years of experience in contracting with FQHC, RHC and IHC offices; our current network consists of 672 FQHCs, IHCs, RHCs, County Health Departments and Community Centers in 20 states.

Within our existing Nevada provider network, which includes more than 1,300 dental providers, we are currently contracted with the following clinics:

- ***Las Vegas Paiute Dental Department***
- ***Fallon Tribal Health Center***
- ***Pyramid Lake Tribal Health Clinic***
- ***Walker River Tribal Dental Clinic***

Upon award of the contract, we are committed to reaching out and building open lines of communication to appropriate advocates and stakeholders to contract with essential community providers, including the following:

A. Federally Qualified Health Center (FQHC) or Rural Health Center (RHC);
B. The University Medical Center of Southern Nevada;
C. The University of Nevada School of Medicine (UNSOM);
D. The University of Nevada, Las Vegas School of Medicine (UNLV SOM);
E. Division of Public and Behavioral Health (DPBH);
F. Division of Child and Family Services (DCFS);
G. Community Centered Behavioral Health Clinics (CCBHC);
H. County Child Welfare Agencies;
I. Other essential community provider as designated by DHCFP

Our Provider Relations Department has a specialized unit that is responsible for contracting with all FQHCs, RHCs, IHCs and other community health centers. This unit continuously monitors the U.S. Department of Health and Human Services (DHHS) Health Resources and Services Administration (HRSA) website to download updated raw data which contains all Qualified Health Centers by region. By comparing each updated file to its predecessor, LIBERTY is able to immediately identify any new centers and whether or not they offer dental services. Once it is determined that the center contains a dental facility, we schedule a meeting with the Center's Director of Contracting to facilitate contracting into LIBERTY's network. We maintain ongoing communication with our existing FQHC networks so we stay well informed of future expansion within the Centers.

Upon award of the Nevada Medicaid contract, LIBERTY will partner with DHCFP to request a list of FQHCs, IHCs, RHCs, community centers and other essential community providers that includes the number of Medicaid recipients along with the associated claims dollars. This will enable us to prioritize our recruitment effort to reach out to those

clinics that account for the largest portion of Nevada Medicaid membership. Our goal is to ensure that there is no disruption to recipients' care. We will also honor this goal in Nevada by ensuring 120 days of care continuity for new members, whether or not their provider participates in our network.

Process to Recruit FQHCs, RHCs, IHCs and Essential Community Providers

The process and strategies listed below are the standard ways we develop and maintain a provider network that includes FQHCs, RHCs, IHCs and essential community providers.

Identify Dental Clinics to Contract

Identify FQHCs, RHCs, IHCs and essential community providers by conducting research online and through our health care partners to determine which clinics have dental providers. Once we have a prospective list, we make contact with all clinics in the geographic service areas currently not contracted with LIBERTY.

Schedule Meeting

If FQHCs, RHCs, ICHs and essential community providers are interested in pursuing the opportunity, our Network Managers reach out to the Center's Director of Contracting to schedule face-to-face meetings to discuss potential contracting.

Presentation

During the initial meeting, we conduct a presentation to review benefit design, the compensation model and Nevada Medicaid program guidelines. The contract provisions for essential community providers may differ from other providers in the same geographic area due to the specific requirements of the FQHC (e.g., FQHC's do not typically have commercial malpractice insurance); LIBERTY is familiar with the contract requirements of an FQHC, and has significant experience negotiating contract requirements with FQHC's and essential community providers. The compensation methodology used with essential community providers is the same as other providers in the same geographic area. We discuss the benefits of having community clinics in our network to attract recipients and increase utilization. The Network Manager continues follow-up until the contract is executed. We start the credentialing process once complete contract documents are received and to ensure that all candidates meet NCQA credentialing standards in order to prior to participating in the program.

3.6.4 Subcontractors

3.6.4.1 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.

3.6.4.2 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:

A. 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;

B. For the evaluation of the prospective subcontractor's ability to perform the activities to be delegated;

C. 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:
   1. 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
   2. 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.

D. 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;

E. 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;

F. 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;

G. 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

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

We have the unique ability to directly and effectively perform virtually all of the activities required under the DHCFP contract. The number of subcontracts LIBERTY intends to engage under the Nevada contract, should it be awarded to us, is limited to only three, due to the high quality of services and expertise these subcontractors offer:

1. ***Interpretation/Translation services provided by MAGNUS***
2. ***Primary source verification services provided by VerifPoint and***
3. ***Fulfillment services provided by OCDM***

Due to our long relationship with these subcontractors providing services in numerous other Medicaid markets throughout the country, they are fully aware of, and compliant with, our strict policy requiring contracts with subcontractors and downstream vendors to adhere to all the same conditions and obligations as those LIBERTY is bound to in our contracts with state and federal entities, including compliance with:

- ***All relevant sections of 42 CFR 438, as applicable;***
- ***Relevant confidentiality and HIPAA provisions, including a BAA, if applicable;***
- ***Insurance requirements (adequate insurance, current industry standards)***
- ***Record retention obligations***

Additionally, our internal protocols require that agreements with subcontractors

- ***Clearly specify the scope of work, including sanctions for failure to perform, or substandard performance;***
- ***Are never structured to provide financial or other incentives for denying, reducing or limiting medically necessary services; and***
- ***Never include "gag" clauses***

Our agreements with these subcontractors are maintained in writing and we can provide DHCFP copies within five days of request. In addition, we regularly maintain through affidavits, and are prepared to provide full and complete information about the ownership of any subcontractor with whom we have had business transactions totaling more than $25,000 during the twelve-month period ending on the date of request. Note that LIBERTY does not hold any ownership interest in these subcontractors, and is aware of, and prepared to comply with, its obligation to disclose any such interests to DHCFP under the Nevada contract.

While we do not intend to engage any subcontractors other than those listed above to perform activities under the Nevada contract, if circumstances arise that require us to engage another contractor, we fully understand and will comply with Nevada's requirement to obtain prior approval from DHCFP. In addition, we will formally submit to DHCFP for review and approval the names of the subcontractors noted above, and the names of their principles and will do so by the service start date, and whenever a change occurs. Similarly, we will notify DHCFP, in writing, immediately upon notifying any relevant subcontractor of our intention to terminate their subcontract.

Due Diligence

Based on their proven track records, and our working relationships with OCDM, MAGNUS, and VerifPoint, all three vendors consistently meet or exceed our contractual performance expectations. Nonetheless, LIBERTY continues to monitor and evaluate their performance to ensure the activities they are delegated provide the best possible service to our members. LIBERTY accomplishes this through specific Policies and Procedures dedicated to the oversight of delegated activities which apply to any entity to which we have delegated administrative or health care functions. At the outset of any engagement, and on an ongoing basis thereafter, our Delegation Oversight Committee formally evaluates each subcontractor's ability to perform delegated activities. Specifically, upon initial contracting any subcontractor, we perform a pre-delegation assessment covering a number of components, including:

- ***Compliance – to determine whether the vendor has adequate systems in place to comply with all applicable regulatory and contractual requirements to which LIBERTY is subject (FWA, False Claims Act, HIPAA Privacy & Security, etc.).***
- ***Organizational and Financial Stability – to evaluate the vendor's business practices and financial and operational stability, including for example their ability to perform all activities LIBERTY requires of a service vendor.***
- ***Onsite Visit – to review, first hand, the vendor's facilities and to meet and interview, in person, key personnel, including outlining expectations to ensure a high level of service quality.***
- ***Privacy & Security – we enter into a Business Associate Agreement with any vendor that handles or has access to our members' PHI.***
- ***Grievances – at the outset of any new vendor engagement, we establish a documented protocol for identifying and referring grievances to LIBERTY for resolution. LIBERTY requires all vendors to fully cooperate with us in researching and resolving complaints, in order to ensure our ability to comply with applicable grievance, appeal, and fair hearing procedures and timelines.***

Vendor Oversight

Moreover, if LIBERTY is awarded the Nevada contract, our Vendor Oversight Program, carried out by LIBERTY's Delegation Oversight Committee will be responsible for the following, consistent with DHCFP's prescribed schedules, and applicable law:

- ***Ensuring delivery of administrative and health care services at an acceptable or higher level of care to meet all standards required by this RFP. In LIBERTY's pre-delegation assessment, and ongoing oversight program, we evaluate whether subcontractors are accountable, responsive, reliable, patient, have well-developed communication skills, and adhere to customer service industry's best practices. In addition, LIBERTY ensures that the subcontractor maintains a reasonable accounting system that enables LIBERTY, our clients, and relevant oversight entities to readily audit, examine, and make copies of or extracts from all financial and other records related to services it performs on behalf of LIBERTY, including onsite inspections, on demand.***

- ***Ensure adherence to required grievance policies and procedures. With each vendor that performs services for us, we establish a documented protocol for identifying and referring grievances to LIBERTY for resolution. LIBERTY requires our vendors to fully cooperate with us in researching and resolving complaints, in order to ensure our ability to comply with applicable grievance, appeal, and fair hearing procedures and timelines. We regularly monitor our vendors' adherence to complaint protocols,***

during monthly joint operating committee meetings and work collaboratively with them to resolve the root causes of any instances of member or provider dissatisfaction.

3.6.5 Access and Availability

The vendor shall:

3.6.5.1 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.

We generate GeoAccess reports, at least quarterly, to evaluate network access and to identify and correct gaps; our focus is to reduce disruption and improve continuity of care for Recipients. We plot the member census against existing provider locations and analyze the impact of projected changes. This enables us to identify where additional contracting is needed to keep the network compliant with DHCFP requirements. Using our dental provider recruitment strategies, we continuously recruit providers to ensure that we continue to maintain our access standards, appointment standards, ratio of member to provider and changes in cultural and linguistic needs of the population. Table 3.6.5.1-1 provides an example of this process.

3.6.5.2 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.

Our experience has taught us that collaborative partnerships with community organizations are imperative in understanding the needs of our recipients from a holistic standpoint that incorporates recipient dental needs, health needs, and socioeconomic needs. This holistic approach is necessary to impact our recipients' lives, help them to adopt healthier lifestyles, and promote wellness.

In Nevada we will partner with stakeholders throughout the State to connect with recipients and plan educational events to support healthy lifestyle changes and identify any barriers to access. These stakeholders can include, but are not limited to: community organizations, providers, advocates and local officials.

We will also implement an action committee, the Dental Advisory Committee (DAC), to meet quarterly to include representatives from stakeholders, advocates, community programs and other entities to ensure we are collaborating closely and regularly addressing any and all coordination, quality opportunities to improve dental care access and availability, and any performance concerns that may arise.

Our current California Public Policy Committee (PPC) will serve as a model for the DAC. Our PPC in California is comprised of representatives from several internal, service-oriented departments, and includes provides recipient representatives and enrollees in California's Medicaid program, Medi-Cal. We solicit recipient representation on the PPC in every Recipient Handbook mailed to recipients. Our enrollment specialists publicize the PPC at open enrollment events, making in-person contact with hundreds of enrollees at once, encouraging recipients to consider applying for seat on the quarterly Committee. Committee recipients receive financial information, grievance and appeals reports, proposed policy, programs and initiatives. This transparency is intended to foster a spirit of collaboration and express how much we value input from stakeholders and our enrollees. Committee members are encouraged to comment on issues and/or problems they, or their fellow members, may have encountered.

LIBERTY is committed to reaching out and building open lines of communication with DHCFP, community providers, the Medicaid MCOs, appropriate advocates and stakeholders. These collaborations can improve dental care access and provide quality care to Nevada's Medicaid and Check Up recipients.

3.6.5.3 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.

Our Member Services Department has an outbound call unit dedicated to recipient outreach. Outreach efforts include initiating calls welcoming recipients to LIBERTY and encouraging them to utilize their dental benefits, including emphasis on continuity of care related to any covered and medically necessary, but uncompleted treatment that had been authorized by their prior Medicaid benefit plan. The Member Services Representative (MSR) will offer to provide the recipient with information on available dental providers and encourage the recipient's selection of a dental home.

Additionally, the MSR will ask the recipient if they would like help with making a dental appointment with the office they have chosen. These calls also provide the MSR an opportunity to educate the recipient on their covered dental benefits, their right to access care and answer any questions they may have.

3.6.5.4 Maintain an adequate network that ensures the following:

A. 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.

B. 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.

3.6.5.5 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.

We understand and agree to comply with requirements of Section 3.6.5.4 and 3.6.5.5.

We will begin network recruitment efforts upon contract award notification, to add to our existing base of more than 1,300 Nevada dental providers. We have experience in monitoring FTE requirements in other Medicaid State programs that we currently administer. On a monthly basis, we generate a report that shows the number of recipients that are assigned to each FTE provider Table 3.6.5.5-1 provides a sample Ratio FTE report. If there is a provider that is close to capacity, we will assign recipients to another provider within the practice. If there is no other FTE provider at the same practice, we will contact the office to discuss and evaluate options. If an office does not have the capacity to accept additional recipients we will assign recipients to another office closest to their residence.

TABLE 3.6.5.5-1. SAMPLE RATIO FTE REPORT

Name of Plan	Name of FQHC, RHC, or Indian Health Facility	Address	Enrollment Status (Current, New or Pending)	Effective Date	Number of FT Providers
LIBERTY Dental Plan	Watts HealthCare - Dental	10300 Compton Ave., LOS ANGELES, CA 90002	Current	11/1/2006	6
	AltaMed Medical and Dental Group - El Monte	10418 Valley Blvd, Suite B, EL MONTE, CA 91731	Current	10/1/2008	28
	Clinica Msr. Oscar A. Romero	123 South Alvardo Street, LOS ANGELES, CA 90057	Current	12/1/2012	5
	AltaMed Dental Group	1300 S. Sunset Ave, WEST COVINA, CA 91790	Current	7/1/2014	23
	QueensCare Family Clinics-Echo Park	150 North Reno Street, LOS ANGELES, CA 90026	Current	1/1/1900	5
	Eisner & Family Medical Center	1500 S. Olive Street, LOS ANGELES, CA 90015	Current	5/1/2012	6
	St. John's Well Child & Family Center	15301 San Jose Ave, COMPTON, CA 90221	Current	8/1/2013	6
	St. John's Well Child & Family Center	1555 W. 110th St, LOS ANGELES, CA 90047	New	8/1/2015	10
	Northeast Valley Health Corporation - FQHC	1600 San Fernando Rd, SAN FERNANDO, CA 91340	Current	4/1/2009	17
	Comprehensive Community Health Center	1704 Colorado Blvd, LOS ANGELES, CA 90041	Current	4/1/2013	4
	Community Health Alliance of Pasadena	1855 N. Fair Oaks Avenue, Ste G100, PASADENA, CA 91103	Current	12/1/2012	2
	St. John's Well Child & Family Center	1910 S. Magnolia Ave, Ste 101, LOS ANGELES, CA 90007	Current	10/1/2012	7
	St. John's Well Child & Family Center	2115 N. Wilmington Ave., COMPTON, CA 90222	Current	10/1/2012	6
	Antelope Valley Community Clinic	2151 E Palmdale Blvd, PALMDALE, CA 93550	Current	10/1/2014	1
	AltaMed Medical and Denta Group - East Los Angeles, 1st	2219 East 1st Street, LOS ANGELES, CA 90033	Current	2/1/2013	27
	Arroyo Vista Family Health Center - Lincoln Heights	2411 N. Broadway, LOS ANGELES, CA 90031	Current	1/1/2013	5
	Huntington Park Family Health Center	2680 Saturn Ave, Suite 220, HUNTINGTON PARK, CA 90255	Current	3/1/2014	6
	NEVHC - Rainbow Dental Center	26974 Rainbow Glen Drive, CANYON COUNTRY, CA 91351	Current	1/1/2013	17
	Dental Wellness Center at Jefferson High School	3410 Hooper Ave, LOS ANGELES, CA 90011	Current	3/1/2014	6
	AltaMed Medical and Dental Group-Boyle Heights	3945 Whittier Blvd, LOS ANGELES, CA 90023	Current	1/1/1900	26
	St. John's Well Child & Family Center, Inc.	4085 S. Vermont Ave, LOS ANGELES, CA 90037	Current	6/1/2015	10
	QueensCare Family Clinics Eagle Rock	4448 York Blvd., LOS ANGELES, CA 90041	Current	11/1/2008	5
	Antelope Valley Community Clinic - Lancaster	45104 10th Street West, LANCASTER, CA 93534	Current	12/1/2012	1
	QueensCare Family Clinics Hollywood	4618 Fountain Ave, LOS ANGELES, CA 90029	Current	1/1/1900	5
	QueensCare Family Clinics East La	4816 E 3rd St, LOS ANGELES, CA 90022	Current	11/1/2008	8
	QueensCare Family Clinics-Eastside	4816 E 3rd St, LOS ANGELES, CA 90022	Current	11/1/2008	8
	JWCH Institute, Inc.	522 S. San Pedro Street, LOS ANGELES, CA 90013	Current	6/1/2013	1
	St. John's Well Child & Family Center	5701 S. Hoover St, LOS ANGELES, CA 90037	Current	10/1/2012	6
	Arroyo Vista Family Health Center	6000 North Figueroa Street, LOS ANGELES, CA 90042	Current	1/1/2013	5
	St. John's Well Child & Family Center	6505 8th Ave, LOS ANGELES, CA 90043	Current	10/1/2012	7
	Valley Community Healthcare	6801 Coldwater Canyon Ave, NORTH HOLLYWOOD, CA 91605	Current	3/1/2014	5
	AltaMed Medical and Dental Group-Bell	6901 S. Atlantic Ave, BELL, CA 90201	Current	4/1/2008	30
	Northeast Valley Health Corporation	7223 N. Fair Ave, SUN VALLEY, CA 91352	Current	6/1/2009	17
	Chinatown Service Center	767 N. Hill St, Suite 213, LOS ANGELES, CA 90012	Current	1/1/2007	4
	Comprehensive Community Health Center	801 S. Chevy Chase Dr, Ste 250, GLENDALE, CA 91205	Current	4/1/2013	5
	St. John's Well Child and Family Center	808 W. 58th Street, LOS ANGELES, CA 90037	Current	8/1/2013	7
	Center for Family Health & Education	8727 Van Nuys Blvd Ste 203, PANORAMA CITY, CA 91402	Current	4/1/2015	2
	Valley Community Healthcare	9119 Haskell Ave, NORTH HILLS, CA 91343	New	8/1/2015	1
	Herald Christian Health Center	923 S San Gabriel Blvd, SAN GABRIEL, CA 91776	Current	7/1/2014	2

We have been successful in maintaining our required ratio of provider to recipients in states that we administer the Medicaid program. In the event that we have a need to increase capacity of our network providers to exceed the requirement of one FTE (1) per 1,500 recipients, we will submit a detailed explanation to DHCFP for approval. We will include our detailed plan to ensure that recipients are still receiving the standard access, quality of care and not impacted by the increase capacity request.

3.6.5.6 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.

We currently administer Medicaid program in California, Florida, Illinois, New Jersey and New York. Our Medicaid networks have an average of 96% of offices currently accepting new patients. On a monthly basis we generate a report showing the percentage of network providers currently accepting new patients. If there are changes, we will monitor access by generating a GEO report to ensure that we continue to meet access standards.

Upon award of the Nevada Medicaid and Check Up contract, we will follow the same process to monitor the network. Within our current Nevada provider network, 98% of participating providers accept newly eligible recipients. LIBERTY is committed to making sure that our provider networks meet the DHCFP access requirements at all times. This includes but is not limited to ensuring that at least fifty percent (50%) of PDPs must accept eligible recipients at all times within the service area, as required by DHCFP.

3.6.5.7 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.

We contract with Endodontists, Oral Surgeons, Periodontists, Pediatric Dentists, Orthodontists and Prosthodontists. We also focus on contracting with additional pediatric dentists with expanded hours to ensure access to care for young children who may have difficulty in receiving treatment from a "regular" dental provider.

We continually develop and initiate specialty recruitment strategies to ensure we have coverage for all specialty types whenever we have membership growth in a region or city, changes in our provider network, when needed improvements in accessibility and appointment times are identified, or when our specialty referral staff has identified specific network needs.

We monitor our provider network on an ongoing basis to ensure that we are meeting DHCFP and LIBERTY access requirements. Our comprehensive strategy to identify gaps in provider specialty types is aligned with our overall process in monitoring our network.

- ***GeoAccess reports— we produce GeoAccess reports monthly to ensure that our network is adequate for the recipients and meets DHCFP requirements. In addition, we review reports to ensure that we meet the requirement of having at least two specialists in their service area and at least one (1) specialist per 1,500 recipients per service area.***
- ***Review of member grievance and appeals—our ongoing review of member grievances and appeals provides insight into network access issues.***
- ***Member utilization trends and out-of-network utilization trends—we review any changes in member utilization trends for a particular specialty or an increase in out-of-network utilization, which can indicate that there is an access issue for our members.***
- ***Review of input from of Internal Response Unit (IRU) -- our Internal Response Unit (IRU) was created within the Member Services Department to support our providers and members in resolving escalated cases and ensuring continuity of care. The IRU is staffed by Customer Care Specialists ("Specialists"), who are trained in all aspects of the call center, and possess the skills required to perform case coordination activities. Our IRU team works closely with the Dental Director, is on the front line of recipient and provider issues and able to quickly recognize when we have an issue in our network. If an issue is identified, the IRU will immediately contact the Provider Relations staff with the network concern. The***

IRU will also assist the recipient with finding an immediate solution for the network issue. Additionally, the IRU will meet with the Provider Relations monthly to discuss any other access, availability, and capacity trends they recognize.

We conduct regional monthly Provider Relations meetings, during which we review input from all of the above sources. The meeting is joined by all operations areas including the Member Services Department, the Claims Department, the Grievance and Appeals Department, Provider Relations Department, Network Managers, Dental Directors, and Dental Consultants.

During these monthly meetings, we collaborate to review information from all of the departments to identify specialty types where access may be limited. If a specialty type or geographic area is identified, we create a strategy to improve access to meet DHCFP requirements. We then run a dentist universe report to identify any additional providers of that specialty type within the area and begin our recruitment process to contract with these providers.

If there is not an available specialist within the required radius of the recipient's home, we assist the recipient in finding an out-of-network provider. Once a provider has been identified, we will contact the provider and send a referral request to them for confirmation. We will agree to pay the out-of-network provider for the service(s) performed according to the agreed upon fee. The referral confirmation will include our payment in full, and the provider is instructed to not seek any payment from the recipient for covered services. Unless we become aware of a quality or other issue with the out-of-network provider, we will attempt to recruit the provider to join the Nevada Medicaid network.

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

A. 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;

We have experience contracting with providers who can treat recipients in a hospital setting or surgery center. We educate providers that recipients have emergency dental services provided in a hospital through their medical MCO benefit using the following methods:

- ***Provider Manual***
  Our Provider Manual outlines rules and regulations by state and program. For Nevada Medicaid, we will dedicate a section about accessing emergency services in a hospital, emergency room, or ambulatory surgery center and make sure there is clear direction for providers that recipients have these benefits as part of their medical MCO benefits.

- ***New Recipient Welcome Package***
  We will provide a Welcome Package for recipients which will include an introduction to LIBERTY amongst other instructions. We will commit to providing educational materials regarding emergency services performed in a hospital, emergency room or ambulatory surgery center.

- ***Orientation with providers and their staff conducted by LIBERTY's Network Manager***

- ***Additional education and communication with LIBERTY Member Services Representative***

B. PDP Appointments

1. Urgent care, including urgent specialty care, must be provided within 24 hours.
2. Therapeutic and diagnostic care must be provided within 14 days.
3. Routine or preventive dental services for eligible recipients within six (6) weeks in accordance with the American Academy of Pediatric Dentistry (AAPD) periodicity schedule.
4. 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.

C. Specialist Appointments

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

1. Same day, emergency appointments within twenty-four (24) hours of referral;
2. Urgent appointments within three (3) calendar days of referral;
3. Routine appointments within thirty (30) calendar days of referral; and
4. Vendor must allow access to a child/adolescent specialist(s) if requested by the parent(s).

We are able to comply with DHCFP's timeframes for maximum appointment wait times, which vary by degree of urgency. They include the following:

For PDPs

- ***Routine and preventive appointments – within six (6) weeks***
- ***Therapeutic or diagnostic appointments – within fourteen (14) days***
- ***Urgent/emergency appointments – twenty-four (24) hours***
- ***Referrals to specialty care – within thirty (30) days***

For Specialists

- ***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***
- ***Child/adolescent specialists – allow if requested by the parent(s)***

All of these standards will be incorporated into our provider agreements, provider manual, communications to providers (i.e., newsletters, fax-blasts, and service calls), and provider training materials.

Figure 3.6.5.8-1 ***provides how well our existing network complies with the benchmark for initial routine appointments.***

FIGURE 3.6.5.8-1 LIBERTY NEVADA NETWORK ROUTINE APPOINTMENT RESULTS

Nevada			
Category	**Benchmark**	**Standards**	**% within standards**
Initial Appointment	98%	30 days	**100.0%**

D. Appointment Standards

The vendor shall have established written policies and procedures:

1. 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.
2. Concerning the education of its provider network regarding appointment time requirements, the vendor shall:
    a. Monitor the adequacy of its appointment process and compliance; and
    b. Implement a Plan of Correction (POC) when appointment standards are not met.

Our policies and procedures and contract language will require that our Nevada providers meet the Nevada Medicaid appointment availability requirements for Urgent Care appointments within 24 hours and routine or preventive dental services to be provided within six weeks. Additionally, wait time for scheduled appointments cannot be more than one hour (unless the dentist is delayed due to an emergency).

We educate our providers on appointment availability standards and requirements during the contracting and onboarding process and during our new provider orientation sessions. Additionally, this information is available in the provider manual and online.

We audit our network for appointment availability using a variety of methods. Initially, during new provider orientations and service calls, our Network Manager will ask the offices their standard appointment wait times and in-office wait times. If there are discrepancies with LIBERTY standards or State requirements, our Network Managers use these discussions as education opportunities to train them on what is expected and required.

During our annual audit calls, as well as during the orientations and service calls/visits, the office staff is asked the average wait time for patients. Our Network Manager will use the average wait time given and update the provider file within our MIS system. We run quarterly reports outlining all offices that were surveyed on their in-office wait time.

If the appointment standards are not met, the office staff will be notified that they did not pass the audit and an education plan will be initiated to educate the provider and staff on the appointment availability guidelines. Further actions with these offices may include:

- ***Verbal re-education.***
- ***Halt referrals to office, and resurvey (e.g. in 1, 3 or 6 months).***
- ***Corrective Action Plan (CAP) requested. A CAP letter to be sent to office and written response requested. Corrective action plans can include such items as:***
  - ***Staff education on appointment availability requirements,***
  - ***Posting the requirements in the office,***
  - ***Modifying emergency protocols of office,***
  - ***Hiring additional staff/hygienist, etc.***

We have comprehensive monitoring, tracking, and enforcement systems in place to further ensure that network providers meet standards for timely access to care and services.

We have multiple methods for monitoring and tracking whether providers are meeting access and appointment wait timeframes, including; regularly scheduled provider

service calls/visits, "secret shopper" calls, recipient calls to Member Services and written or verbal grievances.

In addition to the initial in-person visit for training with network providers, our assigned Network Managers conduct provider service calls or visits at least once annually, or as often as needed. For example, a Network Manager will visit the provider onsite if there is a high number of Nevada Medicaid recipients seen, or if there is a new staff member at the provider's office. At each provider service call or visit, the Network Manager collects information about the provider's appointment wait times, and whether the provider is accepting new members.

In addition, on a biannual basis, we send out a fax blast to all network providers, asking them to confirm their office hours, appointment wait times, and if they are taking new members.

Although our experience is that providers rarely misrepresent their appointment wait times to our staff, even if they are exceeding the required timeframes, we also conduct "secret shopper" calls to our network providers as a secondary method of determining the actual times that the members wait to get an appointment. We utilize a subset of our Member Services Representatives who are trained specifically in the soft skills necessary to accomplish successful "blind" call surveys.

Acting as a member's parent/guardian who is requesting an appointment, the caller enquires about appointment accessibility for initial examinations, preventive dental care appointments, hygiene treatment, routine care, and emergency care. The caller also enquires about appointment wait times for both general dentistry and specialist appointments. A report summarizing the results of the calls is prepared under the direction of the Access and Availability Committee, which then determines any necessary corrective actions. If the need for corrective actions is identified, the Committee forwards the information to our Provider Relations department for immediate feedback to the provider.

We have established the dedicated, internal position of Access & Availability (A&A) Coordinator within our Quality Management (QM) Department. The A&A Coordinator work intimately with our internal operational departments to communicate, monitor, and enforce LIBERTY's access and availability standards.

3.6.5.9 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.

We have policies and procedures and will have contract language in place to help ensure that our providers are meeting the Nevada Medicaid appointment availability requirements for Urgent Care appointments. LIBERTY educates our providers on appointment availability standards and requirements during the contracting and onboarding process and during our new provider orientation sessions. Additionally, this information is available in the provider manual and online.

3.6.5.10 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.

We are committed to meeting the access requirements set forth by Nevada Medicaid program. In the event that a provider is not able to meet access standards and there is appropriate reason(s) to keep the provider in the network, we will submit to DHCFP, in writing within 15 days, a request to allow alternative standards that are experienced within the same geographic service area. Our ultimate goal is to ensure that alternate access standards will not impact access and quality of care to the recipients.

3.6.5.11 Provider Terminations

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

As soon as we become aware that a network provider is leaving the plan, the Network Manager assigned to that provider contacts the office to obtain more information on termination reason(s). Our goal is to keep quality providers in-network and minimize disruption to recipients. If providers still decide to leave the network, the Network Manager submits a Termination form. Upon receipt of the form, our Professional Services department enters the information in our system, creating an action that flags when recipient notification letters need to be generated so that we provide the required

notice within the required time frame. We then generate a report identifying recipients who received services from the terminated provider.

Within 15 business days of the termination notice, we will send written notice to each of the recipients that his/her provider is no longer available and provide them with a list of network providers that are currently accepting new patients in their area, and assist in their selection of a new PDP.

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

If LIBERTY initiates a de-credentialing, disenrollment or termination of a provider due to credentialing or other reasons, we will notify 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:

1. Provider/patient files.
2. Audit reports and findings.
3. Medical necessity reviews.

If LIBERTY takes a professional review action that adversely affects the network status of a dentist for a period longer than 30 days or accepts the termination of the LIBERTY contract with a dentist while the dentist is under an investigation by LIBERTY relating to possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding, LIBERTY will report to the DHCFP the following information:

- ***The name of the practitioner involved,***
- ***A description of the acts or omissions or other reasons for the action or, if known, for the surrender, and***
- ***Such other information respecting the circumstances of the action as appropriate such as; provider's patient files, medical necessity reviews and audit reports and findings.***

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.

In this situation, our report will be filed with the DHCFP Provider Enrollment Unit within five business days after the termination so that necessary requirements from the DHCFP can be fulfilled.

3.6.5.12 Notification of Significant Network Changes

A. 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.

B. 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.

Although we will attempt to find a solution to any provider situation that arises, in the case of a significant network that will impact our provider network, we will notify DHCFP: (a) within one (1) business day of any unexpected change that would impair our provider network, (b) 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. We will include information about the nature of the change and how the change affects the delivery of care to recipients, in the format that is specified by DHCFP.

We will assess the network and volume of recipients being treated and who are assigned to providers in the area that is impacted to assess whether the remaining network will be sufficient to meet availability and access standards. We will meet with dental offices (general dentists and specialists) in the geographic area that will be affected by the changes and develop a transition plan. The transition plan will include:

- ***Notification to affected recipients***
- ***Reassignment of affected recipients to new Primary Dental Provider***
- ***Information for affected recipients on how to contact LIBERTY for any transition of care or access concerns***

- ***Review of authorizations in place for affected recipients and targeted outreach/adjustments of authorizations to enable affected recipients to continue treatment***
- ***Coordination with providers to complete treatment; define what is covered in the transition and what needs to be referred to a new dentist***
- ***Evaluate the dental access for recipients using GeoAccess reports and through meeting with dentists in the area***

Upon receiving confirmation of network changes, Network Managers will review the provider office panel in the area affected by the termination, and identify which dental offices have the capacity to receive the transferred recipients. Our goal is to minimize disruption for recipients, thus we reassign each recipient based on dentists who have open panels in their geographic area closest to their home and will take into account language(s) spoken by the recipient and dentist. We will send written notice to recipients of their new provider assignment. The notice will contain information on recipient re-assignment and will provide the phone number for the Member Services Department. The notice will also advise the recipient that they can change the dentist that they were assigned to in the letter. In case of the immediate termination of a contracting general dentist due to potential of imminent harm to a recipient, notification of the transfer will be provided to recipients immediately upon such termination.

Once we have reassigned these recipients to a new dental home, we will provide the updated list of recipients to the providers. The providers will have access to the recipients' treatment and utilization records through the provider portal. Our Provider Relations staff will also work with the terminated provider group to review any recipient-specific issues or information. As long as the termination reason is not due to imminent harm to patient care, loss of dental license, or conviction of fraud/abuse, we will offer a 120-day transition of care period for recipients to complete covered medically necessary treatment which is in progress, has been prior authorized or has been started but not completed with the termed provider. We will work with the terminated provider on a case by case basis where needed.

As part of LIBERTY's provider agreement contract, we do expect providers to complete all services started prior to the effective date of termination.

We will notify DHCFP of any change to our network that will substantially affect the ability of recipients to access services as soon as we receive notification from providers or within fifteen (15) calendar days before the change, in a format that is specified by DHCFP. Our goal is to ensure that we maintain access and quality of recipient care regardless of any change to our provider network that may result in a reduced delivery of medically necessary covered services.

3.6.5.13 Prohibited Practices

The vendor shall take affirmative action so that recipients are provided access to covered medically necessary services without regard to race, national origin, creed, color, gender, 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:

A. Denying or not providing an enrolled recipient a covered service or available facility;
B. Providing an enrolled recipient a covered service which is different, or is provided in a different manner, or at a different time from that provided to other recipients, other public or private patients, or the public at large;
C. Subjecting an enrolled recipient to segregation or separate treatment in any manner related to the receipt of any covered medically necessary service, except where medically indicated;
D. The assignment of times or places for the provision of services on the basis of race, national origin, creed, color, gender, gender identity, sexual preference, religion, age, physical or mental disability, or health status of the recipient to be served;
E. The vendor may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a recipient who is his or her patient:
   1. For the recipient's health status, dental care, or treatment options, including any alternative treatment that may be self-administered;
   2. For any information the recipient needs in order to decide among all relevant treatment options;
   3. For the risks, benefits, and consequences of treatment or non-treatment; and
   4. For the 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.
F. Employing or contracting with providers excluded from participation in Federal health care programs. [42 CFR 438.214(d)]; and
G. Charging a fee for a medically necessary covered service or attempting to collect a co-payment.

We perform comprehensive, affirmative efforts to ensure all recipients are provided access to covered medically necessary services without regard to race, national origin, creed, color, gender, gender identity, sexual preference, religion, age, health status, or physical or mental disability, except where medically indicated.

Through our contracts and provider manuals, we require our providers to agree to provide services to all recipients, including those with limited English proficiency, visual

or hearing impairments or with diverse ethical and cultural backgrounds, in the same manner, in accordance with the same standards and with the same priority as their other patients. An excerpt from our standard provider contract is conveyed as Figure 3.6.5.12-1 is from our Provider Contract in regards to non-discrimination.

FIGURE 3.6.5.12-1. PROVIDER CONTRACT EXCERPT NON-DISCRIMINATION

(d) Compliance.

i. Non-discrimination. Dental Office shall not, and shall ensure that Dentists and other Dental Office Agents do not, in any way discriminate against Members on the basis of race, color, national origin, ancestry, place of origin or residence, sex, age, religion, sexual orientation, disability, medical condition or health status, marital status, membership in a Dental Plan or program, source of payment, or any other class or status protected by applicable federal and/or state discrimination laws. In addition, Dental Office shall comply with all applicable requirements of 42 U.S.C. Chapter 126 (the Americans with Disabilities Act) and any applicable local requirements concerning adequate space, supplies, sanitation and fire and safety procedures.…"

Similarly, our contracts and manuals strictly prohibit our providers from charging Medicaid recipients a fee for a medically necessary covered service or attempting to collect a co-payment from them. An excerpt of our standard language is conveyed below as Figure 3.6.5.12-2.

FIGURE 3.6.5.12-2. PROVIDER CONTRACT EXCERPT – APPLICABLE COMPENSATION

"…In exchange for the provision of Covered Services to Members, Dental Office shall be compensated in accordance with the applicable compensation set forth in an Exhibit and/or in the applicable compensation addendum or fee schedule based upon the applicable coverage of the Dental Plan(s) in which Dental Office participates. LIBERTY shall pay or deny Dental Office claims in accordance with any applicable prompt payment statutes. Dental Office acknowledges and agrees that all such compensation will be based on the current, applicable Dental Plan(s). Dental Office agrees to accept such compensation as payment in full for the rendered Covered Services.…"

LIBERTY also requires and trains our providers to assist all recipients with obtaining or accessing services, and to have policies prohibiting making improper inquiries regarding a person's race, color, national origin, religion, sex, age or disability. In addition, our provider policies and procedures, captured in our provider manual, strictly prohibit our providers from:

- ***Denying 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;***

In addition, our policies and protocols strictly prohibit us from restricting any provider 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.***

Provider Exclusion Screenings

LIBERTY is committed to preventing individuals and entities that are excluded, debarred, suspended, or are otherwise ineligible to participate in federal or state Health Care Programs or Procurement or Non-Procurement Programs, from direct or indirect affiliation with our company. Since government programs make up the vast majority of our business, we have rigorous internal protocols in place to ensure we conduct all required exclusion screenings upon initial engagement and at least monthly thereafter and, for non-contracted providers, prior to payment; that screenings are properly tracked and monitored; that we immediately and appropriately verify and report exclusions to required oversight agencies, and properly pursue any required

recoupment; and that we maintain all relevant screening documentation for a minimum of 10 years.

The exclusion screenings we perform include an automated, electronic review of the following databases:

- ***The United States Department of Health and Human Services, Office of Inspector General's ("OIG") List of Excluded Individuals/Entities ("LEIE").***
- ***The General Service Administration's ("GSA") Excluded Parties List System ("EPLS")***
- ***State Medicaid Inspector General's Lists of Restricted, Terminated or Excluded Individuals or Entities***
- ***The Office of Foreign Assets Control – Specially Designated Nationals (OFAC)***

In addition, upon initial contract, and at least annually thereafter, LIBERTY requires each participating provider to disclose any person or entity with an ownership interest of five percent or more in the Provider's Office, including disclosure of all owner affiliates and subsidiaries. LIBERTY screens any entities/individuals the provider discloses against the required databases.

Finally, our Quality Management Department also oversees an extensive credentialing process for reviewing and accepting or rejecting the professional credentials of each of our applicant and contracted dental providers. Among other reviews, we perform required individual background history checks on our providers, and review information from the applicable Board of Dental Examiners and other pertinent provider sanction and licensure reports during Credentialing Committee meetings.

3.6.5.14 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.

We understand and will comply with this requirement. Through our network participation mechanisms and through our Centers of Excellence model, our model does create incentives that have the effect of moving patient volume towards our high-performing partners. We also avoid including in our network those providers who do not meet our

quality and other credentialing requirements – or who do not find our payment terms acceptable.

We do not believe these processes conflict with the above requirement, but rather are completely consistent with DHCFP's desire to create an accountable, affordable, and high-quality system of dental care and coverage. Nonetheless, we will fully disclose to DHCFP any incentive arrangements that could conceivably be construed as violating the above requirements, and obtain DHCFP's review and approval.

3.6.6 Provider Contracts

3.6.6.1 The vendor will execute and maintain, for the term of the contract, written provider agreements with a sufficient number of appropriately credentialed, licensed or otherwise qualified providers to provide enrolled recipients with all medically necessary covered services.

As part of the provider contracting process, LIBERTY requires that our providers submit a signed master provider agreement along with our credentialing application for each practicing dentist at the location. Upon successful credentialing of providers, we counter sign the provider agreement and forward an executed copy to the providers for their file. After we enter provider information and activate the contract in our system, we store all contract and credentialing documents in the provide file section of our MIS system.

3.6.6.2 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.

We will share our base provider contract with DHCFP for review and approval before we begin our recruitment effort and before we modify our contracts with our existing Nevada dental network providers. Our Compliance Department will research various regulations and include Nevada and federal requirements to ensure that LIBERTY and our network providers comply with DHCFP requirements. After receiving DHCFP's approval, if there are substantive changes or amendments to the base provider contract, we will further submit to DHCFP for review and approval before implementation. We will make available our provider contracts to DHCFP upon request.

3.6.6.3 The timing and other events associated with provider recruitment must occur in a manner that will ensure meeting the objectives noted within this RFP. The effort must include outreach to providers who are not currently participating in 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.

As an organization founded and led by a dentist, we are committed to establishing and maintaining strong provider relationships. LIBERTY has successfully recruited, contracted, developed, and maintained Medicaid dental provider networks in multiple states. It is LIBERTY's goal to provide the support and resources our network providers need to optimally care for our members.

If LIBERTY is awarded the Nevada Medicaid contract, we will partner with DHCFP and take the following steps to make sure that there is no disruption to recipients' care.

1. Identify Key Providers to Contract. In order to support the growth of the network without disruption to recipients' care, we will work with DHCFP to request a list of providers that shows each dentist's volume of Medicaid recipients, along with claim dollars. This will allow us to prioritize our recruiting efforts to maximize continuity of care, reaching out to those dentists that provide the largest portion of dental care to the Medicaid population.

2. Provide an Endorsement Letter. We will work with DHCFP to provide an endorsement letter for LIBERTY shortly after the award announcement. In our previous recruitment experiences, an endorsement letter affords a huge advantage in enticing providers to sign contracts much more quickly once an award is announced. At minimum, this letter will validate that LIBERTY is the State's selected dental partner for Nevada's Medicaid program.

3. Develop Fee Schedule. We will work closely with DHCFP to ensure that our fee schedule meets the requirements of the Nevada Medicaid program. We will partner with DHCFP to ensure that our efforts to administer dental benefits include cost effective unit pricing.

4. Identify Additional Providers. In addition to prioritizing key providers to recruit by Medicaid recipient volume (see step #1 above), we use our database to identify

Medicaid dentists by county, and we will contact our existing Nevada network, to encourage participation in the Medicaid network.

5. Distribute Recruitment Letters. We will coordinate a mailing to include highly utilized dentists (see step #1), along with additional providers we identified (see step #4). Mailings will include DHCFP's endorsement letter, our provider agreement, a Medicaid addendum, fee schedule, credentialing application and our recruitment flyers.

6. Assemble a Recruitment Team. We will assemble a team of experienced Network Managers that have successfully recruited a Medicaid network in other markets, as well as our current Nevada Network Manager who is already familiar with the Nevada market and has developed great relationships with the dentists. Together, they will contact providers to discuss the award announcement, share our Medicaid experiences in other states, review our mission, assist with contracting questions, and ultimately build and strengthen relationships with the providers.

7. Monitor Recruitment Results. We monitor results by using our recruitment dashboard. This dashboard summarizes the total number of targeted dentists, along with a status of which providers have submitted contracts or are in credentialing, those who have verbally agreed to contract, or are working on making a decision. This dashboard allows us to effectively follow up with Network Managers on a specific provider or status at any time. During an active recruitment project, our Project Management team monitors the dashboard daily to review progress and results; if necessary, we will shift or add resources where needed to ensure we meet our objectives.

8. Generate GeoAccess Reports. During our monitoring of the recruitment effort (step #7), we will generate GeoAccess reports weekly to review adequacy of the Nevada network and identify areas that need further expansion. This will allow us to meet Nevada's recipients' needs by having providers that meet DHCFP's access requirements.

9. Follow Up with Providers. Our Network Managers will follow up with providers after the initial phone call or visit if no decision has been made within 3-5 days. This keeps the momentum going so providers remember our recent contracting discussion. Depending on how close we are to obtaining contract documents, our Network Managers will visit the providers to pick up contracts or even assist them in filling out the necessary documentation.

Network Managers are responsible for obtaining all necessary applications and required contracting information and credentialing documents from the dental providers during the contracting process. Network Managers will work with the dental

offices if they have not yet enrolled in the Nevada Medicaid program to provide enrollment instructions, contact information, and education to help them register with Medicaid. LIBERTY's contracting process requires that each dentist is registered with Medicaid and has a valid Medicaid identification number.

We are aware from this RFP that we can enter into single case agreements with non-Medicaid providers as needed. For providers willing to treat Nevada Medicaid recipients but are outside of Nevada, they must be licensed in their home state of practice in order for us to enter into a single case agreement.

LIBERTY has extensive experience in developing a network within the timeframe requested by clients. Table 3.6.6.3-1 is an example of states where we were successful in building a network organically to meet specific implementation requirements.

TABLE 3.6.6.3-1. NETWORK IMPLEMENTATION TIMEFRAMES

State	Total Providers by Contract Effective Date	Implementation Timeframe	Total Providers in Network after Implementation
Arizona	311	5 months	664
Arkansas	58	6 months	128
Tennessee	164	6 months	457
South Carolina	226	6 months	701
Mississippi	52	6 months	124
Florida	12,867	6 months	14,737
New Jersey	712	6 months	11,664

3.6.6.4 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.

LIBERTY's provider agreement requires that providers comply with our policies and procedures. Below in Figure 3.6.6.4-1 is an excerpt of a Compliance section of our provider contract.

FIGURE 3.6.6.4-1. PROVIDER CONTRACT COMPLIANCE EXCERPT

ii. Compliance with Policies and Procedures. Dental Office shall, and shall ensure all Dentists and other Dental Office Agents, comply fully with, and abide by, the rules, policies, and procedures that LIBERTY has established or will establish, including, but not limited to, those related to timeliness of access to care, coverage rules and payment, quality improvement/management, utilization management (including, but not limited to, precertification procedures, referral processes or protocols, and reporting of clinical encounter data), member grievances, provider credentialing, and LIBERTY's compliance program. Dental Office shall, and shall ensure Dentists and other Dental Office Agents, also comply with all policies, procedures and guidelines identified in the Provider Manual, which may be amended from time to time by LIBERTY.

iii. Compliance with Applicable Laws. Dental Office shall, and shall ensure all Dentists and other Dental Office Agents, comply with all applicable state and federal laws, regulations, rules and guidelines.

We have a systematic process for the ongoing review and evaluation of our network providers to ensure that they comply with our policies and procedures. This can be assessed through the review of member satisfaction survey results, complaints and grievance tracking reports, utilization patterns, and desktop audits to identify potential quality issues.

If we identified that a provider is not complying with our policies and procedures, below are actions that we take to address:

- ***Schedule a counseling session to discuss with the provider and/or office staff on the specific issue. Our goal during the counseling session is to identify the cause of the issue, partner with the provider to resolve the issue; we may include our Dental Director in the meeting when appropriate.***
- ***Re-educate provider on the section(s) or area(s) that they did not comply***
- ***Follow up within x days to ensure compliance (timeframe depends on the severity of the issue)***
- ***Continue to monitor if improvement is shown and follow through until provider is in compliance***
- ***Close the office to accept new recipients if no improvement is shown within 60-90 days (timeframe may be shorter depends on the severity of the issue)***
- ***Terminate the office from the network if there is inadequate effort or a refusal to comply with our policies and procedures.***

3.6.6.5 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.

Our provider contract does not allow providers to provide financial or other incentives to providers and subcontractors for denying, reducing, or limiting medically necessary services to a recipient. Below in Figure 3.6.6.5-1 is an excerpt from our provider contract.

FIGURE 3.6.6.5-1. PROVIDER CONTRACT EXCERPT

Fees. In exchange for the provision of Covered Services to Members, Dental Office shall be compensated in accordance with the applicable compensation set forth in an Exhibit and/or in the applicable compensation addendum or fee schedule based upon the applicable coverage of the Dental Plan(s) in which Dental Office participates. LIBERTY shall pay or deny Dental Office claims in accordance with any applicable prompt payment statutes. Dental Office acknowledges and agrees that all such compensation will be based on the current, applicable Dental Plan(s). Dental Office agrees to accept such compensation and any applicable Cost Sharing as payment in full for the rendered Covered Services. Dental Office acknowledges that LIBERTY shall not be liable in any way for payment for Covered Services rendered by Dental Office to Members to the extent such payment is the responsibility of the Payor under the applicable Dental Plan. In addition, LIBERTY shall not directly or indirectly make payment to a Dental Office as an inducement to reduce or limit medically necessary services furnished to a Member.

3.6.6.6 The use of "gag" clauses in Provider contracts is prohibited.

LIBERTY does not support or include "gag" clauses in our provider contracts.

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

Our executed provider contracts are stored in our MIS system and can be accessed at any time. We will make available to the DHCFP of provider contracts within five (5) business days of the request.

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

LIBERTY has participated in various events in support of the Medicaid programs in multiple States, such as health fairs, free oral screenings, golf tournaments and sponsorship to FQHCs. We will continue to support and participate in any future grants awarded to Medicaid that can favorably affect Nevada's recipients.

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

Network Managers are responsible for obtaining all necessary applications and required contracting information and credentialing documents from the dental providers during the contracting process. Network Managers will work with the dental offices if they have not yet enrolled in the Nevada Medicaid program to provide enrollment instructions, contact information, and education to help them register with Medicaid. Our contracting process requires that each dentist is registered with Medicaid and has a valid Medicaid identification number.

3.6.7 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.

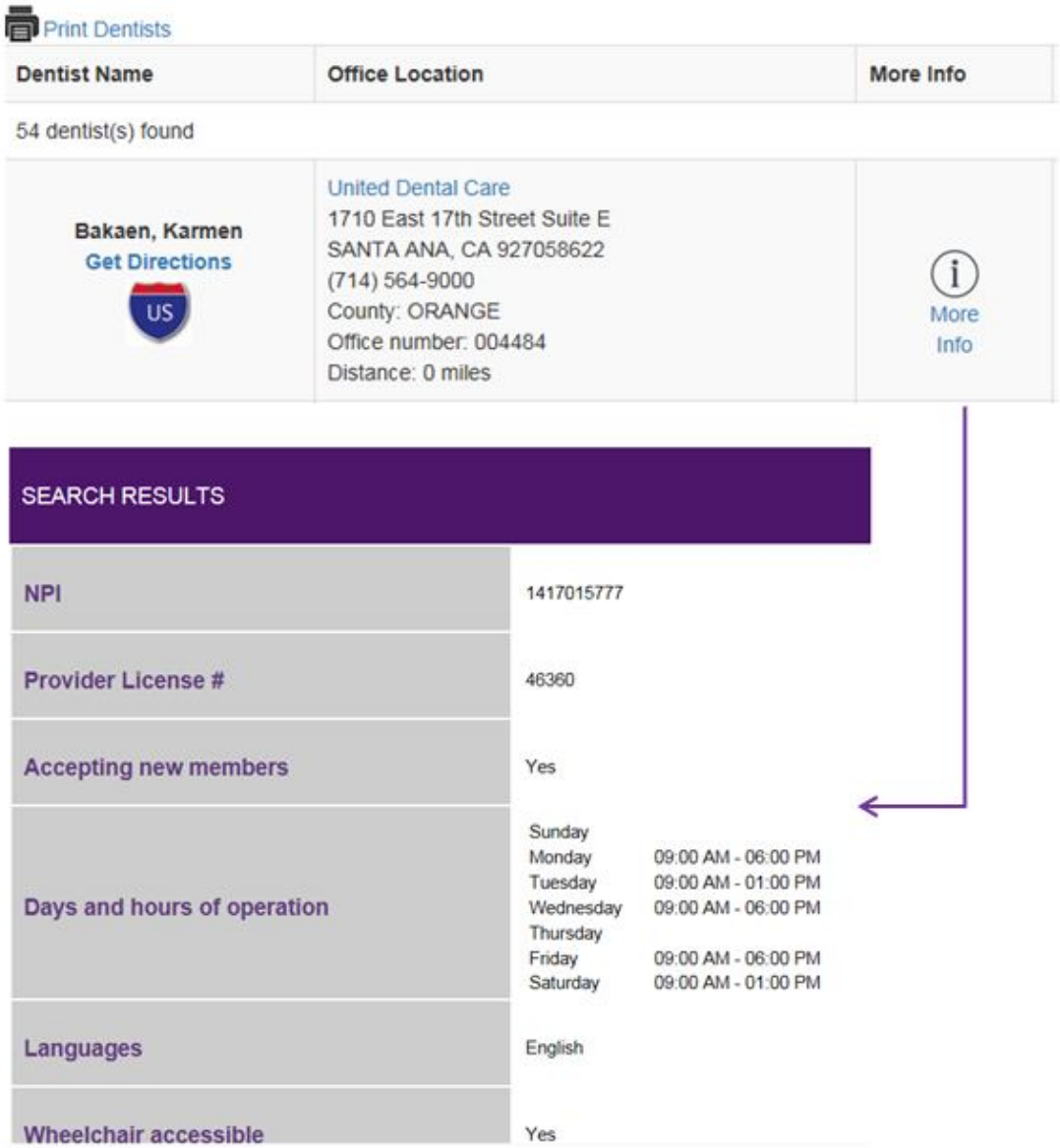
On a monthly basis, no later than the tenth (10) day of the month, the Vendor will submit to the DHCFP a list of all providers who have been enrolled and a list of all providers who have disenrolled, deactivated, terminated, decredentials or been removed from the active provider enrollment in the previous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

Our provider directory assists members in finding and accessing care where they are most comfortable. The provider directory helps members find providers that fit their preferences (e.g. gender, location, accessibility, etc.). The provider directory is available in hard copy in our threshold languages and on our website.

When we are notified that a provider is no longer accepting new members, we immediately "close" the provider in our system. This action prevents the provider from appearing in our online provider directory or our web search. In addition, our Member Services Department sees the "close" status and will refer members to the next closest provider. The results of our findings will be reported to DHCFP on a quarterly basis.

Please find our dentist search sample in Figure 3.6.7-1.

FIGURE 3.6.7-1. SAMPLE DENTIST SEARCH



3.6.8 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.

We have extensive experience with a membership base that is culturally, linguistically, geographically, and demographically diverse. Understanding the multi-cultural nature of our member populations, we ensure our written communications are available in various languages according to the need of the area we are serving.

We also recognize that our membership has varying literacy rates and that Medicaid subgroups have many persons with low literacy. LIBERTY utilizes readability statistics tools, including Flesch-Kincaid and will ensure all written materials are at the appropriate eighth (8th) grade reading level, in the proper font sizes, translated into all required threshold languages (including both English and Spanish), and in formats for the visually and/or hearing impaired prior to submitting to DHCFP for approval. We understand and agree that all initial mass letter mailings and brochures or subsequent changes in content for recipients must be approved by DHCFP and if DHCFP does not respond within ten (10) business days we may consider the communication approved.

Our local Nevada-based team will be involved in the creation of these materials to ensure that we reflect the regional culture in our communications. We will work with DHCFP to create an efficient process to expedite submission and approval. We will revise, finalize, and return the documents to DHCFP for final review within ten (10) business days after receipt of revisions identified by DHCFP. We further agree that all costs associated with developing, printing and distributing materials are our responsibility.

Our Director of Fulfilment will ensure that all member-facing materials receive DHCFP approval prior to printing and/or releasing materials for mass distribution, whether printed or electronic. If materials have not received DHCFP approval within 10 business days of submission, the Director of Fulfilment will send the materials back to the appropriate Account Executive and/or Director of Compliance to ensure approval is received prior to distribution.

3.6.9 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.

We communicate with our network providers as a group through the distribution of quarterly newsletters and provider alerts via fax blasts, in which we continually update them on policies, guidelines and new legislation. We also include reminders on our Language Assistance Program, Accessibility Standard expectations, and Quality Assurance requirements. Before sending out a general communication to our providers, we will send a copy of the content to DHCFP for review.

3.6.10 Provider Policy and Procedure Manual

3.6.10.1 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.

3.6.10.2 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:

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

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

C. Prior authorization procedures and requirements;

D. The procedures for claims administration;

E. Provider credentialing criteria;

F. Provider network management;

G. The benefits and limitations available to enrolled recipients under the program, including any restrictions on recipients' freedom of choice imposed by the program and any/all payment obligations;

H. Administrative and billing instructions, including: a list of procedure codes; edits; units; payment rates; and all pertinent information necessary to submit a clean claim in a timely manner;

I. Procedure to dispute adverse payment and contract decisions; and

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

We understand and will comply with the provisions of Section 3.6.10, Our Provider Policy and Procedure Manual will include all minimum requirements outlined in 3.6.10.2 A-J.

Quality assurance and commitment to recipient care begins with up-to-date, accurate policies and procedures that reflect current processes and changes in federal, state, LIBERTY, and DHCFP requirements. We understand the importance of adhering to compliance regulations at all times, and diligently maintain our information and processes to reflect industry standards.

When preparing our Provider Policy and Procedure (Provider Manual), we include all operational areas to ensure all relevant topics are covered so providers know how to administer our programs and specific State Medicaid program. We have an approval process that includes final review by our Dental Director and/or Chief Dental Officer. Our policies and procedures are reviewed and updated at least annually or more frequent as needed when changes occur.

Our Provider Manual is a comprehensive document designed to inform network providers of our guidelines and requirements to assist them in caring for Nevada Medicaid recipients. We will maintain a Nevada approved manual, and we will update this to include all requirements and changes specific to Medicaid policies and procedures. This includes, but is not limited to, appointment times for periodic evaluations, urgent (requiring immediate attention), non-urgent (problem focused), after hours, and whether provider accepts new membership. Additionally, any other policy and procedure manuals (i.e., information security, physical access, information technology, etc.) that are affected by internal, DHCFP or governmental regulation changes will also be updated on an ongoing basis.

Training is a critical element in ensuring the success of the Nevada Medicaid program. Providers and their staff must be knowledgeable in the terms and expectations of DHCFP as outlined in our Provider Manual, and be equipped to comply with all aspects

of the program. If LIBERTY is awarded this contract, DHCFP providers and their staff will be given comprehensive, in-office training on the DHCFP-approved Provider Manual by an assigned Network Manager. Since they conduct provider training in-person, our Network Managers can get a sense of where the provider's staff may need additional instruction or explanation, and tailor the training accordingly. Providers can additionally obtain an electronic copy of the Provider Manual on our provider portal, or contact our Member Services department to obtain a hard copy at any time.

At the end of the initial training, we will leave our Provider Manual and Orientation Brochure with the provider's staff. This brochure highlights and summarizes the critical elements of the Provider Manual in an easy-to-read format. Topics covered in the Orientation Brochure include patient access and quality standards, specialty care referrals, eligibility, grievance and appeals information, and contact information for the provider's assigned Network Manager, as well as general information and claims submission instructions. A sample of our Orientation Brochure is enclosed as Attachment 8. This brochure will be customized for the Nevada Medicaid program to meet specific DHCFP requirements.

In addition to reviewing the Provider Manual with providers and their staff, our Network Managers also review the following:

- ***Benefit schedules – we review benefit plans that providers currently participate to ensure that they understand patient copayment or payment obligation if applicable***
- ***Provider Reimbursement Schedule – we provide and review a copy of providers' fee schedule to ensure that they understand how the program is reimbursed and how to submit claims to ensure prompt payment***

To ensure that our team is aware of new requirements, our Compliance department monitors and researches any changes to the State regulations or requirements and makes the necessary changes to all applicable manuals accordingly, and in a timely manner. As a general rule, we review the contents of all policies and procedures annually for updates, and as needed. In all instances, we would collaborate with DHCFP to alert you to industry revisions, as well as ensure all changes to our manuals remain in compliance with your specifications.

When policies and procedures need to be revised, whether initiated by LIBERTY or DHCFP, we will make necessary updates to our Provider Manual and submit a hard copy and an electronic copy to DHCFP for approval. As soon as a revised Provider Manual is approved, we update our provider portal and website to ensure that providers can access the most current version. We send notification to providers of the changes via fax blasts or mail.

By maintaining an updated Provider Manual, we ensure that our providers remain in compliance and will adhere to the expectations set forth by the Nevada Medicaid program. This level of training provides recipients with the quality of service they have come to expect from LIBERTY.

3.6.10.3 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.

We will communicate with providers through the distribution of quarterly newsletters and provider alerts, where we continually update them on policies, guidelines and new legislation. We also include reminders on our Language Assistance Program, Eligibility Verification, Accessibility Standard expectations and Quality Assurance requirements. Our Language Assistance Program utilizes both our internal multi-lingual Member Services staff and interpreter services, which are available to both the dentists and their staff. Service calls and visits are all tracked and reported on a monthly basis to our Quality Management committee. When an urgent message needs to be sent out to the network we use a fax blast system to immediately send out our announcements and post them on our online provider portal.

We can conduct provider workshops at specified geographic area annually; however, we find that provider site visits strengthen our working relationships with the providers. Site visits allow our Network Manager to discuss with providers and their staff any questions or feedback that they have in regards to the program. We evaluate the feedback received to address and make necessary enhancements to our policies and procedures so we can better serve the Medicaid recipients.

3.6.11 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.

To maintain and support a provider network that creates the highest standard of care for our recipients, we assign a Network Manager to each dental provider. Our Network Managers are the liaisons to our providers, and are their main point of contact whenever a need or question arises. The Network Manager performs an initial service visit to the provider's office upon contract execution, and then follows up annually, or more frequently, if indicated. Service visits further strengthen the working relationship and provide assistance with issues or questions.

Additionally, the Network Manager provides education and training to our providers and their staff during the onboarding process, after staff changes, and upon request. Our Network Managers encourage and support providers to participate in various community-sponsored events, such as health fairs, as a way to provide free screenings and conduct recipient outreach.

Our Network Managers maintain and ensure the highest quality in our provider networks through various approaches: 1) Conducting service calls 2) Reviewing utilization patterns 3) Addressing recipient complaints, and 4) Monitoring provider networks. These are each described in more detail below.

1. Conducting Service Calls

a. Adding/deleting and periodic contract renewals

At each provider service call, the Network Manager confirms that the provider profile is current. This includes, but is not limited to, confirming wait times for periodic evaluations, wait times for non-urgent and urgent appointments, languages spoken, after hours, dentists participating at the practice, and whether they are accepting new recipients.

b. Provider education

Next, the Network Manager discusses any new policies or procedures that have been implemented that could impact Nevada recipients. We remind providers and their staff where to locate and request a copy of the Provider Manual. In addition, we review any concerns or issues that need to be discussed with providers or their staff. This strengthens our partnership as we work together to resolve issues.

Each service call is documented using our Provider Service Report (PSR) (Figure 3.6.11-1) summarizing the discussion and findings. If there are changes with the provider profile, we update the information in our system accordingly.

FIGURE 3.6.11-1. PROVIDER SERVICE REPORT

PROFESSIONAL RELATIONS
Provider Service Report

Facility Name	[redacted]	Facility #	FQHC5062	Rpt Date	03/14/2015
Address	[redacted] LOS ANGELES, CA 90012-2365	County	LOS ANGELES	Network Manager	[redacted]

REASON FOR VISIT

☐ Orientation ☐ Grievance/Appeal process explained

☐ Low Utilization ☐ QM/UM Follow-Up ☒ Routine Service ☐ Provider Request ☐ Other:

AVAILABILITY / ACCESSIBILITY

INITIAL: 15 Days | HYGIENE: 20 Days | ROUTINE: ~~20~~ 15 Days | IN-OFFICE WAIT: 20 Minutes | SPECIALTY ACCESS: Days

Emergency 24 Hour: ☑ Yes ☐ No **Recall System:** phone calls

Standards Met: ☒ Yes ☐ No If no, explain:

ADD ASSOCIATE(S)

1.	NPI	
2.	NPI	
3.	NPI	

OTHER FACILITY UPDATES:

FACILITY INFORMATION

OFFICE NPI: [redacted]
CONTACT: [redacted]
EMAIL: [redacted]
LAST SERVICE CALL: 02/05/2015
LAST SERVICE VISIT: 11/25/2015
LANGUAGES (OTHER THAN ENGLISH) : Chinese, Cantonese, Mandarin, Spanish, Vietnamese Tagalog

GROUP PRACTICE:
ACCESS CODE: 38705296
WHEELCHAIR ACCESS: ☑ Yes ☐ No
SPECIAL NEEDS: ☑ Yes ☐ No

OFFICE PHONE: [redacted]
OFFICE FAX: [redacted]
ROSTER ONLY: ☐ Yes
SUPPRESS PAPER ROSTER: ☑ Yes ☐ No

FACILITY HOURS

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
08:30 AM to 05:00 PM	08:30 AM to 05:00 PM	08:30 AM to 05:00 PM	08:30 AM to 05:00 PM	08:30 AM to 05:00 PM	08:30 AM to 05:00 PM	

CONTRACTS

Health Net CADuals [EXM] Health Net PHP [OPN] Health Net PHP Adults [OPN] LA Care CADuals [OPN]
PHP [OPN] PHP Adults [OPN]

PROVIDERS & NPI NUMBER

[Dentist] [redacted] [redacted] [Dentist] [redacted] [redacted] [Dentist] [redacted] [redacted]
[Dentist] [redacted] [redacted]

HOSPITAL PRIVILEGES: ☐ Yes ☑ No **SEDATION:** ☑ Yes ☐ No
HOSPITALS:

FOLLOW UP

Is Follow-Up Required? ☐ YES **Date of Next Visit?** ☒ NO

REVIEWED AT VISIT / CALL (List topics discussed and provide a summary)

Met with office Manager, Monica. Verified Appt. Availability for Initial and Hygine Appts. Routine Appts. will be updated to 15 days. Reminded Monica to view Recently published provider Newsletter. Update languages spoken - Remove cantonese; add Tagalog. Discussed PHP utilization; office will continue to reach out to PHP children to set Appointments. Providers, facility Hours, Recall system, and 24 Hour emergency Contact have been verified.

Office Representative Signature: Monica **Office Contact Name:** MONICA

Network Manager Signature: [signature] **Date:** 03·16·15

Revised 6/10/2011

2. ***Reviewing Utilization Patterns – discipline/termination***

Our core MIS system allows us to identify unique elements on claims through custom logic, providing us with an opportunity to evaluate for Fraud Waste and Abuse (FWA) or other outliers. Key elements of data are then analyzed by our Utilization Management team to help minimize or eliminate potential FWA, while maximizing effectiveness of care. If a provider is identified as having any aberrant utilization pattern, the Network Manager is notified. The Network Manager will schedule a counseling session with the provider, the provider staff, and our Dental Director to review claims in question, discuss patterns identified, evaluate standards of care, and determine next steps. A summary of the meeting is documented using our Provider Service Report (PSR). We also take this opportunity to educate providers and review our general standards of care, reminding them of our policies and procedures. A follow up meeting is scheduled within 60 or 90 days (depends on the severity of the concern) to evaluate if there was improvement. If no improvement is made, we may restrict the provider to new recipients and ultimately proceed in terminating the provider from the network. An example has been provided in the sidebar.

If we do proceed with restricting or terminating a provider, we will evaluate the overall network to ensure that recipients continue to have ample choices, and communicate this change to the membership. Our ultimate concern, whenever there is a change to the provider network, will be that all changes to access and availability are clearly and timely communicated to Nevada recipients.

3. ***Addressing Recipient Complaints***

We are able to track and trend recipient complaints, including those that are provider-specific. If a trend is identified where a provider has a high number of complaints, the Network Manager is notified. The Network Manager schedules a counseling session with the provider and their staff to discuss the specific complaints. The Network Manager reviews our policies and procedures as they apply to the complaint. If necessary, the Network Manager may conduct an unannounced service call. A summary of all meetings are documented using our Provider Service Report. Depending on the nature of a complaint, the Network Manager follows up to ensure any corrective action is completed until the issue is resolved.

4. ***Monitoring Provider Networks***

Network Managers are highly familiar with their assigned territories, and use various tools and reports (such as GeoAccess) to confirm when it is necessary to add dentists to the network. GeoAccess reports are reviewed at least quarterly and as often as needed when changes impact the network. When there is a change to the

provider network, such as termination or a provider not accepting new recipients, Network Managers research our system to identify existing providers that are currently participating within 5 or 10 mile radius. This determines the urgency of adding new dentists to the network.

5. ***Re-Credentialing***

Our provider re-credentialing cycle repeats every three years (or more frequently should an issue be identified). Sixty days before the re-credentialing date, the dentist will receive a written request to submit required documents to our designated CVO. If a provider fails to forward any required information to the CVO, our Credentialing Coordinator will assist in obtaining the missing or expired information. We utilize a Peer Review Committee to review any contracted provider who has generated an adverse report. Explanations are then assessed and determined to be either inadequate or satisfactory. Failure to comply with requests for information can result in provider termination from the network.

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3.7 DENTAL RECORDS

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3.7 DENTAL RECORDS

3.7.1 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.

3.7.2 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.

3.7.3 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.

3.7.4 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.

Our provider agreement and Provider Manual require that network providers maintain complete dental records of recipients and make them available upon request to LIBERTY, recipients, CMS, and applicable State agencies. Upon award of contract, we will update our provider agreement and Provider Manual to reflect DHCFP timeframes regarding dental records. In addition, we will educate our Nevada providers of the dental record requests requirements during our initial orientation and ongoing training via fax blast, newsletter and web portal.

LIBERTY has written policies and procedures in place to maintain the confidentiality, accessibility and availability, record keeping, and record review process for all dental records.

Dental Records Availability

Member dental records must be kept and maintained in compliance with applicable state and federal regulations. Complete dental records of active or inactive patients must be accessible for a minimum of 10 years, even if the facility is no longer under contract.

Dental records must be comprehensive, organized, and legible. All entries should be in ink, signed, and dated by the treating dentist or other licensed health care professional who performed services.

We will require contracted dentists to make available copies of all patient records to LIBERTY, recipients, CMS, and applicable State agencies upon request and in compliance with the requirements outlined in 3.7. Non-compliance with requests may result in disciplinary actions, up to and including transfer of enrollment or closure to new enrollment. Continued non-compliance may result in termination.

Our standard provider contract language is shown below in Figure 3.7-1.

FIGURE 3.7-1 INSPECTION, EVALUATION, AUDIT; DOCUMENT RETENTION

2.6 Inspection, Evaluation, Audit; Document Retention.

(a) Access to Records. Dental Office shall permit LIBERTY, upon advance written notice, and all applicable governmental agencies or divisions (and/or the designees of LIBERTY or such governmental agency/division) to inspect, evaluate and audit any physical facilities and equipment, books, contracts, documents, papers, records, including dental records and documentation of the Dental Office that pertain to Members, any aspect of Covered Services performed, reconciliation of benefits and determination of amounts payable (the "Records"). Dental Office shall cooperate and assist with, and provide the Records to, LIBERTY and any applicable governmental agency/division (and/or their designees) for purposes of the above inspections, evaluations, and/or audits, or as otherwise requested by LIBERTY from time to time. Dental Office shall notify LIBERTY of any disclosure of Records it is required to make to a governmental agency or division. Dental Office may not make the access or the provision of Records described in this Section 2.6(a) contingent upon a confidentiality statement or agreement. The above-described rights to inspect evaluate and audit will extend through the period during which Dental Office is required to maintain the Records as set forth in Section 2.6(b) below.

(b) Retention Period. Dental Office shall maintain the Records for ten (10) years from the termination or expiration of the Agreement or the completion date of any audit conducted pursuant to Section 2.6(a) (whichever is later), unless otherwise required by law.

3.8 QUALITY ASSURANCE STANDARDS

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3.8 QUALITY ASSURANCE STANDARDS

3.8.1 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.

We are committed to continuous improvement in the service delivery and quality of clinical dental care provided to members. At LIBERTY, quality is the hallmark of everything we do. We value quality as central to our workplace culture, rather than as a component within the health plan. Our processes, systems, policies, and procedures are designed to facilitate the incorporation of quality throughout every component of the organization. LIBERTY employees have performance goals designed to further quality improvement in every functional area within the enterprise, as all employees advocates quality. Our extensive Quality Management and Improvement (QMI) program allows us to pursue the goal of excellence and safety of clinical care and services provided to our members through LIBERTY's network of providers and our programs and services.

LIBERTY's QMI program ensures that the quality of care provided is being reviewed by dentists, quality of care problems are identified and corrected, and follow-up is scheduled when indicated. The QMI program continuously and objectively assesses dental patient care services and systems, and monitors compliance with prescribed standards to ensure a constant process of quality improvement that encompasses clinical and non-clinical functions.

We currently serve over 2 million Medicaid recipients in 6 states and have extensive experience working with state governmental agencies, as well as EQRO contractors, to monitor and assess the quality of care provided to our recipients.

LIBERTY has been subject to routine dental surveys, conducted by the California Department of Managed Health Care (DHMC) and Department. of Health Care Services, at three year intervals. The purpose of the survey is to assess the overall performance of LIBERTY in providing health care benefits and meeting the health care needs of our recipients in compliance with regulatory requirements. LIBERTY received no deficiencies during our last routine survey. The survey is a comprehensive evaluation of our clinical and non-clinical process.

3.8.2 Quality Measurements

3.8.2.1 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.

3.8.2.2 On an annual basis, vendors are required to report on all performance measures listed in the State Quality Strategy.

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

A. Standard
    1. 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.
    2. 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.

B. 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.

1. 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.

Experience using Performance Measures

LIBERTY has experience monitoring and reporting on various types of performance measures. We currently generate HEDIS, CHIP Core Set and CMS-416 measures and reports, specifically measuring 12-A through 12-E for dental utilization. We monitor these reports to develop comprehensive action plans to increase utilization of services, especially preventive dental services for recipients. We will submit the CMS 416 EPSDT Participation Report to the DHCFP for each quarter of the federal fiscal year (FFY), October 1st through September 30th.

LIBERTY has the necessary systems and resources in place to collect clinical indicator data to implement deliberate strategies to improve outcomes and performance measures. Once clinical and non-clinical areas of measurement have been identified, we analyze the data collected by geographic location and demographic composition and develop programs, initiatives, and or campaigns targeted at improving performance measures and overall dental services for program Recipients.

On behalf of a Florida Medicaid Managed Care Health Plan, we manage approximately 700,000 dental Medicaid members throughout the State of Florida. Over the past two years, we have been actively involved in efforts to improve and exceed HEDIS scores for overall utilization.

*To date, **we have reached a score of 43% (based upon data from August 2014-July 2015), a significant improvement from 23%-26% in 2000-2013,** according to the Health Policy Institute/American Dental Association report.*

We have extensive experience and quantifiable success with HEDIS data collection and related activities designed to improve dental health care for Medicaid and CHIP programs.

Table 3.8.2.3-1 is a report for a Florida health plan with which we are contracted to provide dental services for Medicaid enrollees. This health plan has specific utilization goals to reach year-by-year starting in 2017. The table shows that LIBERTY, acting on behalf of the FL health plan, has already reached the 2019 goal for the preventive measure, the 2018 goal for dental treatment measure and the 2020 goal for Annual Dental Visit (ADV) measure.

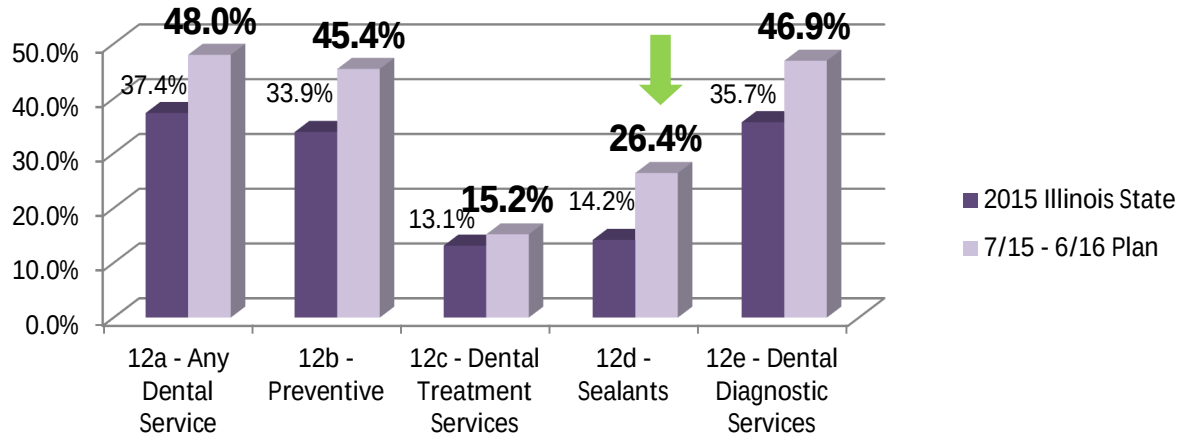
TABLE 3.8.2.3-1. FLORIDA MEDICAID PERFORMANCE MEASURE GOALS VS.2015 ACTUAL PERFORMANCE

	2017	2018	2019	2020	2021	LIBERTY FL Plan 2015
Preventive	30%	32%	35%	38%	42%	36.0%
Dental Treatment Services	14%	16%	18%	20%	22%	16.4%
Annual Dental Visit (ADV)	45%	46%	47%	48%	49%	48.2%

We also have extensive experience monitoring and reporting CMS performance measures. Below are results for a Medicaid health plan in Illinois with whom we are contracted to provide dental services to Medicaid enrollees (Table 3.8.2.3-2). For reporting period July 2015 - June 2016, our Illinois plan is running between 15% and 86% higher than the overall State of Illinois CMS-416 calendar year 2015 results. The largest variance is in sealants, with our Illinois plan showing a 26.4% usage rate compared to the overall State of Illinois' results of 14.2%.

TABLE 3.8.2.3-2. LIBERTY ILLINOIS PLAN PERFORMANCE OUTCOMES

CMS-416 Measure	2015 Illinois State	7/15 - 6/16 IL Plan	IL Plan Higher than Statewide
12a - Any Dental Service	37.4%	48.0%	28.5%
12b - Preventive	33.9%	45.4%	33.9%
12c - Dental Treatment Services	13.1%	15.2%	15.8%
12d - Sealants	14.2%	26.4%	86.1%
12e - Dental Diagnostic Services	35.7%	46.9%	31.5%



Automated reports are generated from LIBERTY's MIS system, along with satisfaction survey results, to evaluate dentally appropriate measures. As directed by the Dental Director, the Quality Assurance (QA) Coordinator ensures that all aspects of monitoring and evaluation meet applicable state and federal privacy/confidentiality laws and that reports of such activities are delivered to the QMI Committee, health plan partners, and regulatory agencies, as required. LIBERTY will report annually on all required performance measures, including those determined by the State of Nevada and included in the State Quality Strategy.

EPSDT Outreach and Engagement Strategy

Member engagement and EPSDT outreach provides us with the opportunity to continuously provide accessible, comprehensive, family-centered, and culturally effective coordination of dental health care for our members. LIBERTY allows and encourages members to choose a "Dental Home" primary care dental office to promote continuity of care and awareness of being an active participant in one's oral health care. (Persons not proactively selecting a Dental Home are assigned to a provider our algorithms determine to be their best fit.) While members can seek services from any network provider, the "Dental Home" has proven to increase utilization of preventive dental visits, and yield overall improvement to oral health. Beyond establishing the optimal Dental Home for each of our members, we believe it is important to continuously reach out and create awareness of routine and EPSDT services available as part of our outreach initiatives.

LIBERTY understands that member (and parent or guardian) education and engagement is an essential part of improving oral health outcomes and is paramount to getting members into the continuum of care, and thus improving their overall quality of life. As described in this response, LIBERTY offers numerous pediatric-specific services focused on improving oral health.

Local Nevada Office

We will hire an Executive Director based in Nevada at our longstanding Las Vegas operations center to manage the Medicaid and Check Up program. Our local staff will coordinate and participate in wellness events and health fairs, meet with providers to create custom programs, and participate in the development of specific member outreach and educational materials. Our existing Nevada presence (including 54 current employees) provide us with local insight into the types of outreach programs that will be most effective in increasing EPSDT service utilization among members.

Member Education

To ensure our education and outreach efforts have the greatest positive impact for the members, we will work in collaboration with the State of Nevada, DHCFP and other local entities, programs, advocates, and stakeholders to develop oral health improvement programs.

Our processes to track compliance with the dental components of EPSDT and to conduct tailored outreach are extensive and will be utilized in Nevada. For example, we reach out to new members upon enrollment to educate members on the benefits of participation in a Dental Home and establish the importance of routine and preventive care. Members will receive our welcome enrollment packet as part of our initial outreach. We then primarily use a combination of outbound call and home mailing campaigns to support our outreach initiatives and educate our members on the importance of dental care. Our onsite, regional Nevada team of experts, dedicated to the overall success of the DHCFP program, will also be supporting our local education efforts as part of our outreach initiatives. This will include, but not be limited to, meeting with DHCFP providers to partner with them on outreach efforts, using local mobile vendors for school based dental programs, and identifying and analyzing specific areas for utilization improvement based on data analysis trends.

LIBERTY also produces educational material for our providers on our various programs, which we distribute at health fairs, provider offices, and on our website. Examples of these materials can be found in Figure 3.8.2.3-3.

FIGURE 3.8.2.3-3. EDUCATION MATERIALS FOR MEMBERS

KidCare
LIBERTY cares about more than just teeth!

LIBERTY Dental Plan health tip:
Benefits of Dental Sealants

fact: Dental sealants protects teeth from cavities for 10 years

A dental sealant is a thin, plastic coating painted on the chewing surfaces of teeth - usually the back teeth (the premolars and molars) - to prevent tooth decay. The sealant quickly bonds into the depressions and grooves of the teeth, forming a protective shield over the enamel of each tooth.

Although thorough brushing and flossing can remove food particles and plaque from smooth surfaces of teeth, they cannot always get into all the nooks and crannies of the back teeth to remove the food and plaque. Sealants protect these vulnerable areas from tooth decay by "sealing out" plaque and food.

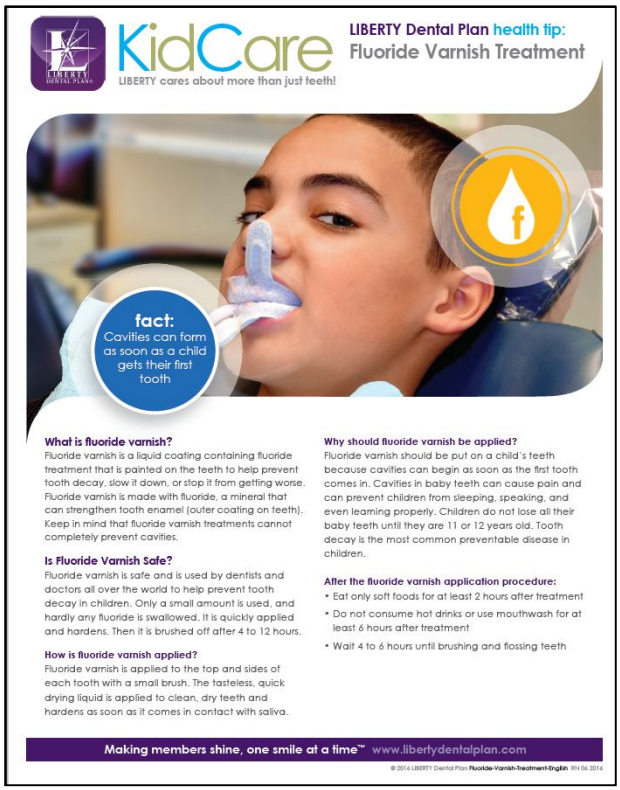
Who Should Get Sealants?
Because of the likelihood of developing decay in the depressions and grooves of the premolars and molars, children and teenagers are candidates for sealants. However, adults without decay or fillings on molars can also benefit from sealants.

Typically, children should get sealants on their permanent molars and premolars as soon as these teeth come in. This way, the sealants can protect the teeth through the cavity-prone years of ages 6 to 14.

How are sealants applied?
Applying sealants is a simple and painless process. It takes only a few minutes for your dentist or hygienist to apply the sealant to each tooth. The application is pain-free, and dentists check the sealants at routine visits to make sure they are still doing their job. Talk to your dentist to decide if dental sealants are right for your child.

How Long Do Sealants Last?
Sealants can protect teeth from decay for up to 10 years. Sealants should also be checked for chipping or wearing at regular dental check-ups. Your dentist can replace sealants, as necessary.

Making members shine, one smile at a time™ www.libertydentalplan.com



KidCare
LIBERTY cares about more than just teeth!

LIBERTY Dental Plan health tip:
Fluoride Varnish Treatment

fact: Cavities can form as soon as a child gets their first tooth

What is fluoride varnish?
Fluoride varnish is a liquid coating containing fluoride treatment that is painted on the teeth to help prevent tooth decay, slow it down, or stop it from getting worse. Fluoride varnish is made with fluoride, a mineral that can strengthen tooth enamel (outer coating on teeth). Keep in mind that fluoride varnish treatments cannot completely prevent cavities.

Is Fluoride Varnish Safe?
Fluoride varnish is safe and is used by dentists and doctors all over the world to help prevent tooth decay in children. Only a small amount is used, and hardly any fluoride is swallowed. It is quickly applied and hardens. Then it is brushed off after 4 to 12 hours.

How is fluoride varnish applied?
Fluoride varnish is applied to the top and sides of each tooth with a small brush. The tasteless, quick drying liquid is applied to clean, dry teeth and hardens as soon as it comes in contact with saliva.

Why should fluoride varnish be applied?
Fluoride varnish should be put on a child's teeth because cavities can begin as soon as the first tooth comes in. Cavities in baby teeth can cause pain and can prevent children from sleeping, speaking, and even learning properly. Children do not lose all their baby teeth until they are 11 or 12 years old. Tooth decay is the most common preventable disease in children.

After the fluoride varnish application procedure:
- Eat only soft foods for at least 2 hours after treatment
- Do not consume hot drinks or use mouthwash for at least 6 hours after treatment
- Wait 4 to 6 hours until brushing and flossing teeth

Making members shine, one smile at a time™ www.libertydentalplan.com

EPSDT Outreach Programs

Below are examples of some of the outreach campaigns we have conducted, and which we will implement in Nevada.

1st Tooth 1st Birthday Initiative

We have worked alongside states, numerous advocates, and other stakeholders over several years to identify ways and means to improve quality within our Medicaid programs. Through analysis of utilization trends and discussions with numerous member advocates, we identified a barrier to access issue for members between the ages of zero to one. Specifically, some providers were refusing to treat members at this age and parents/guardians did not see the importance of having children seen by a dentist at this age. We immediately launched a 1st Tooth 1st Birthday campaign for California Medi-cal (Medicaid), in conjunction with our network providers to ensure our youngest members receive routine preventive, diagnostic, and specialty dental care. Our mission was to promote awareness of the American Academy of Pediatric Dentistry's (AAPD) recommendation to "Get it Done in Year One."

We called the parents/guardians of each of our members aged one and younger to encourage and assist them in selecting a Dental Home to foster their relationship with a general or pediatric dentist. We also reached out to our provider network, and reminded them of the importance of seeing children by their first tooth/first birthday. While this campaign was specifically focused on children aged one and younger, we routinely perform similar campaigns for children of all ages.

CASE STUDY: 1st Tooth 1st Birthday

To examine access issues for the youngest children in Sacramento County, we asked dentists at what age they first start seeing children in their practice. Approximately one-half of all dentist respondents and all general dentist respondents (49% and 51.9%, respectively) reported they start seeing children by age 1 or the first tooth. In a representative sample of dentists statewide, 18% of general dentists started seeing children at age 1; 82.2% of pediatric dentists reported they saw children at the recommended age 1. This finding suggests that a concerted effort has been made in Sacramento County to follow the recommendation for "the first dental visit at the first tooth or first birthday." Not unexpectedly, of the pediatric dentists in Sacramento County, 100% reported they saw children at the recommended age 1.

Fluoride Initiative for Children

In analyzing utilization trend analysis, LIBERTY identified that many of our members were not receiving a high percentage of fluoride treatments during their office visits. Research shows that a simple fluoride swab may be critical to eliminating or diminishing dental disease. Visiting a dental provider at an early age for oral health examinations and preventive services significantly decreases or eliminates a child's anxiety about dental treatment. Therefore, we developed the Fluoride Initiative in California to increase early fluoride application on children three years and younger and strengthen the Member/Dental Home relationship. Our initiative focused on a combination of outreach and education by reaching out to providers and members through mailings and flyers. Additionally, we designed and implemented a successful outbound call campaign, in which our Member Service Representatives (MSRs) call parents to inform them about the program. If the parent agrees to participate, the MSR warm transfers the member to the provider office to schedule an appointment. This outreach program often resulted in parents securing first time dental appointments for their young children. To measure our progress and success, we used claims data to determine the number of eligible children between the ages of zero and three years old, who received fluoride treatments prior to the initiative and again following the initiative. Our program resulted in the improvement of fluoride treatment utilization rates in the California Medicaid Managed Care Program by 31 percentage points for our members.

School Based Dental Programs

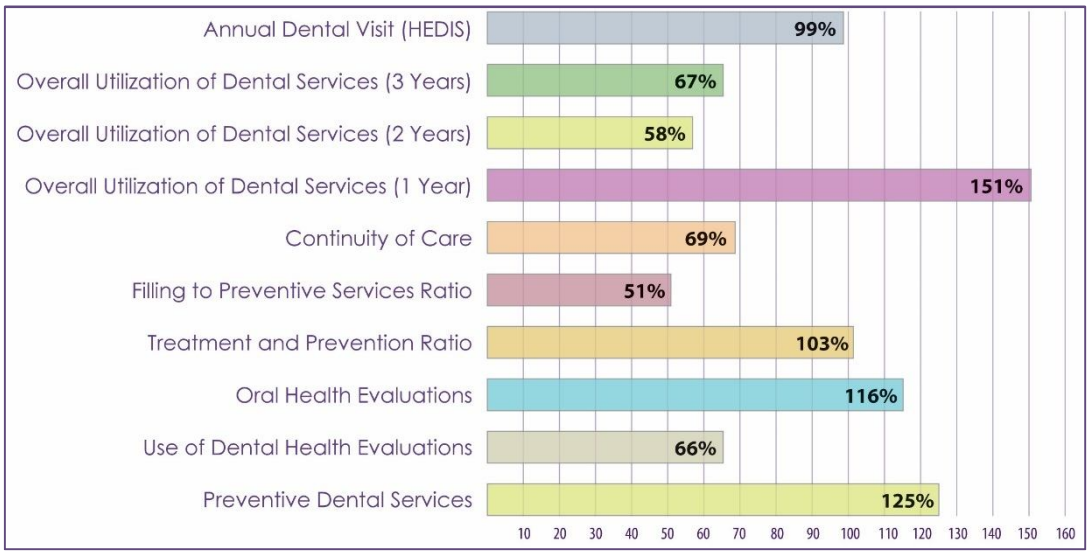
Understanding that the most effective way to improve sealant rates is to go to where the children are, as opposed to waiting for them to come to us, we work with mobile dental providers to create and expand current school based dental programs. For example, in Florida, we are contracted statewide with mobile van dental providers and pay them on a fee-for-service basis for their services performed in schools. We track their progress and work closely with them on outreach efforts in coordination with our health plan and dental provider partners. In California, we are contracted with mobile van providers and recently developed a proprietary mobile unit program with The Centers for Oral Health (COH) in Sacramento County.

Sealant Utilization - Provider Engagement & Pay for Performance Programs

Provider engagement in the process of increasing sealant utilization is paramount, and we approach this need from numerous angles. By identifying providers who currently provide a high rate of sealants, we can guide more members to these providers through our Dental Home efforts and provider location services, both within member services and through our online portals. Partnering with providers and creating Pay for Performance programs has proven effective in increasing sealant rates. As an example, we most recently partnered with numerous providers in the Florida Medical Management Assistance (MMA) program to improve usage which resulted in increases of pediatric sealant utilization at individual providers by as much as 200%. LIBERTY will work with DHCFP and Nevada providers to implement a similar program, should we determine that sealant utilization is a target area for improvement.

Figure 3.8.2.3-4 provides a graph that demonstrates increased utilization of dental services as a direct result of our outreach efforts. After taking over dental care coordination responsibility for a CHIP program in California from another carrier, we made significant improvements in utilization between 2009 and 2011. The chart shows that overall use of dental services over a one-year period increased by 151%, while preventive dental services, including sealants, among the same population increased by 125% as a result of our focused improvement program.

FIGURE 3.8.2.3-4. UTILIZATION OF DENTAL SERVICES



California Healthy Families CHIP Program

Tracking and Monitoring EPSDT Service Utilization

LIBERTY runs monthly CMS-416 (measures 12a – 12f) and HEDIS® Annual Dental Visit (ADV) reports directly in our system to track utilization of EPSDT services, as well as referrals for EPSDT services, for all of our state Medicaid programs, and will do the same for the State of Nevada DHCFP. LIBERTY compares these reports to nationwide statistics as well as previous years' statistics to measure effectiveness of current programs, to ensure services are delivered within established timeframes, to identify opportunities to improve current programs, and to identify opportunities for future programs. Members who are identified as not having received services within established timeframes are contacted via our outbound call campaigns, text messaging, and the additional EPSDT outreach programs listed above.

3.8.3 Plan of Correction (POC) Procedure

3.8.3.1 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:

A. Specific problem(s) which require corrective action;

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

C. The goals of the corrective action;

D. The time-table for action;

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

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

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

3.8.3.2 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.

3.8.3.3 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.

We maintain a well-coordinated EPSDT program that is designed to ensure children receive appropriate diagnostic and preventive care. We recognize the need for multiple varied and innovative strategies to encourage compliance with EPSDT periodicity schedules and visits.

Through our numerous Medicaid contracts throughout the country, we fully understand and comply with EPSDT guidelines and requirements, as well as AAPD's recommendations for eligible members under age 21. This includes periodicity tables and the requirements to provide medically necessary screening and dental services to children, regardless of whether or not the services coincide with our established schedules for said services. We currently generate HEDIS, CHIP Core Set and CMS-416 measures and reports, specifically measuring 12-A through 12-E for dental utilization. We monitor these reports to develop comprehensive action plans to increase utilization of services—especially preventive dental services for members.

LIBERTY uses data to not only optimize our outreach efforts, but to objectively evaluate program performance capitalizing on best practices and addressing inefficiencies in order to improve member health, well-being and health outcomes. Our comprehensive efforts and systems to ensure delivery of EPSDT services include quarterly and annual analyses to identify population-wide trends and opportunities to improve our EPSDT program overall. We continuously strive to improve the quality of care delivered to our recipients through detailed monitoring and analysis of our data, both quantitative and qualitative. We identify, document, evaluate and resolve known or suspected quality of care issues, ensuring that corrective action plans, where necessary, are adequate to bring about improvement in care in conjunction with administrative systems.

Corrective Action Plans

On a quarterly basis, our Data Analytics and Quality Improvement teams will analyze EPSDT related measures for our Nevada members, looking for program performance, trends and opportunities for improvement. As part of these analyses, we evaluate outreach contacts and compliance rates in total as well as by race, region, ethnicity and screening or service. The insights derived are then applied to program enhancements. The measures we use include, but are not limited to

- ***The number and percentage of recipients having screens/visits as prescribed by the EPSDT Periodicity Schedules;***
- ***Recipients receiving diagnostic and preventive services, including referrals.***

We will conduct periodic review of contracted Nevada provider office chart records using criteria based on record documentation standards and adherence to preventive care guidelines. The review identifies compliance with record review standards and if needed, opportunities for improvement. A random sample of providers is selected each year. The EPSDT component of our audit evaluates provider adherence with EPSDT recommendations within each of the randomly selected medical records Individual provider corrective action plans are required for providers who are below 80 percent compliance with all elements of our review.

Our Plan of Correction takes the form of Corrective Action Plans (CAPs). The LIBERTY Dental Director can recommend remedial action in the form of corrective action plans and follow-up whenever inappropriate dental care is identified, over-utilization of services that unfavorably affect patient care, under-utilization of needed services, insufficient accessibility or availability of services, inappropriate referral practices or breaches in LIBERTY policy regarding benefit applications and charges.

On approval, corrective action begins with notifying the appropriate provider or internal functional department of the observed deficiencies and providing an explanation of actions required or recommended to correct the deficiencies. Corrective measures may include one or more of the following:

- ***Clinical peer review***
- ***Special claims review***
- ***Referral to the applicable state dental board***
- ***More on-site assessments***
- ***Mandatory prior authorization***
- ***Member enrollment restrictions***
- ***Termination of the provider agreement***

We have included a sample of an internal Corrective Action Plan/Plan or Correction for our California Plan in Figure 3.8.3-1.

FIGURE 3.8.3-1. SAMPLE INTERNAL CORRECTIVE ACTION PLAN

ISSUE/PROBLEM DEFINITION **(be specific – quantify if possible)**	**ROOT CAUSE EVALUATION - The CAP must include the following:** **1) Root Cause** **2) Plan of Action** **3) Date of Completion** **4) Responsible Staff/Department**
During [redacted] recent file review conducted on 09/16/2016, the reviewer determined that the organization did not meet the standards for **5.0 UM Denial Review**. 22 of the 26 cases reviewed denied dental services not covered by LIBERTY Dental without a referral or re-direction to Denti-Cal. • Contract between [redacted], Centers for Medicare and Medicaid Services (CMS) and Department of Healthcare Services (DHCS): • Under Section A.2 Covered Services. Additionally, Section 2.12.1.13.6 in Enrollee Services is a standard that specifically states that [redacted] Cal-MediConnect (Duals) enrollees should be directed to the Denti-Cal program for any benefits available through Medi-Cal.	**1) Root Cause –** LIBERTY was not aware of this requirement. **2) Plan of Action –** Upon client approval LIBERTY will add the following language to the Member NOA under the section of **"Your Request was Denied"** *You may have additional coverage under Denti-Cal. For additional information please call Denti-Cal Beneficiary Customer Service line at 1-800-322-6384 (TTY users call 1-800-735-2922). The call is free. Medi-Cal dental program representatives are available to assist you from 8:00 a.m. to 5:00 p.m., Monday through Friday. You can also visit the Denti-Cal website at http://www.denti-cal.ca.gov for more information.* LIBERTY will notify the [redacted] members who have been denied service during this audit period by mail. Members who remain eligible with [redacted] and must be notified of the Denti-Cal benefits for completion of the requested dental work. **3) Date of Completion –** Within 15 business days post receipt of [redacted] approval. **4) Responsible Staff/Department –** Machelle Crum, Operational Audits
CERTIFICATION – The undersigned have read this Corrective Action Plan and agree to its terms	
Matt Vitier, Claims Director	**Date**
Machelle Crum, Operational Audits Director	**Date**
Marzena Fercz, Compliance Director	**Date**

SAMPLE

Potential Quality Issues

As part of LIBERTY's Quality Management and Improvement Program, our policies and procedures allow us to conduct investigations of Potential Quality Issues (PQIs) from a variety of sources, and to collate quality information about providers on a regular and routine basis.

We commonly identify PQIs from grievance details, grievances ruled against the provider, provider onsite assessments with a failed score, onsite assessments with a deficient critical indicator, aberrant utilization pattern, significant departure of expected contractual behavior or compliance, external vendor and business partner identification, and others as identified from time to time. Our Dental Director or designee reviews each case to assess the quality of care/service provided, provides a determination for corrective action based on the severity of the individual case and researches further to determine if the deficiency is systemic, or limited to the individual case and researches further to determine if the deficiency is systemic, or limited to the individual case. Follow-up actions, including, but not limited to, provider counseling and/or Corrective Action Plans are required of all involved providers where a quality of care or service issue is confirmed. All PQIs involving action or sanction on a provider are discussed at the Peer Review Committee. The Peer Review Committee may provide direction or guidance in developing the corrective action or sanction. However, the final action is at the sole discretion of the Dental Director, in consultation with Legal and other business units, where appropriate.

3.9 STANDARDS FOR INTERNAL QUALITY ASSURANCE PROGRAMS

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3.9 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.

3.9.1 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:

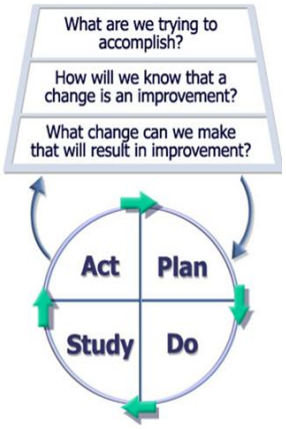
3.9.1.1 Measurement of performance using objective quality indicators;

3.9.1.2 Implementation of system interventions to achieve improvement in quality;

3.9.1.3 Evaluation of the effectiveness of the interventions; and

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

Our Quality Management Improvement (QMI) Program is a comprehensive approach to Quality Improvement. The QMI Program encompasses an array of well-defined processes and functions that are critical to the delivery of dental services. Each quality improvement project is executed with the goal of maintaining or improving the overall health of members.



Our Performance Improvement Projects (PIPs) are formulated using framework based on the Model for Improvement, and developed by the Associates in Process Improvement. The Plan, Do, Study, Act (PDSA) cycle allows us to determine if a given change yields an improvement.

Our PIPs are developed by taking a systematic approach that begins with the assessment of internal processes and services, prioritizing potential risk, developing a strategic action plan, and engaging the appropriate subject matter experts and business units to implement, evaluate and measure to determine effectiveness or need for additional enhancement. We conduct quality improvement initiatives and take action where indicated, including designing new services and or improving existing services.

Our overall methodology includes the following components:

- ***Problem Identification – The QMI Program uses multiple avenues to identify opportunities to improve care and service including, but not limited to, data analysis from all departments, dental record audits, focused studies, credentialing information, and complaints and grievances.***

- ***Prioritization – The QMI Program prioritizes identified opportunities for improvement based on acuity, prevalence, risk, practice standards, and available resources described on the annual QMI Work Plan.***

- ***Indicator Development – Indicators are selected to monitor important aspects of care and service. An indicator may be utilized to monitor more than one aspect of care or service. We establish performance goals for each indicator or study.***

- ***Data Sources – Data analyzed in QMI activities may include membership data, utilization and claims data, referral patterns, survey data, complaint and grievance data.***

- ***Data Collection, Analysis and Reporting – For each QMI activity, the most representative data is selected, information is compiled, results analyzed and reported. QMI staff interfaces with other involved departments to coordinate and collaborate on study design and analysis.***

- ***Development of Improvement Plans – Following analysis of collected results, the QMI Committee performs barrier analysis to identify opportunities for improvement. Individuals or teams affiliated with the specific process being evaluated are assigned responsibility for development and implementation of improvement plans.***

- ***Evaluation of Improvement Plans – Monitors are built into all improvement plans and are tracked through the QMI Work Plan to assess effectiveness.***

- ***Provider Feedback/Performance Assessment – At the conclusion of QMI Program activities, we disseminate results to dental care providers, along with***

expectations for improvement, and opportunities for assistance from LIBERTY Dental in formulating improvement plans.

- ***Disciplinary Action – When we identify a quality issue or trend that is severe enough to be reportable, our QMI Committee acts in accordance with the Corrective Action Policy and Procedures (see Appendix A). This includes the judicial review procedure, if requested by the provider. Corrective action will be reported to the State Board of State Examiners and the National Practitioner Data Bank.***

LIBERTY's governing body and CEO are key supporters of our performance improvements. This involvement of organizational leadership assures that quality improvement initiatives are consistent and aligned with LIBERTY's mission and goals.

We have included two examples of PIPs conducted in our California Medicaid dental program:

- ***Fluoride Initiative for Children***
- ***1st Tooth 1st Birthday Initiative***

Fluoride Initiative for Children

Overview

Mindful that diligent oral health care begins at an early age, many of LIBERTY's QIPs are focused on children. Many children suffer from preventable dental diseases including Early Childhood Caries (ECC). These diseases culminate into aggressive, costly procedures, which if not addressed early may require treatment under general anesthesia. Research shows that a simple fluoride swab may be critical to eliminating or diminishing dental disease. Visiting a dental provider at an early age for oral health examinations and preventive services significantly decreases or eliminates a child's anxiety about dental treatment. Therefore, we developed the Fluoride Initiative in California to increase early fluoride application on children three years and younger. We will work with Nevada to consider this initiative as part of the outreach campaign, as it improved utilization rates of fluoride treatments in the California Medicaid Managed Care Program by 31 percent for our members. Below, we describe the premise of the outreach program, as well as its successful results.

LIBERTY Dental Plan Performance Improvement Projects Snapshot

Fluoride Initiative for Children – As a result of this initiative, LIBERTY improved utilization rates of fluoride treatments in the California Medicaid Managed Care Program by 31 percent for our members.

1st Tooth 1st Birthday Initiative -As a result of this initiative, approximately one-half of all dentist respondents (including general and specialist dentists) and one-half of all general dentist respondents (49% and 51.9%, respectively) in Sacramento County, CA reported they start seeing children by age 1 or by the eruption of the first tooth. Of the pediatric dentists 100% reported they saw children at the recommended age 1.

Measurement of performance using objective quality indicators

Through utilization trend analysis and discussions with numerous professionals, advocates and stakeholders, we identified that many of our members were not receiving a high percentage of fluoride treatments during their office visits. We launched this clinical initiative to increase the early application of fluoride treatments and strengthen the Member/Dental Home relationship. We utilized HEDIS measures focused on children to measure our pre-and post-performance.

Implementation of system interventions to achieve improvement in quality

Our initiative focused on a combination of outreach and education. This was accomplished by reaching out to providers and members through mailings and flyers. Additionally, we designed and implemented a successful outbound call campaign, where thousands of calls resulting appointments were made with parents of young children for their first dental visit. We worked with several providers chosen specifically for their ability to work with and effectively treat young children. These providers were paid an additional supplemental payment to perform child visits and apply fluoride varnish to children between the ages of zero and three years old. For this outreach program, we contacted the parents and guardians of the zero to three populations via an outbound phone call campaign, and helped those members set dental appointments at the identified providers.

Evaluation of the effectiveness of the interventions

To measure our progress and success, we used claims data to determine the number of eligible children between the ages of zero and three years old, who received fluoride treatments prior to the initiative and again following the initiative. Table 3.9.1-1 below demonstrates the significant utilization improvement of 31 percentage points for fluoride treatments for the California Medicaid Managed Care Program due to our initiative.

Table 3.9.1-1: INCREASED USE OF FLUORIDE TREATMENTS CHILDREN 0-3 PRE-AND POST-INTERVENTION

	Prior	After
Eligible Members Age 0-3	*4,298*	*5,040*
Members Who Received Fluoride Treatments	*828*	*2,515*
Percentage of Member Who Received Fluoride Treatment	*19%*	*50%*

Planning and initiation of activities for increasing or sustaining improvement

We reevaluate our PIPs annually, and modify our approaches according to performane based on the data collected. We will continue and expand our current programs In Nevada, and will continue to seek new and innovative approaches to increasing flouride treatments for children ages 0-3.

1st Tooth 1st Birthday Initiative

Overview

We have worked with states, numerous advocates and other stakeholders over several years to identify ways and means to improve quality within our Medicaid programs. Recently, through analysis of utilization trends and discussions with numerous member advocates, we identified a barrier to access issue for members between the ages of zero to one. Specifically, some providers were refusing to treat members at this age and parents/guardians did not see the importance of having them seen by a dentist at a young age. We immediately launched a 1st Tooth 1st Birthday campaign in conjunction with our network providers to ensure our youngest members receive routine preventive, diagnostic, and specialty dental care. Our mission was to promote awareness of the American Academy of Pediatric Dentistry's (AAPD) recommendation to "Get it Done in Year One."

Measurement of performance using objective quality indicators

We measure our performance through monitoring and analysis of CMS-416 (measures 12a – 12f) and HEDIS® Annual Dental Visit (ADV) reports. LIBERTY compares these reports to local and nationwide statistics as well as previous years' statistics to measure effectiveness of current programs, to ensure services are delivered within established timeframes, to identify opportunities to improve current programs, and to identify opportunities for future programs.

Implementation of system interventions to achieve improvement in quality

We called the parents/guardians of each of our members aged one and younger to encourage and assist them in selecting a Dental Home to foster their relationship with a general or pediatric dentist. We also reached out to our provider network, and reminded them of the importance of seeing children by their first tooth/first birthday. While this campaign was specifically focused on children aged one and younger, we routinely perform similar campaigns for children of all ages within Medicaid Managed Care Dental programs.

Evaluation of the effectiveness of the interventions

To examine access issues for the youngest children in Sacramento County, we surveyed dentists to determine at what age they first start seeing children in their practice. Approximately one-half of all dentist respondents (including general and specialist dentists) and one-half of all general dentist respondents (49% and 51.9%, respectively) reported they start seeing children by age 1 or the first tooth. In a representative sample of dentists statewide, 18% of general dentists started seeing children at age 1; 82.2% of pediatric dentists reported they saw children at the recommended age 1. This finding suggests that a concerted effort has been made in Sacramento County to follow the recommendation for "the first dental visit at the first tooth or first birthday." Not unexpectedly, of the pediatric dentists in Sacramento County 100% reported they saw children at the recommended age 1.

Planning and initiation of activities for increasing or sustaining improvement

We reevaluate our PIPs annually, and modify our approaches according to performane based on the data collected. We will continue and expand our current programs into Nevada, and will continue to seek new and innovative approaches to ensuring all children have their first dental visit by the eruption of their first tooth or first birthday.

3.9.2 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.

We will comply with the requirements in section 3.9.2.

We are currently conducting required periodic reporting for a California Medicaid, including an annual report of the results of our quality improvement initiatives. Figure 3.9.2-1 below is an excerpt from the most recent report we submitted, illustrating the type of information we are experienced in reporting back to state agencies. A full copy of the report can be found in Attachment 6. We will report the status and results of each project to DHCFP in a format chosen by DHCFP.

3.9.3 The Vendor must:

3.9.3.1 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.

3.9.3.2 Submit to the DHCFP data specified by the DHCFP which enables the DHCFP to measure the vendor's performance.

Experience using Performance Measures

We report performance and quality measurement data for over 2 million members in multiple states across the nation. We currently generate HEDIS, CHIP Core Set and CMS-416 measures and reports, specifically measuring 12-A through 12-E for dental utilization. We monitor these reports to develop comprehensive action plans to increase utilization of services, especially preventive dental services for recipients. We will submit the CMS 416 EPSDT Participation Report to the DHCFP for each quarter of the federal fiscal year (FFY), extending from October 1st through September 30th.

We collect clinical indicator data to implement deliberate strategies to improve outcomes and performance measures. Once clinical and non-clinical areas of measurement have been identified, we analyze the data collected by geographic location and demographic composition and develop programs, initiatives, and or campaigns targeted at improving performance measures and overall dental services for program Recipients.

We have extensive experience and quantifiable success with HEDIS data collection and related activities designed to improve dental health care for Medicaid and CHIP programs.

LIBERTY will 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, as well as submit data specified by the DHCFP which enables the DHCFP to measure LIBERTY's overall performance.

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

We monitor external quality resources, regulations, and other pertinent sources for any changes in best practices to ensure we remain current in our clinical practice standards and guidelines. We will comply with all of DHCFP's IQAP guidelines.

3.9.5 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:

Overview

Through our platforms and integrated solutions, LIBERTY offers the DHCFP a seamless system that integrates payer-provider collaboration, claims/encounters processing and payment, fraud prevention, care management, eligibility and enrollment management, utilization and quality management, provider relations, and member services. This system supports achieving the objectives of the ongoing IQAP.

Through LIBERTY's Information Technology Plan, we facilitate seamless integration with the capacity to provide better care to our members, support to our providers and transform the way they deliver care. Our MIS platform, offers an integrated application to support business functions across our systems. While this system structure has worked extremely well and is tailored to the Medicaid populations that comprise the majority of our membership, we are continuously open to enhancement opportunities given the rate of change and improvement occurring in the information technology arena. LIBERTY is and analyzing, and identifying need for improvement

Our information technologies have Our MIS serves 3 million members,

In 2010, LIBERTY adopted the core MIS data warehouse, Medimart, which has allowed for expanded reporting capabilities and additional process automation. The application is now on a SQL.NET platform that stores the data for all aspects of claims processing.

Many applications that make up the MIS application suite share the same databases and image server that store the data, documents, and images. These include:

- ***Meditrac for claims, provider, group, and enrollment management. This also houses the tools to both build and manage the benefit plans, as well as the tools to help manage the claims processes.***
- ***HIPAA Gateway for transaction management of the EDI files processing.***
- ***Uniflow for member services and workflow management.***

- ***MIS Administrator*** ***for application security management. It also houses the tools for transaction management for the non EDI files to import data through batch and automated processes.***
- ***Online Website and Portals*** ***for member and provider engagement.***
- ***Scanning Assistant*** ***for document and attachment scanning.***
- ***Medimart*** ***for data warehousing.***
- ***Perfect Claim*** ***for paper claim data capture.***

3.9.5.1 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;

We will resoundingly fulfill DHCFP's data collection requirements. Our information systems have a proven ability to accommodate the collection and integrated use of recipient information, provider information, claims information, and our own care coordination and outreach activities. Due to the volume of Medicaid business we perform (currently entailing more than two million members) and the fact that Medicaid represents more than half of our overall business, LIBERTY's information systems are tailored to the needs of serving the Medicaid population. Our information systems structure and features are described in detail in our response to Section 3.17.

3.9.5.2 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);

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

We offer sophisticated capabilities with regard to storing, tracking, and making optimal use of provider data. Our system is robust with the ability to store all elements to manage our networks. Some of these elements are listed below:

- ***Office data***
- ***Provider data***
- ***Reimbursements (Can hold unlimited per provider)***
- ***Fee Schedules***
- ***Contracts***
- ***NPIs***
- ***Assigned members***

- ***Capitation Setup and mappings***
- ***Taxonomy/specialties***
- ***Languages Spoken***
- ***Claims***

Our Provider Directory offers real-time data (reflecting the most accurate and up-to-date information we have available) to our members to assist the members in finding and accessing care where they are most comfortable. The provider directory helps members find providers that fit their preferences (e.g. gender, location, accessibility, etc.). The provider directory is available in hard copy in our threshold languages and on our website.

When we are notified that a provider is no longer accepting new members, we immediately "close" the provider in our system. This action prevents the provider from appearing in our online provider directory or our web search.

We also process claims submissions and encounter files (837D) for approximately 2.5 million members in both Medicaid and Medicare programs. These are automated to interface with each client and delivered on time and accurate at a 99% success rate.

3.9.5.4 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

We will ensure that all data collected is available to DHCFP per the timeframes listed below in Table 3.9.5.4-1, and in the format required by DHCFP as outlined in the reporting guide, or as requested by DHCFP or CMS.

TABLE 3.9.5.4-1. REQUIRED REPORTS AND TIMEFRAMES

Report #	Description	Due Date
Report 1A	Dental Report, Provider	1st business day of month with a 3-month lag time to allow sufficient time for claims to be processed.
Report 1B	Dental Report, Patient	
Report 1C	Dental Report, Service Count and Cost	
Report 1D	Dental Report, Enrollment	
Report 2	CMS 416 Report	60 days after FFY end and 45 days after FF quarter-end to the report form
Report 3A	Dental Network Adequacy Report	Reports 3A-3B are due 45 days after quarter-end
Report 3B	Out of State Services Report	
Report 4	Insure Kids Now Dental Provider Network	1st business day of the month after quarter-end

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

LIBERTY will designate an Applications Analyst who will work collaboratively with DHCFP on the review and submission of our encounter data to DHCFP.

3.9.6 Written IQAP Description

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

Overview

Our Quality Management and Improvement Program (QMI) Program is designed to continuously improve the oral health of our members and their dental care experience. Through this program we objectively assesses dental patient care services and systems, and monitor compliance with prescribed standards to ensure a constant process of quality improvement that encompasses clinical and non-clinical functions. We document all quality improvement initiatives, processes and procedures in writing in a formal QMI Work Plan. This document is updated annually.

LIBERTY currently operates a QMI Program that has been successfully implemented in California with the Department of Managed Health Care (DMHC), as well as with our various Managed Care Plan partners across 27 states.

Our QMI Work Plan identifies the dental healthcare needs of members, improves member accessibility to dental services, improves member satisfaction with participating providers and improves member and provider satisfaction. Through the use of different quality data sources, we can measure the effectiveness of our initiatives, identify opportunities for improvement, and implement interventions designed to support our providers and members.

3.9.6.1 Goals and Objectives.

Goals

The goal of LIBERTY's Quality Management Improvement (QMI) Program is to comprehensively identify and address the quality of dental care and service to our members. The program has been designed to provide a review of the entire range of care to establish, support, maintain and document improvement in dental care through the ongoing, objective assessment of services, systems, issues, concerns and problems that directly and indirectly impact the member's dental health care.

We are committed to continuous improvement in the service delivery and quality of clinical dental care provided to members with the primary goal of improving the dental health status of members and, where the Member's condition is not amenable to improvement, maintain the Member's current dental health status by implementing measures to prevent any further decline in condition or deterioration of dental health status. LIBERTY has established quality of care guidelines that include recommendations developed by organizations and specialty groups such as the American Academy of Pediatric Dentistry, the American Academy of Endodontists, the American Academy of Periodontists, the American Association of Oral Surgeons, the American Academy of Orthodontists and the American Dental Association. We apply these guidelines equally to general practice dentists and specialists and uses them to evaluate care provided to members.

Objectives

Consistent with the Program's stated purpose and goal, our QMI Program's objectives are to:

- ***Ensure the provision of quality dental services that focus on patient needs, comfort and function, in an environment that emphasizes safety and appropriate dental improvement by competent staff***
- ***Ensure diagnostic evaluation and treatment is based on professionally recognized standards of care***
- ***Provide a structure for provider education that promotes preventive services and appropriate treatment of dental conditions through the use of dental practice guidelines that optimize outcome and reduce morbidity***
- ***Develop population-based quality indicators for assessment of dental service that are objective, measurable, and in accord with current standards of care and clinical experience***
- ***Monitor program effectiveness and adherence to regulatory guidelines through analysis of QMI and utilization data, peer review, member and provider grievances and risk improvement issues***
- ***Identify, document, evaluate and resolve known or suspected quality of care issues, ensuring that corrective action plans, where necessary, are adequate to bring about improvement in care in conjunction with administrative systems***
- ***Promote patient education as a means of increasing overall dental health in compliance with preventive care standards***

- ***Ensure professional competence through a structured and consistent credentialing and re- credentialing process***
- ***Ensure that members receive dental services in facilities that meet appropriate standards for access, environmental health and safety/infection control***
- ***Ensure that dental records meet established standards for accuracy, legibility and completeness***
- ***Provide a mechanism to monitor confidentiality that LIBERTY Dental has based on HIPAA standards***
- ***Evaluate the effectiveness of the QMI Program on an annual basis***
- ***Provide an annual written report to the QMI Committee that addresses the Quality Improvement activities undertaken, the results of the activities and the evaluations of the status of ensuing action plans***
- ***To provide immediate feedback for the benefit of our members through constant oversight and monitoring.***

3.9.6.2 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.

LIBERTY's QMI encompasses an array of well-defined processes and functions that are critical to the delivery of dental services. Each Quality Assurance activity is executed with the goal of maintaining or improving the overall health of members. LIBERTY examines, monitors, and revises processes within the QMI Program to ensure the highest quality of care. Our QMI program includes the follow main components:

- ***Provider Collaboration.***
- ***Quality Improvement.***
- ***QMI Work Plan.***
- ***Annual QMI Program Evaluation.***

Provider Collaboration

We join forces with providers to actively improve the quality of care provided to our members. LIBERTY's contracted providers are contractually required to cooperate with ongoing QMI goals. Our Provider Relations staff are responsible for the ongoing communications of quality assurance activities through the following means:

- ***Initial and continuing training programs.***
- ***Provider newsletters and Fax Blasts.***

- ***Online notices.***
- ***Local and Regional meetings to discuss and identify issues relating to claims, enrollment and any other issues that the provider can identify.***
- ***Provider Satisfaction Surveys.***
- ***Onsite office visits.***

Quality Improvement

We approach the concept of continuous quality improvement and total quality management through both clinical and non-clinical functions within our QMI Program. Our efforts include, but are not limited to:

- ***Evaluating performance using objective quality indicator data;***
- ***Fostering data-driven decision making;***
- ***Recognizing that opportunities for improvement are limitless;***
- ***Soliciting Member and network provider input on performance and QMI activities;***
- ***Supporting continuous ongoing measurement of clinical and non-clinical effectiveness and Member satisfaction;***
- ***Supporting programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements; and***
- ***Supporting re-measurement of effectiveness and member satisfaction, and continued development and implementation interventions as appropriate.***

QMI Work Plan

Our QMI Work Plan is designed to provide a formal ongoing process by which LIBERTY, and participating providers utilize objective measures to monitor and evaluate the quality of services, clinical and administrative, provided to members. The work plan addresses services, defines, and facilitates a systematic approach to identify and pursue opportunities to improve services and resolve identified problems. The Work Plan is updated, reviewed and accepted by LIBERTY's Board of Directors on an annual basis.

On an annual basis, a QMI Work Plan is developed under the direction of the Chief Dental Officer/Dental Director to assist with the following tasks:

- ***Documentation of the next year's goals and objectives for planned projects and activities, including clinical and non-clinical programs, initiatives and measurement activities.***
- ***Required effort to accomplish stated goals and objectives.***
- ***Identification of tasks and subtasks according to a work breakdown structure.***
- ***Allocation of resources, task planning and scheduling.***

- ***Monitoring and control of task progression.***
- ***Preparation of the Annual QMI Evaluation and Report.***

Annual QMI Program Evaluation

The Dental Director and Quality Assurance staff evaluates the QMI Plan annually to appraise the effectiveness of the previous year's clinical and non-clinical initiatives, including but not limited to the following:

- ***Adherence to QMI standards, policies and procedures.***
- ***Development of quality initiatives that support data-driven decision-making and support continuous ongoing measurement and re-measurement of clinical and non-clinical effectiveness.***
- ***Member and Provider satisfaction.***
- ***Development and implementation of programmatic improvements to clinical and non-clinical processes, based on results from ongoing measurement.***
- ***Results of focused quality of care studies and other quality initiatives.***
- ***Effectiveness of corrective action plans.***

3.9.6.3 Scope

A. 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.

B. 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.

LIBERTY maintains comprehensive Quality and Utilization Review programs intended to identify, evaluate and remedy problems relating to access to care, continuity and quality of care, utilization and the cost of services. Our Quality & Utilization Review Programs include standards, policies and procedures for credentialing and re-credentialing dentists as well as a Peer Review Committee that is utilized to conduct quality of care and utilization review compliant with applicable state and federal laws and regulations.

Our QMI Program is an integrated effort across multiple departments and includes the following:

- ***Dental management***

- ***Credentialing***
- ***Standards of care***
- ***Dental records***
- ***Utilization review***
- ***Peer review***
- ***Environmental health and safety/infection control***
- ***Member and provider grievances***

Our QMI program is comprised of various activities that support these departments and processes, including, but not limited to:

- ***Providing immediate and responsive feedback to members, providers, and the public as appropriate.***
- ***Policy and Procedure Development.***
- ***Clinical criteria guidelines and practice parameters development, compliance, and revision.***
- ***Annual QMI Evaluation and Report.***
- ***Annual QMI Work Plan Development.***
- ***Identification of Quality Issues and Trends.***
- ***Monitoring of Quality Measurements.***
- ***Quality of Care Focus Studies.***
- ***Monitoring of the Provider Network.***
- ***Monitoring utilization trends including over-and under-utilization.***
- ***Review of Acceptable Standards of Dental Care.***
- ***Continuing Provider Educations.***
- ***Evaluating member and provider satisfaction.***
- ***Member Health Education.***
- ***Cultural and linguistic issues.***

LIBERTY's QMI Program utilizes both clinical and non-clinical measures to address the following components of quality that are included in established definitions of high-quality dental care services:

- ***Accessibility of care:*** ***the ease and timeliness with which patients can obtain the care that they need when they need it.***
- ***Appropriateness of care:*** ***the degree to which the correct care is provided, given the current standard of the community.***
- ***Continuity of care:*** ***the degree to which the care needed by patients is coordinated among practitioners and is provided without unnecessary delay.***
- ***Effectiveness of care:*** ***the degree to which the dental care provided achieves the expected improvement in dental health consistent with the current standard of the community.***
- ***Safety of the care environment:*** ***the degree to which the environment is free from hazard and danger to the patient.***

Children with special needs who are entitled to both Medicare and Medicaid demonstrate higher percentages of vulnerabilities and additional health service needs. We focus on improving coordination of care and access to healthcare services, improving both individual and population-based health outcomes as well as reducing overall healthcare costs. We are committed to ensuring that service delivery for children with special needs recipients is high-quality and provided according to the processes outlined in the QMI Program and Work Plan.

As a part of the QMI Program we engage in ongoing activities to monitor performance goals, health outcome measures and utilization. Special needs population data is collected and analyzed by the Dental Care Management and Quality Departments and then reported to the Quality Improvement Committee for oversight.

In addition, we ensure that our processes support CMS requirements as outlined in the Medicare Managed Care Manual which includes annual submission of collected SNP-specific HEDIS measures.

3.9.6.4 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.

LIBERTY documents all QMI improvement initiatives, process and procedures, defines goals, objectives, specific activities, responsible parties and targeted timeframes for completion or resolution of activities. The Work Plan is developed annually with National Committee for Quality Assurance (NCQA) best practice standards simulated for dental services and built upon

In our California business, there were 84 verified potential quality issues (PQI) resolved in the 1st quarter of 2016.

the evaluation, recommendations and findings of the previous year's Work Plan.

Our Work Plan focuses on the accessibility, availability, appropriateness, continuity, effectiveness, and timeliness of dental care as well as the safety of service delivery environment. The Work Plan encompasses distinct functions that mirror applicable NCQA components for the delivery of care. An excerpt of our QMI Work Plan can be found in Table 3.9.6.4-1.

TABLE 3.9.6.4-1. EXCERPT OF LIBERTY'S QMI ANNUAL WORK PLAN

QI Topic(Identified QI Need or Ongoing Monitoring)	Objective	Action Steps	Goal/Benchmark	Responsible Party	Frequency	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Target Met
Access Monitoring	To Ensure Compliance with Approved Access Standards and Demonstrate Access Effectiveness	Review Access and Availability policies and procedures and propose revisions to QMI Committee	Annual review	Access and Availability Committee	Annual	T			E	☐Mid-year ☐Annual
		Review Established Standards for Geographic Access	On-going; quarterly reporting	Compliance Director	Quarterly	O	O	O	O	☐Mid-year ☐Annual
		Coordinate Corrective Action Plans for Deficiencies and identify New Recruitment Opportunities	On-going; quarterly reporting	VP of Provider Relations	On-going	O	O	O	O	☐Mid-year ☐Annual
		Report compliance of access standards	Quarterly review for tracking and trending	VP of Provider Relations	Quarterly	O	O	O	O	☐Mid-year ☐Annual
		Review and Report Provider Compliance for approved Timeliness of Preventive Care Appointments, Routine Appointments, Urgent Appointments, Emergency Care, After Hours Care Access, Wait Time in the Provider Office, and Elements of Telephone Service	Quarterly review for tracking and trending	VP of Provider Relations	Quarterly	O	O	O	O	☐Mid-year ☐Annual
		Tracking of provider network management through service activities of recruitment, orientation, re-orientation, service calls, service visits and on-site audits	On-going; quarterly reporting	VP of Provider Relations	Quarterly	O	O	O	O	☐Mid-year ☐Annual
Coordination of Care	To Effectively Monitor and Evaluate Services Rendered by Members to Ensure Quality Service Delivery	Review policies an procedures and the Process of Specialty, Hospital, Sedation, and General Anesthesia Cases and if necessary, propose changes to the QMI Committee	Annual review	Director of Claims	Annual	O	O	O	O	☐Mid-year ☐Annual
		Report orthodontic cases includinf denial and approval rates to State regulatory Agencies as appropriate	Quarterly	Director of Claims	Quarterly	O	O	O	O	☐Mid-year ☐Annual
		Track and Report Number of Hospital and General Anesthesia Cases to Utilization Management Committee	Quarterly review	Director of Claims	Quarterly	O	O	O	O	☐Mid-year ☐Annual

ACTION: T=Target Completion O=On-going Activity E=Evaluation S=Project Start

Page 4

3.9.6.5 Continuous Activity

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

LIBERTY approaches the clinical and non-clinical functions of QMI with the tangible concept of continuous quality improvement (CQI) and total quality management (TQM). Our approaches include, but are not limited to:

- ***Evaluating performance using objective quality indicator data;***
- ***Fostering data-driven decision making;***
- ***Recognizing that opportunities for improvement are limitless;***

- ***Soliciting Member and network Provider input on performance and QMI activities;***
- ***Supporting continuous ongoing measurement of clinical and non-clinical effectiveness and Member satisfaction;***
- ***Supporting programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements; and***
- ***Supporting re-measurement of effectiveness and Member satisfaction, and continued development and implementation interventions as appropriate.***

We apply CQI/TQM principals towards the progression of improvements through training and ongoing participation in quality assurance activities. LIBERTY builds upon the following principles:

- ***Strong leadership at all levels then can convey the goals and objectives of the QMI***
- ***The three dimensions of quality:***
  - ***People***
  - ***Processes***
  - ***Informed decision making***
- ***Cohesive understanding of systems and processes that lead to quality improvement decisions***

3.9.6.6 Provider Review

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

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

An integral component of our QMI program is ensuring providers understand the importance we place on quality and the components of our QMI program. We utilize various strategies to communicate with and educate our providers and their office staff regarding the QMI Program and its related goals, efforts, and ongoing performance improvement projects.

Provider Communication

LIBERTY's quality improvement goals are to join forces with providers to actively improve the quality of care provided to members. Quality assurance activities are continuously communicated to providers through our Provider Relations staff. Various communication platforms include, but are not limited to the following:

- ***Provider Orientation.***
- ***Provider Manual.***
- ***Provider Web Training.***
- ***Initial and continuing training programs.***
- ***Provider newsletters (excerpt in image to the right) and Fax Blasts.***
- ***Online notices.***
- ***Local and Regional meetings to discuss and identify issues relating to claims, enrollment and any other issues that the provider can identify.***
- ***Provider Satisfaction Surveys.***
- ***Onsite office visits.***

Critical Incident Awareness Training

Did you know providers are required to report critical incidents to LIBERTY Dental Plan and the proper authorities? To help you comply with this requirement, LIBERTY has supplied a **Critical Incident Awareness Training** on our website, which providers must complete within 60 days of contract effective date.

Members participating in Medicaid and Medicare programs may be vulnerable to abuse or neglect due to their health condition, age, social isolation and economic situation. There are a number of critical incidents to look out for, which have been identified by CMS. These critical incidents include:

- **Abuse**
- **Neglect**
- **Exploitation**
- **Disappearance**
- **Death**
- **Serious, life threatening event requiring immediate emergency evaluation**
- **Seclusion and restraints**
- **Suicide Attempt**

To find out more about this requirement, please visit www.cms.gov. There may be additional state-specific requirements in your state.

To comply with and complete this CMS-required training, please visit our website at www.libertydentalplan.com/Providers/Critical-Incident-Training-page or call our Provider Relations Team at **888.352.7924.**

did you know
LIBERTY provides online training for Providers

Be in the Know

Members are given the opportunity to participate in Satisfaction Surveys on an ongoing basis. The survey results are reviewed frequently to identify opportunities to improve quality of service and care.

3 LIBERTY Dental Plan Quarterly

We communicate the following information to our Providers pertaining to our QMI Program:

- ***Status and results of performance improvement projects (PIPs).***
- ***Public Policy updates.***
- ***Grievance and Appeals information.***
- ***Call Center Stats.***
- ***Utilization data.***
- ***Claims processing timeframes.***
- ***Results of member and provider satisfaction surveys.***
- ***LIBERTY's continuous quality improvement (CQI) program, including policies and procedures on corrective action plans.***

Provider Profiling

To assure that our providers are performing high quality services, LIBERTY engages in a comprehensive and unique utilization management model that incorporates extensive provider profiling. Utilizing our extensive claims history data base, each individual provider's performance is measured against average patterns and numerous benchmarks. We utilize a proprietary Provider Profiling tool which combines tracking and trending of data from numerous quality indicators to compare providers to their peers. When identifying utilization patterns and trends, we include multiple aspects of a member's experience to analyze provider patterns in a more meaningful way. The quality indicators include, but aren't limited to, utilization, grievances and appeals,

access, availability and member satisfaction data, for different categories of service and patient demographics.

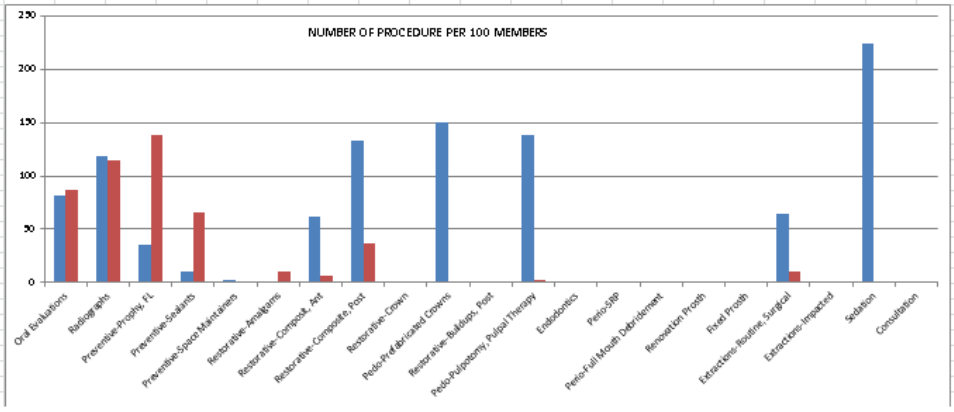
The providers' grievance and appeal trends and any member service issues are also evaluated. Providers whose performance deviates over or under our statistically expected utilization are readily identified and reviewed.

Corrective action plans are developed for the outlier providers including counseling by our dental directors and possibly desk audits and onsite reviews. Counseling and education normally results in providers changing their behaviors. Deviations can result in corrective action plans including office closure to new patients, limitation of referrals, implement more extensive pre-authorization, compensation restructure or termination if necessary. This effectively combines the process of evaluating medical necessity with the appropriateness of care and leads to better health outcomes. The over/under-utilization of services is reduced and members remain more engaged in the continuum of care. Assuring that the right care is provided not only results in the most appropriate and efficient care, but also the most cost effective care. As a result, we not only improve the health of our members, we also assure the most effective use of the funding. Figure 3.9.6.6-1 below includes an example of provider quality report.

FIGURE 3.9.6.6-1. EXAMPLE OF PROVIDER QUALITY REPORT

Office Selection:
Mbrs seen 106

# Procedures per 100 Members	Oral Evaluations	Radiographs	Preventive-Prophy, FL	Preventive-Sealants	Preventive-Space Maintainers	Restorative-Amalgams	Restorative-Composite, Ant	Restorative-Composite, Post	Restorative-Crown	Pedo-Prefabricated Crowns	Restorative-Buildups, Post	Pedo-Pulpotomy, Pulpal Therapy	Endodontics	Perio-SRP	Perio-Full Mouth Debridement	Renovation Prosth	Fixed Prosth	Extractions-Routine, Surgical	Extractions-Impacted	Sedation	Consultation
Office Locations	81	119	35	11	2	0	62	133	0	150	0	139	0	0	0	0	0	64	0	224	0
Average for Population	87	114	139	66	0	11	7	37	0	1	0	2	1	0	0	0	0	11	1	1	0



3.9.6.7 Focus on Health Outcomes

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

At LIBERTY, our QMI program is structured to facilitate concentrated attention on assessing and enhancing dental outcomes for young adults, youth, and children. We work diligently to ensure that each recipient experiences suitable individualized services which meet dental needs, while achieving the highest standards of dental, developmental, critical safety, permanency and quality of life goals.

Analysis of key demographics and outcomes for all LIBERTY recipients allows us to identify and understand variables which affect the ability of recipients to improve in accomplishing their dental health goals. Data derived from this analysis assesses LIBERTY's approach and emphases, as we continually enhance the programs and services we provide to serve recipients better. Results are monitored to assess the accessibility, effectiveness, and quality of how we deliver services.

By focusing on the specific outcomes of individual recipients, LIBERTY is able to capture and analyze information which is used to design the services and programs we implement to improve the dental health and well-being of our recipients.

3.9.7 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:

3.9.7.1 Specification of Dental Services Delivery Areas to be monitored;

LIBERTY conducts focused quality of care studies on a regular basis to evaluate clinical outcomes of dental service delivery. Our proactive approach to quality of care benefits everyone and focused quality of care studies plays an integral role in improving the oral health outcomes. The Dental Director and the QA Coordinator are actively involved in each study's development, analysis and interpretation. LIBERTY performs such studies in accordance with the Centers for Medicare & Medicaid Services.

Our quality of care studies play an integral role in how we specify the dental services to be monitored.

3.9.7.2 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;

LIBERTY will monitor and evaluate those priority areas and areas of concern as indicated by DHCFP and CMS. We have extensive experience monitoring care and services for the over 2 million Medicaid recipients we cover across the country and will implement our monitoring and improvement strategies in Nevada.

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

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

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

3.9.7.4 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;

LIBERTY agrees to comply with the requirements set forth in 3.9.7.3 and 3.9.7.4. All clinical and non-clinical Performance Improvement Projects (PIPs) will be conducted in compliance with State and federal regulations and reported to DHCFP. A detailed description of our approach to and process of PIPs is conveyed in 3.9.1.

3.9.7.5 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;

We conduct performance improvement projects as appropriate to meet federal and state program requirements, including those CMS guidelines as outlined in the most recent version of the CMS publication EQR Protocols.

3.9.7.6 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;

Quality Improvement Monitoring and Evaluation

LIBERTY's QMI Program makes the most of an integrated approach to the process of quality improvement. The QMI Program incorporates activities and information from its delegated administrative service organizations, to establish a high level of quality care that ensures patient safety and the delivery of dental services that meet professionally recognized standards. Our system incorporates the following components to achieve improvement in quality:

- ***Problem Identification – The QMI Program uses multiple avenues to identify opportunities to improve care and service including, but not limited to, data analysis from all departments, dental record audits, focused studies, credentialing information, and complaints and grievances.***
- ***Prioritization – The QMI Program prioritizes identified opportunities for improvement based on acuity, prevalence, risk, practice standards, and available resources described on the annual QMI Work Plan.***
- ***Indicator Development – Indicators are selected to monitor important aspects of care and service. An indicator may be utilized to monitor more than one aspect of care or service. Performance goals are established for each indicator or study.***
- ***Data Sources – Data analyzed in QMI activities may include membership data, utilization and claims data, referral patterns, survey data, complaint and grievance data.***
- ***Data Collection, Analysis, and Reporting – For each QMI activity, the most representative data is selected, information is compiled, results analyzed and reported. QMI staff interfaces with other involved departments to coordinate and collaborate on study design and analysis.***
- ***Development of Improvement Plans – Following analysis of collected results, the QMI Committee performs barrier analysis to identify opportunities for improvement. Individuals or teams affiliated with the specific process being evaluated are assigned responsibility for development and implementation of improvement plans.***
- ***Evaluation of Improvement Plans – Monitors are built into all improvement plans and are tracked through the QMI Work Plan to assess effectiveness.***
- ***Provider Feedback/Performance Assessment – Following the completion of QMI Program activities, results are disseminated to dental care providers, along with expectations for improvement, and opportunities for assistance from LIBERTY Dental in formulating improvement plans.***
- ***Disciplinary Action – When LIBERTY identifies a quality issue or trend that is severe enough to be reportable, the QMI Committee acts in accordance with the Corrective Action Policy and Procedures (see Appendix A). This includes the judicial review procedure, if requested by the provider. Corrective action will be***

reported to the State Board of State Examiners and the National Practitioner Data Bank.

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

LIBERTY Annual QMI Program Evaluation

LIBERTY reviews, evaluates, and documents the effectiveness of our QMI program on an annual basis. Results of the evaluation are used to formulate corrective actions needed for the next year's program and are the basis of the programs work plan. The annual evaluation, revised program, and work plan activities are submitted to LIBERTY's QMI Committee for review, input, and reporting to the board of directors for approval. The evaluation is available, upon request in any required format and timeframe specified by DHCFP.

The Dental Director and Quality Assurance staff evaluates the QMI Plan annually to appraise the effectiveness of the previous year's clinical and non-clinical initiatives, including but not limited to the following:

- ***Adherence to QMI standards, policies and procedures***
- ***Development of quality initiatives that support data-driven decision-making and support continuous ongoing measurement and re-measurement of clinical and non-clinical effectiveness***
- ***Member and Provider satisfaction;***
- ***Development and implementation of programmatic improvements to clinical and non-clinical processes, based on results from ongoing measurement;***
- ***Results of focused quality of care studies and other quality initiatives***
- ***Effectiveness of corrective action plans.***

Approximately three months prior to the end of each contract year, LIBERTY reviews the Plan to identify issues and potential revisions, incorporating the concerns and feedback from staff, customers, members and providers. The Quality Management and Improvement Committee (QMI) is presented with the evaluation report, which is reviewed to formulate recommendations for continuous process improvement revisions. After the revisions have been approved, they are formally presented to the Board of Directors for review and approval. All approved revisions are incorporated into the Work Plan, and distributed to employees and plan partners, as appropriate.

The QA Department also prepares an annual report that summarizes the previous year's quality activities. The Dental Director and QA Coordinator will prepare the first draft of the annual report. The report will summarize the overall effectiveness of the previous

year's Work Plan. Once finalized, it is reviewed by the dental director and presented to the QMI for first-level review and approval. The

Annual QMI Evaluation and Report includes but is not limited to the following:

- ***Results and outcomes of internal performance***
- ***Focused quality of care studies***
- ***On-Site visits***
- ***Effectiveness of provider reviews***
- ***Potential Quality of Care Issues***
- ***Grievances***
- ***Member/Provider Satisfaction Survey results***

3.9.7.8 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

We actively monitor and evaluate various aspects of care and service that intersect with and have an impact on delivering high quality dental services. Our QMI Program is an integrated effort across multiple departments and includes the following:

- ***Dental management***
- ***Credentialing***
- ***Standards of care***
- ***Dental records***
- ***Utilization review***
- ***Peer review***
- ***Environmental health and safety/infection control***
- ***Member and provider grievances***

Our QMI Program structure and activities focus on the following components of quality that are included in established definitions of high-quality dental care services:

- ***Accessibility of care: the ease and timeliness with which patients can obtain the care that they need when they need it.***
- ***Appropriateness of care: the degree to which the correct care is provided, given the current standard of the community.***
- ***Continuity of care: the degree to which the care needed by patients is coordinated among practitioners and is provided without unnecessary delay.***
- ***Effectiveness of care: the degree to which the dental care provided achieves the expected improvement in dental health consistent with the current standard of the community.***

- ***Safety of the care environment: the degree to which the environment is free from hazard and danger to the patient.***

3.9.7.9 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.

We understand the quality penalty fee as outlined in 3.9.7.9. We proactively assess the effectiveness of a given PIP, allowing us to implement any corrective actions, adjustments or improvements to the PIP to address a decline in performance.

3.9.8 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.

3.9.8.1 The vendor is required to:

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

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

C. 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

D. 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.

We assess clinical and non-clinical aspects of quality activities and performance improvement by monitoring and evaluating objective quality indicators. The quality indicators are used in the development, assessment and modification of the Quality Management Improvement (QMI) Program. LIBERTY complies with standards developed by NCQA and the American Dental Association to ensure that measures reflect best practices of dental health care.

Experience using Performance Measures

We have experience monitoring and reporting on various types of performance measures. We currently generate HEDIS, CHIP Core Set and CMS-416 measures and reports, specifically measuring 12-A through 12-E for dental utilization. We monitor these

reports to develop comprehensive action plans to increase utilization of services, especially preventive dental services for beneficiaries.

We have the necessary systems and resources in place to collect clinical indicator data to implement deliberate strategies to improve outcomes and performance measures. Once clinical and non-clinical areas of measurement have been identified, we will analyze the data collected by geographic location and demographic composition and develop programs, initiatives, and or campaigns targeted at improving performance measures and overall dental services for recipients.

We have extensive experience and quantifiable success with HEDIS data collection and related activities designed to improve dental health care for Medicaid and CHIP programs.

Table 3.9.8-1 is a report for a Florida health plan with which we are contracted to provide dental services for Medicaid enrollees. This health plan has specific utilization goals to reach year-by-year starting in 2017. The table shows that LIBERTY, acting on behalf of the FL health plan, has already reached the 2019 goal for the preventive measure, the 2018 goal for dental treatment measure and the 2020 goal for Annual Dental Visit measure.

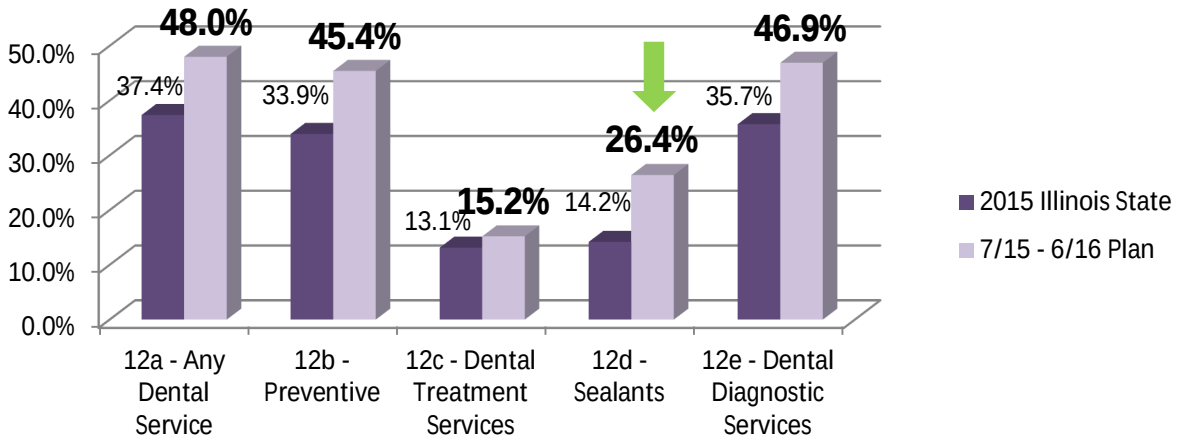
TABLE 3.9.8-1. FLORIDA MEDICAID PERFORMANCE MEASURE GOALS VS.2015 ACTUAL PERFORMANCE

	2017	2018	2019	2020	2021	LIBERTY FL Plan 2015
Preventive	30%	32%	35%	38%	42%	36.0%
Dental Treatment Services	14%	16%	18%	20%	22%	16.4%
Annual Dental Visit (ADV)	45%	46%	47%	48%	49%	48.2%

We also have extensive experience monitoring and reporting CMS performance measures. Below are results for a Medicaid health plan in Illinois with whom we are contracted to provide dental services to Medicaid enrollees (Figure 3.9.8-2). For reporting period July 2015 - June 2016, the Illinois plan is running between 15% and 86% higher than the overall State of Illinois CMS-416 calendar year 2015 results. The largest variance is in sealants, with our Illinois plan showing a 26.4% usage rate compared to the overall State of Illinois' result of 14.2%.

FIGURE 3.9.8-2. LIBERTY ILLINOIS PLAN PERFORMANCE OUTCOMES

CMS-416 Measure	2015 Illinois State	7/15 - 6/16 IL Plan	IL Plan Higher than Statewide
12a - Any Dental Service	37.4%	48.0%	28.5%
12b - Preventive	33.9%	45.4%	33.9%
12c - Dental Treatment Services	13.1%	15.2%	15.8%
12d - Sealants	14.2%	26.4%	86.1%
12e - Dental Diagnostic Services	35.7%	46.9%	31.5%



We generate automated reports, along with satisfaction survey results, to evaluate appropriate dental measures. As directed by the Dental Director, the Quality Assurance (QA) Coordinator ensures that all aspects of monitoring and evaluation meet applicable state and federal privacy/confidentiality laws and that reports of such activities are delivered to the QMI Committee, health plan partners (where applicable), and regulatory agencies, as required.

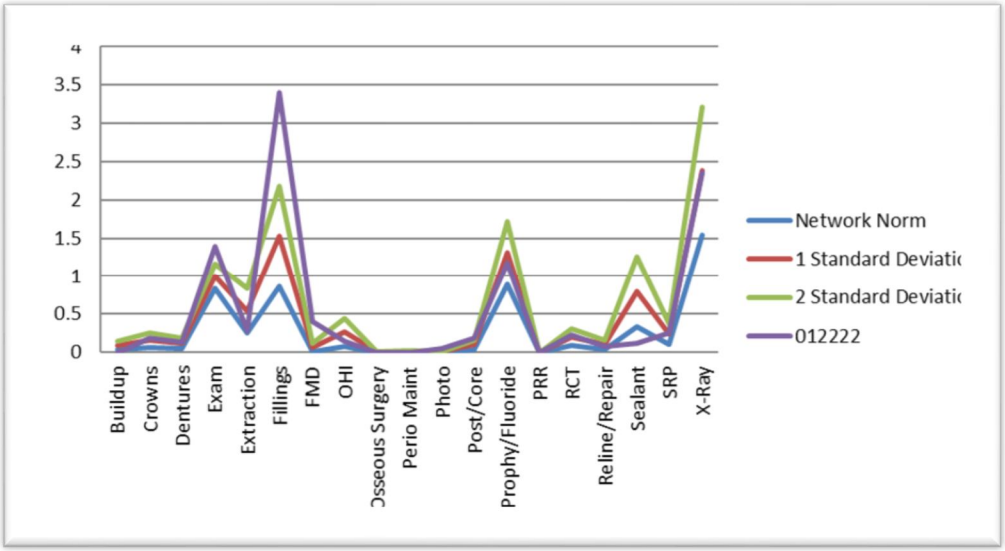
Monitoring and Addressing Over- and Under-Utilization

LIBERTY relies on utilization data to monitor trends in member utilization, as well as provider prescribing patterns, to ensure beneficiaries are accessing appropriate services and providers are emphasizing preventive and restorative services when

appropriate. In the past year, we have developed a proprietary UM analysis tool that allows us to establish network normative patterns for every dental service category. LIBERTY's core MIS application is a single source application that houses all data in a single platform, creating a flexible, integrated system that provides both functionality and customization capabilities. We use various methods to identify and track Utilization Data from our core application. Our system houses Claims, Estimate, Check, Provider/Office, Group, Billing, Member communications, and all other supporting data. Our reporting tools enable us to pull data from the core system on a regular basis, using the existing datasets, which can then be exported and referenced for a variety of reporting needs. These include test and reporting environments, data warehouse, and custom applications that share data from the core system.

In addition, our UM analysis tool automatically analyzes every network dental office against the established patterns of utilization and identifies both over and under-utilizing providers in each dental service category. The UM Tool (Figure 3.9.8-3) allows us to develop customized corrective actions and counseling for every provider identified.

FIGURE 3.9.8-3. UM TOOL AUTOMATED OUTPUT CHART – INDIVIDUAL OFFICE COMPARED TO NORMS BY SERVICE



Our system can also add custom logic to the claims adjudication process (Transforms), which allows us to identify unique pre-authorization and/or claim elements (e.g., at the procedure code, category of service and/or provider level) on claims for Nevada Medicaid. Custom logic provides the opportunity to evaluate for fraud, waste, and abuse (FWA) and other outliers. Through our automated custom evaluation logic, we

can rapidly identify potential over- and under-utilization patterns to ensure beneficiaries are seeking the appropriate care.

Our UM analysis tool automatically analyzes every network dental office against the established patterns of utilization and identifies both over and under-utilizing providers in each dental service category. The Dental Director or designee assesses over- and under-utilization and reports findings and recommended actions to the Utilization Management Committee. The UM Committee reviews, analyzes, and assesses trends of providers. Annual utilization trends occur in the month of January and involve review of the previous year. Assessment trends include, but are not limited to the following:

- ***Analysis of the utilization data (members eligible, members utilized, annual utilization rate, procedures per visit, procedures per member, average UCR per member, fees per member, capitation difference, etc.).***
- ***Analysis of utilization trends (diagnostic, preventive, restorative, endodontic, periodontic, oral surgery, etc.).***
- ***Analysis of procedure ratios (i.e.: crowns/fillings, root canals/extractions, etc.).***
- ***Analysis of provider trends.***
- ***Evaluation of member access and availability to service.***
- ***Evaluation of utilization related grievances.***
- ***Monitoring under-/adequate-/over-utilization.***
- ***Member satisfaction survey results.***
- ***Provider satisfaction survey results.***
- ***Denial and appeal rates.***
- ***Provider referral and specialist care patterns of practice.***
- ***Access to Specialty care, ancillary services and appropriate preventive dental services.***

FIGURE 3.9.8-4. SAMPLE UTILIZATION MANAGEMENT REPORT FOR UNDER-UTILIZATION

			Standard Deviation	$40.65		0.9		0.15906																
			Threshold	$251		7.7		0.434056																
Office Number	Office Name	Mbrs Seen	Total Paid	Avg Paid/Mbr	Non D&P Proc	Avg Non D&P Proc/Mbr	D1351	Avg Sealant/mbr	D2140	D2150	D2160	D2161	D2330	D2331	D2332	D2335	D2390	D2391	D2392	D2393	D2394	Fillings	Avg Fillings/Mbr
34	Office1	127	$41,785	$329	934	7.4	26	0.204724	1				2	11	5	1		23	55	28		126	1.0
35	Office2	73	$20,136	$276	539	7.4	24	0.328767					3	2	2	9		3	15	5		39	0.5
36	Office3	107	$26,491	$248	704	6.6	25	0.233645					2	4	2			19	49	17		93	0.9
37	Office4	261	$60,961	$234	2,200	8.4	122	0.467433					14	7	9	7		73	127	33		270	1.0
38	Office5	248	$57,250	$231	1,653	6.7	24	0.096774					1	1	3	5		33	63	1		107	0.4
39	Office6	133	$30,469	$229	922	6.9	8	0.06015						1		2		31	52			86	0.6
40	Office7	207	$46,572	$225	1,649	8.0	44	0.21256					3	1	16		5	6	119	25		175	0.8
41	Office8	697	$154,130	$221	3,910	5.6	211	0.302726					3	5			11	90	80	3		192	0.3
42	Office9	269	$55,758	$207	1,804	6.7	66	0.245353					24	2	1	1		40	66	8		142	0.5
43	Office10	133	$27,429	$206	743	5.6	41	0.308271					3	2	4	2	3	13	70	15		112	0.8
44	Office11	104	$20,616	$198	680	6.5	34	0.326923					1	2	1			24	30	1		59	0.6
45	Office12	156	$29,366	$188	1,023	6.6	9	0.057692							1	1		20	30			52	0.3
46	Office13	194	$35,733	$184	1,582	8.2	31	0.159794	9	18	1		1		2	4		7	76	21		139	0.7
47	Office14	259	$47,225	$182	1,610	6.2	58	0.223938					8	1	4	1	1	90	90	8		203	0.8
48	Office15	135	$24,348	$180	977	7.2	16	0.118519	2	5			5	1	12	1		12	64	20		122	0.9
49	Office16	288	$51,754	$180	1,495	5.2	159	0.552083					4	2	3			47	100	26	7	189	0.7
50	Office17	98	$17,274	$176	675	6.9	27	0.27551								5		12	32	8		57	0.6
51	Office18	284	$49,100	$173	1,518	5.3	155	0.545775					3		4	5		51	130	20		213	0.8
52	Office19	172	$29,096	$169	1,328	7.7	32	0.186047	2	7			2		6			9	74	18		118	0.7

The UM Tool allows us to develop customized corrective actions and counseling for every provider identified. Analysis and determination of corrective action is scheduled at least quarterly or more often as needed. The results of the UM analysis and identified over and under-utilizing providers are forwarded with our Dental Care Management (DCM) team where custom corrective action plans and counseling are created. DCM also determines the severity of the corrective action and determines if immediate, more invasive action is required by our clinical staff. DCM also uses the UM analysis to make determinations about potential fraud, waste and abuse cases that are forwarded to our Special Investigations Unit (SIU) for further investigation and development to appropriate internal actions as well as fulfilling our regulatory reporting requirements to appropriate authorities as necessary.

3.9.8.2 Use of Clinical Care Standards/Practice Guidelines

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

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

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

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

E. 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;

F. The standard/guidelines must address preventive dental services;

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

H. The IQAP shall use these standards/guidelines to evaluate the quality of care provided by the vendor's providers, whether the providers are organized in groups, as individuals, or in combinations thereof.

Clinical Dentistry Criteria and Practice Guidelines

LIBERTY's Clinical Criteria Guidelines and Practice Parameters (CCGs) were developed in 2005 and are subject to periodic revisions and an annual review by our Peer Review Committee. The CCGs were developed internally by our Dental Director with input from participating panel general dentist and specialists to ensure sound dental clinical principles, processes and evidence to consistently evaluate the appropriateness of preventive and restorative dental services.

LIBERTY understands that unlike in medicine, there are multiple treatment alternatives for many dental conditions and therefore, single source clinical guidelines aren't readily available. LIBERTY's CCGs are derived from publications of organized dentistry and education from United States based dental schools. References Include:

4. ***Knox-Keene Dental Guidelines. Department of Corporations Health Care Service Plan Division, Sacramento, Calif; December 1985:26.***
5. ***ADA Clinical Practice Guidelines Handbook – a guide to creating clinical guidelines (http://ebd.ada.org/~/media/EBD/Files/ADA_Clinical_Practice_Guidelines_Handbook-2013.pdf?la=en).***
6. ***California Dental Association Guidelines for the Assessment of Clinical Quality & Professional Performance; 1995-2010 (http://www.cda.org).***

Our CCGs are an essential component of Utilization Management and Dental Care Management programs. The CCG and Practice Parameters, and are based on sound clinical dentistry and the professionally recognized standards of care. Clinical staff,

including, but not limited to, members of the Peer Review Committee and the QMI Committee, conduct an annual review of the CCGs and perform periodic revisions as appropriate; such revisions are reported to the Board of Directors on a quarterly basis. The CCG document was developed internally by our Dental Directors with input from participating panel general dentists and specialists. LIBERTY utilized NCQA standards, the American Dental Association's "Dental Practice Parameters," and "Guidelines for the Assessment of Clinical Quality and Professional Performance," sound dental clinical principles, processes and evidence to consistently evaluate the appropriateness of dental services.

Our CCGs are currently undergoing an evaluation and upgrade, and we anticipate the new criteria will be finalized in early 2017.

Informing Providers and Recipients about Clinical Criteria Guidelines

We understand that implementing new and existing clinical guidelines is a multifaceted approach. The CCGs are available to providers through, the provider manual, our exclusive web-based provider portal and through fax blasts. The Guidelines are consistently reinforced by our Provider Relations team and on-site visits and service calls. Additionally, our CCGs are reinforced through pre-authorization and claim decisions.

Recipients can request a copy of the CCG document at any time through our Member Services department.

Monitoring Implementation

LIBERTY has significant experience in monitoring dental office compliance with our CCGs in dental programs in 27 states. Monitoring of guidelines is done through a combination of utilization management, review of member complaints/grievances, provider and member satisfaction surveys, and on-site visits from Provider Relations staff. Section 3.9.8 contains Figure 3.9.8-3 **which depicts** ***a sample UM reports we utilize to determine whether providers are performing procedures in compliance with the CCGs.***

Additionally, on an annual basis, we select a random sampling of general dentist to conduct a review of member's dental records. In this exercise we evaluate the provider's performance and patient care against our Clinical Criteria Guidelines and the professionally recognized standards of dental care. All results and any corrective actions plans are shared with our QMI Committee and if necessary our Peer Review Committee.

In 2016 there were over 600 provider offices selected for routine dental chart reviews in California to ensure compliance with state and program regulations and guidelines consistent with the CCGs. The chart audit tool included in Attachment 12 is used to monitor adherence to the CCGs. Provider offices that are identified with 3 or more occurrences of elements which LIBERTY considers critical are issued a Notice of Corrective Action.

In our California Plan, a total of 618 provider offices were selected for dental chart reviews in 2016.

Corrective Action Plans (CAPs) were issued for 99 offices as of the end of Q2

Chart Review Critical Deficiencies:

- ***Missing or inadequate soft tissue/oral cancer exams.***
- ***Missing, inadequate or unsigned Informed Consent for Treatment Plan.***
- ***Clinically unacceptable Overall Patient Care (to the extent possibly determined by x-rays and available information).***

The average chart audit score at the end of Q2 2016 was 91%. There were 37 offices with one or more critical procedural deficiency identified during our review of dental charts. Those 37 offices were added to the Potential Quality Issues log for tracking and trending. Interventions based on the findings of each review may include:

- ***A Dental Director call to educate the provider on adherence to the CCGs.***
- ***A Notice of Corrective Action Letter requiring acknowledgement and attestation to correct deficiency.***
- ***A Desktop focused claims review to substantiate potential quality issues.***
- ***A follow up shortened audit to confirm continued compliance with CCGs.***

3.9.8.3 Analysis of Clinical Care and Related Services

A. Qualified clinicians monitor and evaluate quality through the review of individual cases where there are questions about care, and through studies analyzing patterns of clinical care and related service. For issues identified in the IQAPs targeted clinical areas, the analysis must include the identified quality indicators and use clinical care standards or practice guidelines;

B. 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;

C. Clinical and related service areas requiring improvement are identified;

D. 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

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

We conduct focused quality of care studies on a regular basis to evaluate clinical outcomes of dental service delivery. Our proactive approach to quality of care benefits everyone and focused quality of care studies plays an integral role in improving the oral health outcomes. The Dental Director and the QA Coordinator are actively involved in each study's development, analysis and interpretation. LIBERTY performs such studies in accordance with the Centers for Medicare & Medicaid Services'.

We assess clinical aspects of quality activities and performance improvement by monitoring and evaluating objective quality indicators. The quality indicators are used in the development, assessment and modification of the Quality Management Improvement (QMI) Program. LIBERTY complies with standards developed by NCQA and the American Dental Association to ensure that measures reflect best practices of dental health care.

We maintain a specific focus on the quality of clinical care and related services delivered by our network providers. Our goals are to:

- ***Ensure the provision of quality dental services that focus on patient needs, comfort and function, in an environment that emphasizes safety and appropriate dental improvement by competent staff***
- ***Ensure diagnostic evaluation and treatment is based on professionally recognized standards of care***
- ***Provide a structure for provider education that promotes preventive services and appropriate treatment of dental conditions using dental practice guidelines that optimize outcome and reduce morbidity***
- ***Develop population-based quality indicators for assessment of dental service that are objective, measurable, and in accord with current standards of care and clinical experience***

We have the necessary systems and resources in place to collect clinical indicator data to implement deliberate strategies to improve outcomes and performance measures. Once clinical and related service areas of measurement have been identified, we will analyze the data collected by geographic location and demographic composition (including race and ethnicity) and develop programs, initiatives, and or campaigns targeted at improving performance measures and overall dental services for program Members.

LIBERTY analyzes the quality of clinical services through the following mechanisms:

- ***Evaluating performance using objective quality indicator data;***
- ***Fostering data-driven decision making;***
- ***Recognizing that opportunities for improvement are limitless;***

- ***Soliciting Member and network provider input on performance and QMI activities;***
- ***Supporting continuous ongoing measurement of clinical and non-clinical effectiveness and Member satisfaction;***
- ***Supporting programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements; and***
- ***Supporting re-measurement of effectiveness and member satisfaction, and continued development and implementation interventions as appropriate.***

3.9.8.4 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.

3.9.8.5 These written corrective action procedures must include:

A. Specification of the types of problems requiring corrective action;

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

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

D. The schedule and accountability for implementing corrective actions;

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

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

3.9.8.6 Assessment of Effectiveness of Plans of Correction (POC)

A. 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.

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

Corrective Action Plans

Our Dental Director can recommend remedial action in the form of corrective action plans and follow-up whenever inappropriate dental care is identified, over-utilization of services that unfavorably affect patient care, under-utilization of needed services, insufficient accessibility or availability of services, inappropriate

Provider Corrective Action Plans include discussion and counseling calls, as well as routine and focused desk and on-site reviews, which are accomplished professionally, effectively and efficiently.

referral practices or breaches in our policy regarding benefit applications and charges.

We review various tools to identify opportunities for improvement and the need to enforce a corrective action plan. We monitor the following sources for evidence that a provider is delivering substandard services or not meeting goals for utilization:

- ***Utilization data***
- ***Quality metrics***
- ***Access and availability data***
- ***Recipient surveys***
- ***Grievance and appeals data***

Implementing Corrective Action

Upon approval, corrective action begins with notifying the provider of the observed deficiencies and providing an explanation of actions required or recommended to correct the deficiencies. Corrective measures may include one or more of the following:

- ***Clinical peer review***
- ***Special claims review***
- ***Referral to the applicable state dental board***
- ***More on-site assessments***
- ***Mandatory prior authorization***
- ***Member enrollment restrictions***
- ***Termination of the provider agreement.***

If a provider is identified as having any aberrant utilization pattern or concern for potential quality issue, the Network Manager is notified. The Network Manager will schedule a counseling session with the provider, the Care Management staff, and our Dental Director to review the occurrence in question, discuss patterns identified, evaluate standards of care, and determine next steps. A summary of the meeting is documented using our Provider Service Report (PSR). We also take this opportunity to educate providers and review our general standards of care, reminding them of our policies and procedures.

A follow up meeting is scheduled within 60 or 90 days (depending on the severity of the concern) to evaluate if there was improvement. If no improvement is made, we may take a variety of actions including but not limited to: (a) conduct an additional counseling session, (b) request a formal corrective action plan from the provider, (c) restrict the provider to new beneficiaries and (d) ultimately proceed in terminating the

provider from the network. LIBERTY will not consider a corrective action plan closed from a dental office until we are certain our members are receiving excellent dental care.

3.9.8.7 Evaluation of Continuity and Effectiveness of the IQAP

A. 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;

B. 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

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

LIBERTY's Quality Management and Improvement (QMI) Work Plan is designed to provide a formal ongoing process by which LIBERTY, and participating providers utilize objective measures to monitor and evaluate the quality of services, clinical and administrative, provided to members. The work plan addresses services, defines and facilitates a systematic approach to identify and pursue opportunities to improve services and resolve identified problems. The Work Plan is updated, reviewed and approved by LIBERTY Dental Plan's Board of Directors on an annual basis.

In our California business, there were 84 verified potential quality issues (PQI) resolved in just the 1st quarter of 2016.

The QMI Work Plan is developed under the direction of the Chief Dental Officer/Dental Director to assist with the following tasks:

- ***Documentation of the next year's goals and objectives for planned projects and activities, including clinical and non-clinical programs, initiatives and measurement activities.***
- ***Required effort to accomplish stated goals and objectives.***
- ***Identification of tasks and subtasks according to a work breakdown structure.***
- ***Allocation of resources, task planning and scheduling.***
- ***Monitoring and control of task progression.***
- ***Preparation of the Annual QMI Evaluation and Report.***

We document all QMI improvement initiatives, process and procedures, defines goals, objectives, specific activities, responsible parties and targeted timeframes for

completion or resolution of activities. The Work Plan is developed annually with National Committee for Quality Assurance (NCQA best practice standards simulated for dental services and built upon the evaluation, recommendations and findings of the previous year's Work Plan.

Our Work Plan focuses on the accessibility, availability, appropriateness, continuity, effectiveness, and timeliness of dental care as well as the safety of service delivery environment. The Work Plan encompasses distinct functions that mirror applicable NCQA components for the delivery of care. An excerpt of our QMI Work Plan can be found in section 3.9.6.4 – Table 3.9.6.4-1.

3.9.9 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:

3.9.9.1 Oversight of IQAP

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

Our quality improvement resources are designed to meet its enrollees' needs and to effectively carry out all designated QMI Program functions including the development, implementation, and evaluation of quality improvement program activities. The senior leadership of LIBERTY Dental Plan consists of experienced, well-qualified administrative and clinical leaders with a commitment to the delivery of quality care and service.

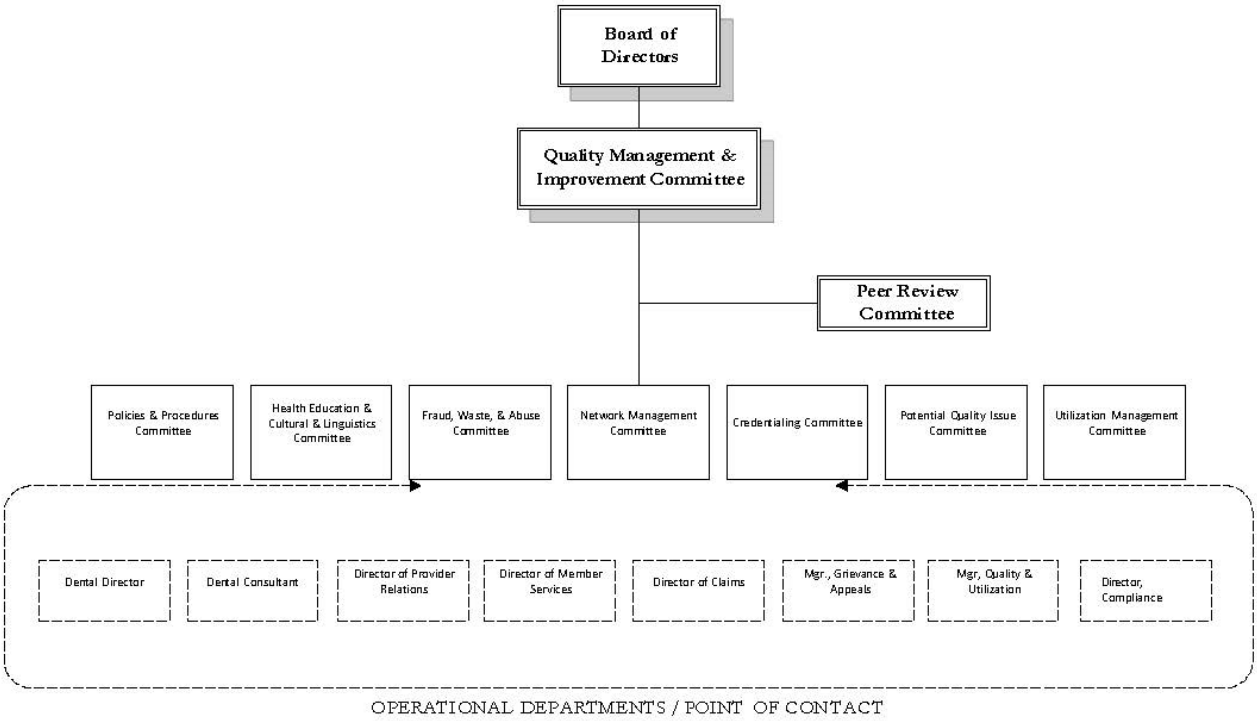
The LIBERTY Dental Plan Board of Directors has ultimate responsibility for the quality of care and service delivered to the members and retains overall responsibility for the Quality Management and Improvement Program. The Board of Director's authority is delineated in LIBERTY's Quality Program Description.

3.9.9.2 Oversight Entity

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

The LIBERTY Board of Directors delegates oversight of the Program to LIBERTY's Dental Director. The Dental Director delegates specific responsibilities to the QMI Committee and its Sub-Committees. Figure 3.9.9.2-1 below illustrates our QMI Program Structure.

FIGURE 3.9.9.2-1 LIBERTY DENTAL PLAN QMI PROGRAM ORGANIZATIONAL STRUCTURE



3.9.9.3 IQAP Progress Reports

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

The LIBERTY Quality Management and Improvement (QMI) Committee meets quarterly, where the delegated entities report findings and actions taken, and if deficiencies and issues exist, identify the specific providers or dental care process issues that present new or chronic quality of care issues, as appropriate.

A quarterly report summarizing the QMI Committee activity is prepared by the LIBERTY Dental Director and submitted to the QMI Committee of LIBERTY Dental. An example from our California program is included in TABLE 3.9.9.3-1 below. Annually, a summary of the data reported for the year's work plan objectives is presented to the QMI Committee and forwarded to the Board of Directors. This report indicates trending of clinical services, quality indicators and other relevant performance data. It measures improvements in accessibility, availability and quality of care. It cites evidence that supports the goal of the QMI Program to contribute to improvement in care and

services. LIBERTY conducts additional performance measurements and performance improvement projects as appropriate to meet federal and state program requirements, including CMS.

TABLE 3.9.9.3-1. Q1 2016 CALIFORNIA QUALITY MANAGEMENT AND IMPROVEMENT (QMI) REPORT SUMMARY

QMI Committee Reporting	Status
I. California Public Policy Committee	
II. Peer Review Committee	
A. Professional Appeal Activity	COMPLIANT – TIMELY
B. Independent Quality of Care Assessments	MINOR DEFICIENCIES – ACTIONS PENDING
C. Inter-Rater Reliability	COMPLIANT – TIMELY
D. Potential Quality Issues	COMPLIANT – TIMELY
III. Grievance and Appeals	
A. Grievance Activity	COMPLIANT – TIMELY
B. Grievances Pertaining to Access and Availability	COMPLIANT – TIMELY
C. Exempt Grievances	COMPLIANT – TIMELY
D. Exempt Grievances Pertaining to Access and Availability	COMPLIANT – TIMELY
E. Appeals Activity	COMPLIANT – TIMELY
F. Grievance and Appeals Ratios	COMPLIANT – TIMELY
G. National Provider Dispute Report	COMPLIANT – TIMELY
IV. Network Management Committee	
A. Network Accessibility Report	COMPLIANT – TIMELY
B. Specialist Accessibility Report	COMPLIANT – TIMELY
C. Appointment Availability Report	COMPLIANT – TIMELY
D. Network Management Activity	COMPLIANT – TIMELY
V. Credentialing Committee	
A. Initial and Re-Credentialing Activity	COMPLIANT – TIMELY
B. Adverse Credentialing Determinations	COMPLIANT – TIMELY
VI. Cultural and Linguistics Committee	
A. Cultural and Linguistics Report	COMPLIANT – TIMELY
VII. Utilization Management Committee	
A. Utilization Report	COMPLIANT – TIMELY
B. Utilization Review Report	COMPLIANT – TIMELY
C. Under-Utilization/Non-Reporting	COMPLIANT – TIMELY
D. Referral Track and Trend	COMPLIANT – TIMELY
VIII. Special Investigations Unit	
IX. Call Center	
A. Call Center Metrics	MINOR DEFICIENCIES – ACTIONS PENDING
X. Health Education and Outreach Work Group	
A. Member Education/Outreach	COMPLIANT – TIMELY
B. Member Satisfaction Surveys	MINOR DEFICIENCIES – ACTIONS PENDING
C. Provider Education/Outreach	COMPLIANT – TIMELY
D. Provider Satisfaction Surveys	N/A
XI. Policy, Procedures and Program Evaluations	
A. Program Management Policy & Procedures	COMPLIANT – TIMELY
B. Quality Program Evaluations	N/A
XII. Annual Reporting	
XIII. Regulatory and Client Reporting Compliance	
A. Client Delegated Audits	COMPLIANT – TIMELY
B. Regulatory or Client Deliverables	COMPLIANT – TIMELY
XIV. Quality Improvement Projects and Activities	

3.9.9.4 Annual IQAP Review

3.9.9.5 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:

A. Studies undertaken;

B. Results;

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

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

3.9.9.6 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.

Annual QMI Program Evaluation

The Quality Management and Improvement Program document and the effectiveness of the program are reviewed, evaluated and revised on an annual basis. Results of the evaluation are used to formulate corrective actions needed for the next year's program and are the basis of the programs work plan. The annual evaluation, revised program and work plan activities are submitted to the QMI Committee of LIBERTY Dental for review, input and reporting to the Board of Directors for approval. The Evaluation, as provided in Attachment 13, is available upon request in any required format and timeframe specified by any Health Plan Partner or Government Agency.

The QMI Committee appraises the effectiveness of the previous year's clinical and non-clinical initiatives, including but not limited to the following:

- ***Adherence to QMI standards, policies and procedures***
- ***Development of quality initiatives that support data-driven decision-making and support continuous ongoing measurement and re-measurement of clinical and non-clinical effectiveness***
- ***Member and Provider satisfaction;***
- ***Development and implementation of programmatic improvements to clinical and non-clinical processes, based on results from ongoing measurement;***

- ***Results of focused quality of care studies and other quality initiatives***
- ***Effectiveness of corrective action plans.***

Approximately three months prior to the end of each contract year, LIBERTY reviews the Plan to identify issues and potential revisions, incorporating the concerns and feedback from staff, customers, members and providers. The QMI Committee is presented with the evaluation report, which is reviewed to formulate recommendations for continuous process improvement revisions. After the revisions have been approved, they are formally presented to the Board of Directors for review and approval. All approved revisions are incorporated into the Work Plan, and distributed to employees and plan partners, as appropriate.

The QA Department also prepares an annual report that summarizes the previous year's quality activities. The Dental Director and QA Coordinator will prepare the first draft of the annual report. The report will summarize the overall effectiveness of the previous year's Work Plan. Once finalized, it is reviewed by the dental director and presented to the QMI for first-level review and approval. The Annual QMI Evaluation and Report includes but is not limited to the following:

- ***Results and outcomes of internal performance***
- ***Focused quality of care studies***
- ***On-Site visits***
- ***Effectiveness of provider reviews***
- ***Potential Quality of Care Issues***
- ***Grievances***
- ***Member/Provider Satisfaction Survey results***

3.9.10 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:

3.9.10.1 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.

3.9.10.2 Established Parameters for Operating

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

3.9.10.3 Documentation

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

3.9.10.4 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.

3.9.10.5 Membership

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

Proposed QAPI committee membership and committee responsibilities.

The QMI Committee is responsible for annual review of the Quality Management and Improvement Program. The Chief Dental Officer/Dental Director, who is the senior dental executive with responsibility for our Quality Management and Improvement Program, delivers the annual written report on the status of QMI activities to LIBERTY Dental Plan's Board of Directors. The results of the annual reviews are noted in the minutes of QMI Committee meetings, which are available for inspection by governmental and independent auditors.

Our QMI Committee and any delegated entities to which QMI responsibilities have been delegated shall meet quarterly or more frequently if problems have been identified, to oversee their respective QMI program responsibilities. At the quarterly meeting, the delegated entities will report findings and actions taken, and if deficiencies and issues exist, identify the specific providers or dental care process issues that present new or chronic quality of care issues, as appropriate.

The QMI Committee incorporates into its assessment any information it receives on the results of LIBERTY's Peer Review Committee and various regulatory agencies, and ensures that any identified issues are addressed with LIBERTY's Dental Director, with recommendations for appropriate Quality Management and Improvement Program modifications. This process is designed to facilitate a rapid response to identified concerns, in order to maintain a program that effectively and efficiently monitors the quality of dental care.

QMI Committee Representatives

Our QMI Program enlists the expertise and guidance of various quality-related departments throughout our Dental Plan. Membership of the QMI Committee consists of representatives from quality departments that support our operations and are listed below:

- ***LIBERTY Dental Director.***
- ***Utilization Management Dental Director.***
- ***Chief Operating Officer.***
- ***Vice President Provider Relations.***
- ***Director of Claims.***
- ***QM/UM Director.***
- ***Credentialing Supervisor.***
- ***Contract/Network Manager.***
- ***Director, Member Services.***
- ***Compliance Director.***
- ***Grievance and Appeals Director.***
- ***Dental Consultants.***
- ***A general dentist(s) representative provider from each of LIBERTY's network.***
- ***Specialty Dentist active with LIBERTY.***

QMI Committee Responsibilities

The Quality Management and Improvement Committee is responsible for the development and implementation of policies and procedures that establish processes and monitoring mechanisms for:

- ***Member grievances.***
- ***Member accessibility of services.***
- ***Confidentiality of patient information.***
- ***Assessment of patient satisfaction.***
- ***Audit standards.***
- ***Linkage between utilization management, administrative and QMI functions.***
- ***Assessment of provider satisfaction.***
- ***Utilization analysis.***
- ***Evaluation of clinical issues.***
- ***Program guidelines.***
- ***QMI Processes and Studies (audit results, quality and outcome studies/results and studies overtime).***
- ***Panel Recruitment and Retention Summaries.***

- ***Health promotion activities targeting the enrolled population.***

The committee meets a minimum of four times per year. Contemporaneous minutes are taken and maintained by designated dental staff. Voting rights are limited to dentists. Each member of the QMI Committee abides by a Confidentiality and Conflict of Interest agreement.

3.9.11 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.

The LIBERTY Board of Directors delegates oversight of the Program to LIBERTY's Chief Dental Officer/Dental Director. The Chief Dental Officer/Dental Director is the senior dental executive with responsibility for LIBERTY Dental Plan's Quality Management and Improvement Program and delivers the annual written report on the status of QMI activities to LIBERTY Dental Plan's Board of Directors.

3.9.12 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.

LIBERTY Dental has provided staff resources and a structure required to provide quality management continuity of care, utilization management, grievance and appeal systems, and access and availability of services. The qualifications and educational requirements for LIBERTY Dental Plans key staff, committees, and bodies responsible for quality improvement activities include the following key roles:

Dental Director

The Dental Director is instrumental in driving how to develop and manage programs, centered on continuously evaluating and improving our clinical model and how participation in the delivery of dental benefits solutions. The Dental Director collaborates with other health care providers in reviewing actual and proposed dental care and services against established criteria guidelines. This position also supervises and coordinates activities under the Utilization Management (UM) Program including prior authorizations, dental review and review under the guidance of the criteria established by the UM committee. Qualifications for this position include A current, valid state

license to practice dentistry, At least five years' experience in the active practice of dentistry, and a thorough understanding of the delivery of dental managed care.

Dental Consultant

The Dental Consultant is responsible for the determination of Quality Management (QM) cases (i.e. enrollee, grievances, second opinion request, pre-determination of benefits, provider disputes, regulatory complaints, and related appeals). The Dental Consultant collaborates with other health care givers in reviewing actual and proposed dental care and services against established criteria guidelines. Qualifications for this position include A current valid state license to practice dentistry, At least five years' as a practicing dentist, and knowledge of current dental terminology, practices, materials, and generally accepted standards.

Compliance Director

The Compliance Manager is responsible for all phases of project management for regulatory and client contract compliance audits. The Compliance Manager creates and implements internal controls to ensure compliance with federal and state laws and regulations. Responsibilities include planning, directing, and completing compliance audits. Qualifications for this position include a JD, MBA or other advanced degree; 5-7 years of progressive experience delivering and managing compliance audit services with experience in a healthcare setting; Experience with Medicare programs; Familiar with HIPAA regulations and other federal and state laws that pertain to healthcare. In addition, Experience performing healthcare audits and managing corrective action plans is required.

- ***Excellent Computer Skills mainly with Microsoft Applications.***
- ***Project Management experience.***

Director, Quality and Utilization Management

The Manager of Quality and Utilization Management is responsible for managing Quality, Utilization, and Case Management operations in accordance with LIBERTY Dental Plan's policies, procedures, and processes. Qualifications for this position include:

- ***Bachelor's Degree, in a Healthcare related field., a thorough understanding of dental benefit plan administration including federal CMS, managed care, a minimum of 3-5 years in UM/QM or case management experience.***

Director of Member Services

The Director of Member Services has an overall strategic and operational responsibility for Member Services and Fulfillment. This position provides direction and leadership

toward the achievement of the organization's philosophy, mission, strategy and its goals and objectives. Manages daily activities of Member Services and Fulfillment departments while ensures the highest level of customer satisfaction, accuracy and compliance with all reporting benchmarks. Also oversees long-term planning, technology strategies and continuous improvement of operational efficiencies. Keeps current on State and Federal regulatory issues and industry activities and trends and is responsible for regulatory reporting. Diligently works to foster a positive and cohesive work environment, while ensures exemplary service is provided to all customers. Qualifications for this position include A BA/BS or 10 years of Management Experience in Dental Insurance, and at least 7 years of experience in a managerial capacity with a minimum of 5 years in healthcare administrations/operations role

Director of Professional Relations

The Director of Professional Relations directs the recruitment and retention of all LIBERTY proprietary provider networks in the assigned region(s), develops provider reimbursement schedules by product and region and maintains mandated regulatory requirements. Qualifications for this position include a BA/BS degree and/or preferably an RDA or RDH license or equivalent; a minimum seven years in healthcare or dental insurance experience, and previous management and network development experience Director of Claims

- ***The Director of Claims directs the Claims Department, to ensure quality standards are met and the best possible service is provided to our customers. Provides strategic leadership to operations including; long-term planning, technology strategy, and continuous improvement of operational efficiency. Qualifications for this position include a BA/BS required, with an MBA of other advanced degree in Healthcare preferred; a minimum of 7 years of experience in a managerial capacity with a minimum of 5 years in health plan/operations role, and Claims experience in healthcare environment.***

Manager, Grievance, Appeals and Quality Management

The Manager of Grievance, Appeals and Quality Management (G&A, QM) manages all aspects of the Plan's grievance system, which consists of member grievances and appeal, as well as provider disputes. The Manager, G&A, QM ensures that cases are resolved in compliance with all applicable state and federal regulations and in accordance with client-specific requirements across all lines of business. This position also supports the Plan's Quality Improvement Program and functions by managing staff contributing to multiple QM Committees and Functions. Qualifications for this position include BA/BS Degree preferred; a minimum seven years in healthcare insurance,

(dental preferred.), and Quality Management and/or Compliance background preferred.

3.9.13 Provider Participation in IQAP

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

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

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

LIBERTY works with our providers to actively improve the quality of care provided to members. LIBERTY contracted providers are contractually required to cooperate with ongoing QMI goals. LIBERTY's Provider Relations staff is responsible for the ongoing communications of quality assurance activities through the following means:

- ***Initial and continuing training programs.***
- ***Provider newsletters and Fax Blasts.***
- ***Online notices.***
- ***Local and Regional meetings to discuss and identify issues relating to claims, e enrollment and any other issues that the provider can identify.***
- ***Provider Satisfaction Surveys.***
- ***Onsite office visits.***

LIBERTY's Provider Contract and Provider Manual require that Recipient dental records be kept and maintained in compliance with applicable state and federal regulations. Complete dental records of active or inactive patients must be accessible for a minimum of 10 years, even if the facility is no longer under contract with a LIBERTY network. Dental records for children should be maintained up to 10 years beyond the age of majority. Below in Figure 3.9.13-1 is an excerpt from our Provider Contract. Upon award of contract, we can update our Provider Contract to include additional elements to meet DHCFP requirements.

FIGURE 3.9.13-1. PROVIDER MANUAL EXCERPT

2.6 Inspection, Evaluation, Audit; Document Retention.

(a) Access to Records. Dental Office shall permit LIBERTY, upon advance written notice, and all applicable governmental agencies or divisions (and/or the designees of LIBERTY or such governmental agency/division) to inspect, evaluate and audit any physical facilities and equipment, books, contracts, documents, papers, records, including dental records and documentation of the Dental Office that pertain to Members, any aspect of Covered Services performed, reconciliation of benefits and determination of amounts payable (the "Records"). Dental Office shall cooperate and assist with, and provide the Records to, LIBERTY and any applicable governmental agency/division (and/or their designees) for purposes of the above inspections, evaluations, and/or audits, or as otherwise requested by LIBERTY from time to time. Dental Office shall notify LIBERTY of any disclosure of Records it is required to make to a governmental agency or division. Dental Office may not make the access or the provision of Records described in this Section 2.6(a) contingent upon a confidentiality statement or agreement. The above-described rights to inspect evaluate and audit will extend through the period during which Dental Office is required to maintain the Records as set forth in Section 2.6(b) below.

(b) Retention Period. Dental Office shall maintain the Records for ten (10) years from the termination or expiration of the Agreement or the completion date of any audit conducted pursuant to Section 2.6(a) (whichever is later), unless otherwise required by law.

3.9.14 Delegation of IQAP Activities

3.9.14.1 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:

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

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

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

Coordination with Delegated Entities

There is a written, executed agreement between the plan and each delegate that includes the delegated entities specific responsibilities to monitor the quality of care and services rendered. The responsibilities of the delegated entities include, but are not limited to:

- ***Compliance with LIBERTY Dental Plan Policies and Procedures when performing delegated responsibilities.***
- ***Participation in QMI and Peer Review Committees.***
- ***Providing quarterly, or more frequently if appropriate, reports to the committees to facilitate the issues.***
- ***Plan's evaluation of complaints, assessing trends, and implementing action to correct identified problems.***
- ***Identifying and presenting to the Committees opportunities for improvement and to monitor interventions assuring that the improvement activities are implemented and effective.***

3.9.15 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:

3.9.15.1 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.

3.9.15.2 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.

3.9.15.3 Credentialing Entity

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

3.9.15.4 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.

3.9.15.5 Process

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

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

1. Any physical or mental health problems that may affect current ability to provide dental care;
2. Any history of chemical dependency/ substance abuse;
3. History of loss of license and/or felony convictions;
4. History of loss or limitation of privileges or disciplinary activity; and
5. An attestation to correctness/ completeness of the application.

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

A. 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.

B. 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.

Written Policies and Procedures

We have written credentialing and re-credentialing policies and procedures in place in order to provide a fair, consistent, and non-discriminatory process in the initial credentialing and re-credentialing of all applicant and network dentists. The credentialing/re-credentialing of LIBERTY's network dentists is in adherence with National Committee for Quality Assurance (NCQA) standards and complies with state and federal requirements, including CMS and state mandated credentialing applications where required. A provider is not authorized to treat any of our recipients until the Credentialing Committee approves the provider's admittance to the network. Routine re-credentialing is conducted every three years for all providers in the network, or more frequently if indicated, on a case by case basis.

We have extensive experience in credentialing and re-credentialing dental providers and we conduct these activities on a large scale on an ongoing basis. From January of 2016 through August, for example, we have performed initial credentialing for 3,229 providers and have re-credentialed 4,729 providers. Our comprehensive and robust processes ensure that we are able to maintain a quality network of providers to ensure the best care for our recipients. The process used to assess and validate the provider's qualifications and credentials to provide dental treatment to recipients and participate in our networks is described below.

LIBERTY acknowledges the DHCFP's right to request and inspect our credentialing process. We have extensive experience working directly with other states, including the state of California and various government health plans, as they assess our processes and policies. In 2016, our credentialing program has been audited by 16 government health plans that serve Medicare and Medicaid recipients with audit scores consistently above 98%.

Credentialing Committee

Our Credentialing Committee is a sub-committee under the Quality Management and Improvement Program that oversees credentialing for our provider network. Chaired by LIBERTY's Dental Director, the Committee consists of both clinical and non-clinical (i.e., administrative) staff responsible for reviewing, accepting, and/or rejecting the professional credentials of each applicant dentist or contracted dental provider. The Committee abides by approved policies and procedures of the Quality Management Improvement (QMI) Committee to determine whether a provider will be approved as a member of our provider network. The Credentialing Committee is responsible for reviewing and updating the credentialing policies and procedures on an annual basis. Proposed updates are formally submitted to the QMI Committee for approval.

The Credentialing Committee utilizes online resources and VerifPoint, a contracted NCQA and URAC accredited credentials verification organization (CVO), to obtain and verify information on dental providers (more information on the delegation of credentialing activities is found below). The Credentialing Coordinators are responsible for maintaining the credentialing files and updating the credentialing database in order to provide our recipients with the utmost professional oral health care network available through the verification of provider information. The Committee convenes on a monthly basis, or more frequently when applicable.

Initial Credentialing

Prospective network providers must submit a completed application to the Network Management Department, which will then review the application materials and forward to the Credentialing Department to be considered for participation. Prospective provider applications will be processed and a decision rendered within 30 days, unless additional information is needed or verification of credentials is not possible (e.g., verification of dental education at a dental school that is no longer in operation, or a foreign dental school). If credentialing or enrollment is denied due to potential concerns about provider fraud, integrity, or quality, LIBERTY will report this to the DHCFP Provider Enrollment Unit within 15 calendar days. To be considered for participation in the network, a provider must complete a credentialing application and submit the following:

"LIBERTY Dental Plan is great at being accessible for us with whatever needs we have had. I appreciate how quickly you get doctors credentialed since this is imperative for us. We have a huge multi-doctor/ multi-specialty facility and making sure all our doctors are in network is critical to us being able to provide comprehensive patient care." --Brian Sakakida, Manager

- ***Practice name, address, phone and fax numbers.***

- ***TIN and SSN for processing and collecting the required individual background history checks.***
- ***Provider NPI (Type I) and billing entities NPI (Type II), as applicable.***
- ***Education and training information as appropriate to practice specialty(ies).***
- ***Specify if Board Certified and Hospital Privileges, as applicable.***
- ***The most recent five (5) years of work history.***
- ***Signed and dated Credentialing Attestation, Authorization and Release Forms.***
- ***A current professional Dental License(s), including***
- ***A current DEA Certificate or State Controlled Substance certificate, if applicable.***
- ***Any revocation or suspension of a State license or DEA number***
- ***Any censure by any state or county Dental Association or any other applicable licensing or credentialing entity.***
- ***A current Malpractice Insurance Certificate showing 'Professional Liability' coverage with coverage of at least $1,000,000 per occurrence and $3,000,000 aggregate, unless different limits are required under state or federal regulations***
- ***A Specialty Certification from the educational facility attended (if applicable).***
- ***Any curtailment or suspension of medical staff privileges (other than for incomplete Dental records).***
- ***Any sanctions imposed by the OIG or the DHCFP.***
- ***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.***
- ***An attestation to correctness/ completeness of the application.***

Credentialing and re-credentialing requirements are shown below in Figure 3.9.15-1.

FIGURE 3.9.15-1: CREDENTIALING/RE-CREDENTIALING ELEMENTS

VerifPoint (CVO) Primary Source Verification		
Items Requiring Verification for Credentialing & Re-credentialing	***Sources of Verification***	***Methods of Verification***
Current State Dental License	***State Dental Board***	***Performed by contracted credentialing verification organization (CVO) or by LIBERTY staff***
State board status check for validation of license and report of sanction, restriction, and/or limitation on scope of practice from any state in which the applicant is licensed	***Verification from state dental board in writing or by telephone***	***Performed by contracted CVO or by LIBERTY staff***
DEA	***Copy of DEA certificate OR verification through National Technical Information Service (NTIS) database***	***Performed by contracted CVO or by LIBERTY staff***
Current Malpractice Liability Insurance Coverage	***Malpractice liability carrier in writing or by telephone OR copy of certificate of insurance from practitioner***	***Performed by contracted CVO or by LIBERTY staff***
Board Certification (when applicable)	***American Board of Dental Specialties*** ***Appropriate specialty board in writing or by telephone***	***Performed by contracted CVO or by LIBERTY staff***
Education	***Dental school and residency institution in writing or by telephone***	***Performed by contracted CVO or by LIBERTY staff***
Professional Liability Claims History	***National Practitioner Data Bank (NPDB) report***	***Performed by contracted CVO or by LIBERTY staff***

VerifPoint (CVO) Primary Source Verification		
Items Requiring Verification for Credentialing & Re-credentialing	*Sources of Verification*	*Methods of Verification*
Hospital Privileges, if applicable	*Hospital medical staff office in writing or by telephone*	*Performed by contracted CVO or by LIBERTY staff*
Medicare/ Sanction Activity	*NPDB Report* *Department of Health & Human Services (DHHS) Cumulative Sanction Report*	*Performed by contracted CVO or by LIBERTY staff*

Furthermore, Network Managers are responsible for obtaining all necessary applications and required contracting information and credentialing documents from the dental providers during the contracting process. Network Managers will work with the dental offices if they have not yet enrolled in the Nevada Medicaid program to provide enrollment instructions, contact information, and education to help them register with Medicaid. We will begin the initial credentialing documents gathering process as providers are enrolling in Medicaid. LIBERTY's contracting process requires that each dentist is registered with Medicaid and has a valid Medicaid identification number.

Identifying excluded providers and persons convicted of crimes searches.

During the initial credentialing process, we identify excluded providers and persons convicted of crimes. VerifPoint reviews sanctions and exclusions for Medicare and Medicaid, using State Medicaid Agency websites, the Office of Inspector General Medicare Exclusion Database, and the National Practitioners Data Bank. Each applicant must meet verification requirements prior to acceptance by the Credentialing Committee. An applicant provider that is identified as having a Medicare/Medicaid Sanction, or has a conviction for fraudulent billing and/or misrepresentation of credentials, will be notified in writing that the Credentialing Committee has denied his/her credentialing application.

The Credentialing department will also identify, investigate, and review information concerning a participating provider's performance and any potential adverse issues reported from the Nevada State Board of Dental Examiners, National Practitioner Data Bank, Office of the Inspector General, System for Award Management, or other

regulatory agencies on a monthly basis. Participating providers that are identified on sanction or exclusion lists or found to have been convicted of defrauding Medicare and Medicaid are notified that continued network participation is denied. Please see our YTD Provider Sanction Ongoing Monitoring Log in Attachment 14.

Facility Site Review

LIBERTY reviews the offices of contracting primary care dentists prior to finalizing the credentialing/contracting process and on an on-going, calendar basis. We attempt to conduct a review on the first anniversary of the date on which the contracting dentist was authorized to provide dental services to beneficiaries in that office and semi-annually thereafter. If necessary, and if there are quality assurance concerns, the Dental Director may require additional reviews at any time.

As part of each review, LIBERTY verifies:

- ***Office staffing (e.g., the number of dentists, dental auxiliaries, hygienists available to recipient in the office).***
- ***Office hours (including after-hours availability and availability for emergencies).***
- ***Appointment availability (for initial appointments, routine appointments, and preventive dental care appointments).***
- ***Waiting time for scheduled appointments.***
- ***Patient capacity.***
- ***Foreign languages spoken by the office staff.***
- ***Office's physical accessibility (e.g., location, handicap accessibility).***

At the end of the review, LIBERTY will conduct an exit interview with the primary care dentist to discuss the findings made by our Dental Director during the review.

After the exit interview, the Dental Director reviews the summary findings and will determine whether the office meets all required standards and norms. The Dental Director then sends a letter to the primary care dentist stating one of three results:

- ***The office met or exceeded all LIBERTY guidelines;***
- ***The overall review was acceptable, but the office did not meet certain guidelines; or,***
- ***The office failed to sufficiently meet the LIBERTY's guidelines.***

In situations involving either of the latter two items above, the Dental Director's letter specifies any corrective actions the contracting dentist must take. The letter also includes a time frame for the completion of any corrective actions. If necessary, the Dental Director may schedule a follow-up review to determine whether a primary care

dentist has successfully implemented the corrective actions required. The documentation of each structured review of the site and Dental record keeping practices are maintained to ensure conformance with LIBERTY's standards.

3.9.15.6 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:

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

B. The vendor conducts periodic review of information from the National Practitioner Data Bank and all other applicable licensing entities, along with performance data, on all practitioners, to decide whether to renew the participating practitioner agreement. At a minimum, the recredentialing, recertification or reappointment process is organized to verify current standing in required areas.

C. The recredentialing, recertification or reappointment process also includes review of data from:

1. Recipient grievances and appeals;

2. Results of quality reviews;

3. Utilization management;

4. Recipient satisfaction surveys; and

5. Re-verification of current licensure, if applicable.

D. 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.

Recredentialing

LIBERTY has established policies and procedures for re-credentialing providers and is dedicated to assessing and verifying the credentials of all applicants and participating dentists. We strive to assure that the LIBERTY network consists of quality providers who meet clearly defined criteria and standards. These guidelines ensure that the providers approved to remain in our network and see our recipients will meet appropriate standards of education, specific training and experience, current competence, and ability to perform the oral health care services that recipients need.

The re-credentialing process includes an appraisal of the provider's overall performance, which is considered during the Credentialing Committee review. We rely on a variety of quality and utilization measures including the following:

- ***Detection of a pattern of recipient complaints against a particular facility or provider.***
- ***Deficiencies identified through ongoing monitoring of each provider's compliance with established accessibility and availability standards.***
- ***Deficiencies identified through the routine or non-routine queries of the NPDB, OIG, State Board of Dental Examiners, and CMS Medicaid/Medicare Exclusion lists allow for the review of malpractice settlements, Medicaid or Medicare fraud, state board license sanctions, etc.***
- ***Recipient satisfaction surveys which may indicate poor quality service by a provider or dental office.***
- ***Utilization management review of encounter or claims data which may indicate a pattern of over/under utilization of services.***

Our provider re-credentialing cycle is consistent with NCQA standards and occurs every three years (or more frequently should an issue be identified). Sixty days before the re-credentialing date, the dentist will receive a written request to submit required documents to our designated CVO. If a provider fails to forward any required information to the CVO, the CVO will notify LIBERTY and our Credentialing Coordinator will assist in obtaining the missing or expired information. The Credentialing Committee reviews any contracted provider who has generated an adverse report. Explanations are then assessed and determined to be either inadequate or satisfactory. Failure to comply with requests for information can result in provider termination from the network.

Although oversight responsibility remains within LIBERTY's purview, LIBERTY may delegate all or a portion of its credentialing activities to VerifPoint. Prior to delegation of any activity, LIBERTY's Credentialing Committee will perform an assessment of the delegate's programs and capabilities during an annual delegation audit. No credentialing activity is considered delegated until a signed delegation agreement is on file.

Providers are credentialed and re-credentialed according to NCQA standards, which meet current LIBERTY regulatory and NCQA guidelines. All providers must maintain good standing with state and federal regulatory bodies.

Ongoing Compliance

Our Credentialing program includes a systematic process for the ongoing review and evaluation of an individual network provider's performance. Provider performance is assessed through the review of recipient satisfaction survey results, complaints and grievance tracking reports, utilization patterns, and desktop audits to identify quality and/or potential quality issues.

On an ongoing basis, information on sanctions, limitations on licensure, and complaints are reviewed. These sanctions and disciplinary reports are addressed within 30 days of their release. Information from the State Board of Dental Examiners and other pertinent provider sanction and licensure reports are reviewed at Credentialing Committee meetings. Complaints and adverse events (e.g., injury to a recipient that happened while receiving health care services from a provider) are tracked and reported to the QMI Committee at least quarterly, or as areas for improvement are identified.

3.9.15.7 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.

Delegation of Credentialing Activities

We have maintained a successful relationship with VerifPoint, a leading NCQA certified and URAC accredited Credentials Verification Organization (CVO), since 2007. VerifPoint provides primary source verification of provider information for LIBERTY including: dental school education, residency training completion, board certification, work history, current adequate malpractice insurance, malpractice history, licensure information, and sanctions. VerifPoint will be contracted to conduct the primary source verification of credentials for new and existing providers for the DHCFP program. Our longstanding working relationship with VerifPoint has allowed us to improve and expedite the credentialing process of our dental care providers, which has expanded to 23 states in 2016. VerifPoint also reviews provider licensure information on a daily basis and generates reports on providers who nearing the expiration of their license.

Our Credentialing Committee is ultimately accountable for all functions performed within its purview, whether those functions are performed directly or indirectly by the CVO. We conduct delegation oversight of VerifPoint annually to evaluate the structures, functions and processes necessary to achieve/maintain program compliance and ensure consistent performance across the network. VerifPoint has consistently scored above our 90% benchmark during their delegation reviews. Most recently, VerifPoint scored 100% during the 2016 delegation audit, which was conducted on May 25, 2016, and approved by our Credentialing Committee for continued delegation.

3.9.15.8 Retention of Credentialing Authority

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

3.9.15.9 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.

3.9.15.10 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.

Suspension, Reduction, or Termination of Provider Privileges

A provider's network status may be reduced, suspended or terminated for any lawful reason, including, but not limited to:

- ***A lapse in basic qualifications, such as licensure, insurance, board certification, required dental staffing, or privileges at a specified hospital/healthcare facility***
- ***A determination that the provider does not deliver appropriate quality or efficiency of recipient care***
- ***A determination that the provider does not follow our established clinical and/or administrative guidelines***

Issues raised about a provider's performance shall be presented to the Credentialing Committee, who shall have the broad discretion to determine how to proceed as delegated by our Board of Directors. The Committee's options include, but are not limited to: maintaining a record of the matter without further investigation or action; investigating the matter and making a report and recommendation to the QMI Committee as warranted; or referring the matter for further investigation and corrective action. If, for any reason, a provider is terminated and is brought before the Credentialing Committee for reinstatement, the provider must go through the initial credentialing process again if the break in service is 30 days or more.

The DHCFP will be notified if LIBERTY denies a provider credentialing application, disenrolls a provider for program integrity-related reasons, or otherwise limits the ability of a provider to participate in the program for program integrity reasons. When awarded a contract, LIBERTY will establish processes to inform the DHCFP within 15 days of a decision to decredential, terminate, or disenroll a provider.

Provider Dispute Process

LIBERTY has established policies and procedures in place to provide a mechanism for providers to appeal actions, including a denial, reduction, suspension, or termination of provider privileges. Our policies assure that all providers have the right to appeal the decision of the Credentialing Committee. Providers are required to request any such appeal in writing within 60 days of a receipt of a notice of Adverse Determination.

Reconsideration of initial recommendation

If a provider does not agree with the Credentialing Committee's initial recommendation, he or she may request Reconsideration by submitting a signed letter explaining why he or she believes the decision was incorrect. Providers should also include any new or additional information the Credentialing Committee should consider. The Credentialing Committee then discuss all Reconsiderations, review all information, and vote to sustain, modify, or overturn its original decision.

If the provider does not agree with the Credentialing Committee's initial recommendation or Reconsideration decision, he or she may request an appeal hearing before the Appeals Advisory Committee following a similar process as the initial Reconsideration request. Upon receiving a request for a formal hearing, the representative of the QM Committee, in consultation with the Dental Director and President, schedules and arranges for the hearing. The provider is notified of the time, place, and date of the hearing, which our policies require to occur between 30 and 60 days from the date the representative of the QM Committee received the request for a hearing.

The Appeals Advisory Committee is comprised of three independent professionals who did not participate in the initial decision. They are appointed by LIBERTY's Advisory Committee. One of these professionals will be in the same or like specialty as the disputing provider. The Appeals Advisory Committee will make a formal recommendation to the Credentialing Committee about the decision to accept or reject the provider's application, suspension, or termination. If the Appeals Advisory Committee's findings do not result in a recommendation to reverse the Credentialing Committee's initial decision, the Credentialing Committee's decision will be final. Disputing providers will be notified within 5 business days of the Credentialing Committee's final decision.

3.9.16 Recipient Rights and Responsibilities

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

3.9.16.1 Written Policy on Recipient Rights

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

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

B. To be provided with information about the vendor, its services, the practitioners providing care, and recipients' rights and responsibilities;

C. To be able to choose their primary Dental care practitioner;

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

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

F. To formulate advance directives;

G. To have access to his/her 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;

H. 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

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

3.9.16.2 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:

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

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

C. Recipient obligation to participate in their health care decisions; and

D. 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 i.e. 24-48 hrs ahead of scheduled appointment, report provider fraud/abuse, provide feedback on recipient needs and expectations, etc.

3.9.16.3 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.

3.9.16.4 Communication of Policies to Recipients

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

3.9.16.5 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:

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

B. Documentation of the substance of grievances, appeals, and actions taken;

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

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

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

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

3.9.16.6 Recipient Suggestions

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

3.9.16.7 Steps to Assure Accessibility of Services

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

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

B. At a minimum, recipients are given information about:
   1. How to obtain services during regular hours of operations;
   2. How to obtain urgent, emergency and after-hour care;
   3. How to obtain emergency out-of-service area care;
   4. 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
   5. How to access concierge services and assistance from the vendor when needed to gain access to care.

3.9.16.8 Information Requirements

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

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

3.9.16.9 Confidentiality of Patient Information

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

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

B. 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;

C. Hold confidential all information obtained by its personnel about recipients related to their examination, care and treatment and shall not divulge it without the recipient's authorization, unless:
   1. It is required by law, or pursuant to a hearing request on the recipient's behalf;
   2. It is necessary to coordinate the recipient's care with other dental care providers, physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; or
   3. It is necessary in compelling circumstances to protect the health or safety of an individual.

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

E. May disclose recipient records whether or not authorized by the recipient, to qualified personnel, defined as persons or agency representatives who are subject to standards of confidentiality that are comparable to those of the State agency.

3.9.16.10 Treatment of Minors

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

3.9.16.11 Assessment of Recipient Satisfaction

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

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

B. The survey(s) assess at least a sample of:
   1. All recipients;
   2. Recipient requests to change practitioners and/or facilities; and
   3. Disenrollment by recipients.

C. As a result of the survey(s), the vendor must:
   1. Identify and investigate sources of dissatisfaction;
   2. Outline action steps to follow up on the findings; and

3. Inform practitioners and providers of assessment results.

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

We understand and agree to comply with section 3.9.16 through 3.9.16.11.

Written Policy on Recipient Rights and Responsibilities and Their Communication to Recipients and Providers

LIBERTY has established written policies and procedures, clearly defining the ways and means by which member rights and responsibilities are addressed, communicated, monitored, and delivered. Understanding the vulnerability and unique requirements of the Nevada Medicaid population, LIBERTY is committed to providing recipients with a systematic approach to understanding member rights and responsibilities. To facilitate this approach, LIBERTY's Nevada Medicaid membership will be serviced by our Internal Response Unit (IRU), a specialized business unit staffed with subject matter experts in each operational department, including Member Services.

Training activities for existing and new Member Services Representatives emphasize benefits of the plan, member rights and responsibilities, member's privacy, importance of confidentiality, right to be treated respectfully, cultural diversity, process for provider selection and transfers, referrals and the grievance process.

Communication of Policies

We understand that the more we educate members, the higher the utilization rate of preventive services—and that this lowers the overall and long term cost of dental care. LIBERTY makes all our written communication materials available either in print or in electronic form for convenient distribution to our members and providers. Our materials are designed to provide valuable information to our general adult, pregnant women, and child target markets, as well as persons with special needs (e.g., within those eligible for Medicaid due to a disabling condition), through a number of tools as described within this section.

Upon notification of enrollment, we send the member a Welcome Packet within 10 business days. Additionally, we will make these materials available online to all Nevada members. A sample of our Welcome Packet for Nevada has been included as Attachment 5. The complete Welcome Packet includes:

- ***Welcome letter highlighting program features.***
- ***A dental provider directory and information on how members can access cared and locate dentists online, telephonically or via our smart phone application. This directory will identify the languages spoken by each provider, whether or not the provider is accepting new patients, and will also identify each provider's***

specialty type. We will also ensure the most current directory is available to members upon request are sent within five (5) business days of the request.

- ***An ID Card for each eligible members in full compliance with the DHCFP requirements.***
- ***A detailed explanation of dental benefit services.***
- ***LIBERTY's contact information, including our address, telephone number, web site, fax number and email address.***
- ***LIBERTY call center hours.***
- ***A description of any restrictions on the member's freedom of choice among network providers.***
- ***Member rights and protections, including at minimum:***
    - ***Treatment with respect and due consideration for his or her dignity and privacy.***
    - ***Receipt of information on available treatment options and alternatives.***
    - ***Participation in decisions regarding his or her health care including the right to refuse treatment.***
- ***A detailed explanation of the amount, duration and scope of services available under the contract sufficient to ensure members are fully informed of the services to which they are entitled, including service authorization requirements.***
- ***Information on urgent dental care, including at minimum:***
    - ***Information noting that prior authorization is not required to obtain dental services from a network dental provider.***
    - ***The fact that providers must inform their patients the extent to which, and how, after hours and urgent dental care is provided, including how to contact a network dental provider twenty-four (24) hours a day, seven (7) days a week for urgent dental care.***
    - ***The locations where providers and hospitals furnish urgent dental services covered under the MCO contract.***
    - ***The member's right to use any network dental provider for urgent dental care.***
- ***Information on alternative methods or formats for communicating with visually and hearing-impaired members and non-English speaking members, and how those members can access those alternative formats and methods.***
- ***An explanation of how LIBERTY will cover services with out-of-network providers for as long as the services are unable to be provided within the network.***

Distribution of Communications

All member-facing materials that are mass distributed to new members will be submitted to the DHCFP for review and approval prior to distribution. Our Nevada staff will be involved in the creation of these materials to ensure that we reflect the regional culture in our communications. We will work to create an efficient process to work with the DHCFP to expedite submission and approval. We commit that any and all costs associated with developing, printing and distributing materials are our responsibility. Our Director of Fulfilment will ensure that any and all member-facing materials receive approval prior to printing and/or releasing materials for mass distribution, whether printed or electronic.

Member rights are communicated through numerous avenues to multiple audiences. LIBERTY's policies regarding member rights and responsibilities include the right to be treated with respect, dignity, and recognition of their need for privacy and confidentiality, access to care, to be informed of provider assignments and how to transfer, how to request a second opinion, to have access to benefit information and the specialty referral process, to participate in making informed decisions regarding their course of treatment and how to submit grievances and be informed of the grievance and appeal process. Recipients are informed of LIBERTY's policies on their rights and responsibilities via the following communication channels:

- ***Evidence of Coverage Booklets***
- ***LIBERTY Website***
- ***Via LIBERTY's Member Service Representatives***
- ***Educational brochures***

Providers are also informed of LIBERTY's policies regarding recipients' rights and responsibilities via:

- ***Provider orientations that include cover to cover review of the Provider Reference Guide with emphasis on policies and procedures, specialty care referrals, access and availability standards, quality management expectations and LIBERTY's language assistance program***
- ***Provider campaigns and sweeps***
- ***Quarterly newsletters***

LIBERTY addresses all member rights and responsibilities, including those of minors, in Company Policies and Procedures and the member's Evidence of Coverage booklet. Below is a general summary of some of those procedures, which protect the rights of recipients of all ages.

RECIPIENT RIGHTS

Plan Information and Services

LIBERTY's policies regarding member rights and responsibilities state that a member has the right to receive information regarding LIBERTY's services, benefits, specialty referral process and available treatment options and alternatives. LIBERTY's policies for communicating plan information and services include providing each member with a detailed Evidence of Coverage booklet and access to LIBERTY's experienced MSRs who can assist with all aspects of their inquiry. Members preferring a self-service option can access LIBERTY's website for plan benefits, eligibility, and provider information.

Evidence of Coverage booklets are made available in threshold languages. Other languages can be accommodated upon request from the member and will be completed within the cultural and linguistic guidelines and timeframes.

Covered Services

LIBERTY's policies regarding member rights and responsibilities state that a member has the right to access and availability to care. LIBERTY's policy is to ensure that all members have access to covered services whenever needed. LIBERTY details all covered services within the member's EOC and ensures our Member Service Representatives (MSRs) are able to communicate member benefits and covered services clearly and concisely. MSRs receive in-depth training related to covered services, enabling them to effectively communicate with the members. When a MSR receives an inquiry regarding benefits, they access the member's record where they have immediate access to the member's calling history and an outline of the member's dental benefits. It is the MSR's responsibility to assist members in receiving all benefits they are entitled to within acceptable timeframes and to discuss services available under this program. MSRs encourage the members to use their Evidence of Coverage booklets as a guide and to contact LIBERTY's Member Services department for questions and requests for assistance with accessing their dental benefits.

Choosing a Primary Care Dentist

LIBERTY's policy is to ensure all members fully understand their right to select the Primary Care Dentist (PCD) of their choice within LIBERTY's provider network. LIBERTY will assign members who do not make a selection to a PCD based on distance, provider availability, age, and language requirements. LIBERTY explains, through our MSRs and member EOC, that all members have the right to request a transfer to another network provider at any time by contacting LIBERTY's Member Services department. Members can access LIBERTY's website to search for network providers. Search results provide the member with pertinent information, such as the office /provider name, address, phone number, ID, languages spoken in the office and hours of operation.

Federally Qualified Health Centers, Rural Health Clinics and Indian Health Service Facilities

LIBERTY's policy is to contract with Federally Qualified Health Centers and Rural Health Clinics and that the member has the right to choose to seek services at this type of facility. These offices are included in the provider listings and on LIBERTY's website.

LIBERTY's Member Handbook outlines the procedures members should follow when exercising their right to receive services from an Indian Health Center or American Indian Health Clinic.

Services for Pregnant Women & Federally Required Adult Dental Services (FRADS)

LIBERTY's policy states that all pregnant women and adults under this program are entitled to receive their FRADS benefits and additional benefits for pregnant women. It ensures that pregnant women and all adults are aware of the benefits available to them through the communication methods noted above, and how to obtain them when needed. LIBERTY's MSRs are trained specifically in the FRADS and pregnant women benefits to ensure they are able to explain them to the members clearly and concisely.

Emergency Services

LIBERTY's policy is to ensure that all members have access to emergency dental care. This is accomplished by requiring that all LIBERTY affiliated dental offices make Emergency Dental Care available 24 hours per day, seven days per week. In the event a member requires Emergency Dental Care, they will contact their selected dentist to schedule an immediate appointment.

If a member is unable to connect with their dental office after-hours, they can contact LIBERTY and they will be referred to an emergency answering service that has immediate access to a licensed Dentist. The Dentist will assist the enrollee in receiving appropriate treatment for their individual circumstance.

Should the after-hours call not be an actual emergency, the caller has the ability to request a return call the next business day. These requests are automatically routed to MSRs for follow-up when the call center is open.

LIBERTY recognizes that 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 and will educate recipients and providers about availability of, and how to access emergency dental services.

Treatment Options and Alternatives

LIBERTY's policy is that members have the right to participate in decision making regarding their own dental care, including the right to refuse treatment and the

formulation of advance directives. LIBERTY's policy requires all contracted Dental providers to present each member with a treatment plan indicating the covered benefits and options or upgrades available to the member and in a manner that is appropriate to the member's condition and ability to understand. LIBERTY encourages members to contact Member Services to review the treatment plan prior to having services rendered. This helps prevent members from agreeing to optional or upgraded treatment without being fully aware of what is covered, not covered, and any associated fees.

Interpretation Services for their Language

LIBERTY's policy for interpretive services ensures that members have access to communicate in their preferred language. Member Service Representatives are able to assist members in 11 languages. Immediate assistance is provided by a third party language vendor for all languages not supported by the Member Services department. LIBERTY initiates a three-way call to the language vendor and the representative remains on the line through the duration of the call. LIBERTY also provides TTY/TDD for those in need.

LIBERTY's policy is that face-to-face interpretive services are available to members upon request through LIBERTY's Member Services department. Member Services Representatives will make arrangements for the interpreter to be present at the time of the member's dental appointment. These services require a minimum of 24-48 (sign language) hour advance notice.

LIBERTY's policy is to translate qualifying documents into threshold languages for distribution. All other languages can be accommodated upon request and sent to the member within 21 days.

Dental Records

Members are guaranteed the right obtain access to and, where legally appropriate, receive copies of, amend, or correct their dental records.

Freedom From Restraint

LIBERTY's policies guarantee Members the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

Disenrollment Information

LIBERTY's policies regarding disenrollment fall in line with member rights and responsibilities. LIBERTY's policy is that members have the right to disenroll at any time. LIBERTY's policies indicate that the following triggers will cause a member to be dis-enrolled from LIBERTY:

- ***Member initiates a request for disenrollment through LIBERTY or through the formal Recipient Dental Exception (BDE) process***
- ***An American Indian elects to receive services at an Indian Health Service facility***
- ***Member eligibility is terminated, including death of a member***
- ***Member changes residence outside of LIBERTY's service area***
- ***A child receives services under the Foster Care or Adoption Assistance Program***
- ***Member is enrolled in another Medicare or commercial managed care plan***

Grievance Reporting

LIBERTY's policy is that members have the right to grievances and to be informed of the grievance and appeal process (described below). LIBERTY's policies also indicate that members have the right to request a DHCFP fair hearing, including information on the circumstances under which an expedited fair hearing is possible. Members are made aware of their right to file a grievance directly through LIBERTY Dental Plan in their Evidence of Coverage (EOC) booklet as well as the LIBERTY Dental Plan website. Additionally, instructions on how to file a grievance and/or appeal, including Independent Medical Review (IMR), are included in every notice of denial or modification of services.

Member complaints or grievances may be made in person at LIBERTY's office, 6385 S. Rainbow Blvd., Suite 200, Las Vegas, NV 89118, from 8:00 a.m. to 5:00 p.m. Monday through Friday (holidays excluded), by telephone, in writing, by fax or through LIBERTY's website at www.Libertydentalplan.com.

Health Education Programs

Dental health education is one of LIBERTY's top priorities. Education is a necessary step toward prevention and building good oral health for a better quality of life.

LIBERTY's policy is to provide dental health education and prevention to all members and that members have access to its health education programs and outreach services. Outreach programs are designed to actively raise awareness about the importance of oral health and its impact on systemic health; increase the availability of dental health care services to members regardless of income or ethnicity; and increase the public's understanding of the importance of dental health care---particularly for young children---and a dental home.

Education and outreach resources are developed to meet the cultural and linguistic needs of the members and are presented at an eighth grade level.

LIBERTY also requires the network providers to assist with this endeavor. Providers communicate the importance of maintaining proper nutrition and good oral hygiene, including tooth brushing and dental flossing, the use of sealants and topical fluoride solutions for teeth, as well as the advantages of water fluoridation. Members are encouraged to incorporate these practices into their daily health regimens in order to reduce the incidence of dental diseases.

Specialty Referrals

LIBERTY addresses specialty referrals through policies defining emergency and non-emergency situations. LIBERTY's policy is that all non-emergency specialty referrals require prior authorization. However, emergency referrals do not require prior determination of benefits via review of diagnostic records such as radiographs.

LIBERTY's policy indicates that members will receive an evaluation from their Primary Care Dentist (PCD). The PCD will determine if the member requires the care of a Specialist and will determine if the situation requires an emergency or routine referral.

The PCD will initiate the emergency referral by contacting LIBERTY by phone, facsimile, on-line submission or email. For all emergency calls, LIBERTY will immediately begin coordinating an appointment for the member with the specialist's office.

Routine referrals can be mailed or faxed to LIBERTY and will be processed within five calendar days of receipt. All referrals are reviewed for completeness. Additional documentation is requested, if necessary. Referral requests are evaluated to determine covered benefits based on submitted documentation, established criteria and benefits as outlined in the evidence of coverage booklet.

All specialty referral requests are reviewed by the Dental Director or a licensed dentist to determine dental necessity. LIBERTY will address any referral affecting care where the member faces an imminent and serious threat to their health within 72 hours of the receipt of the necessary documentation.

Upon approval, a copy of the specialty referral letter is sent to the specialist, the member, and the PCD.

Members are encouraged to contact their PCD to schedule a follow-up appointment after the completion of the treatment by the Specialist.

If the referral request is denied, the member and PCD are notified in accordance with Plan guidelines for denial of referrals.

Referral requests to non-contracted dentists are approved if there is no available contracted specialist within 50 miles of the member's residence.

RECIPIENT RESPONSIBILITIES

Respect Staff

Recipients are expected to respect and be courteous to LIBERTY's contracted dentists, dental office staff and LIBERTY administrative staff.

Conduct and Communication

Recipients are expected to keep scheduled appointments or contact the dental office twenty-four (24) hours in advance to cancel an appointment. Further, it is expected of recipients that they will report provider fraud/abuse and provide feedback on their needs and expectations.

Cooperate with Treatment Plans

It is a recipient's responsibility to cooperate with LIBERTY's contracted dentists in following a prescribed course of treatment and to otherwise participate in their health care decisions. This includes following instructions and oral health care recommendations/guidelines given by those providing dental services.

Provide Updated Information

Recipients are expected to notify LIBERTY Member Services of changes in family status and other information needed by professional staff to care for the recipient.

Be aware of and follow LIBERTY's guidelines in seeking dental care.

Recipient Grievances and Appeals

LIBERTY appreciates the importance of advocating for our Medicaid members and ensuring their member rights are enforced, including the right to file grievances and submit appeals. LIBERTY's current grievances and appeals processes and timelines align with the DHCFP due process and fair hearings policies and procedures specific to Nevada Medicaid and Nevada Check Up recipients, as well as 42 CFR 438 Subpart F. In general, however, LIBERTY's grievances and appeals process is highly customizable and we would have no trouble adopting any new turnaround times or other provisions as necessary.

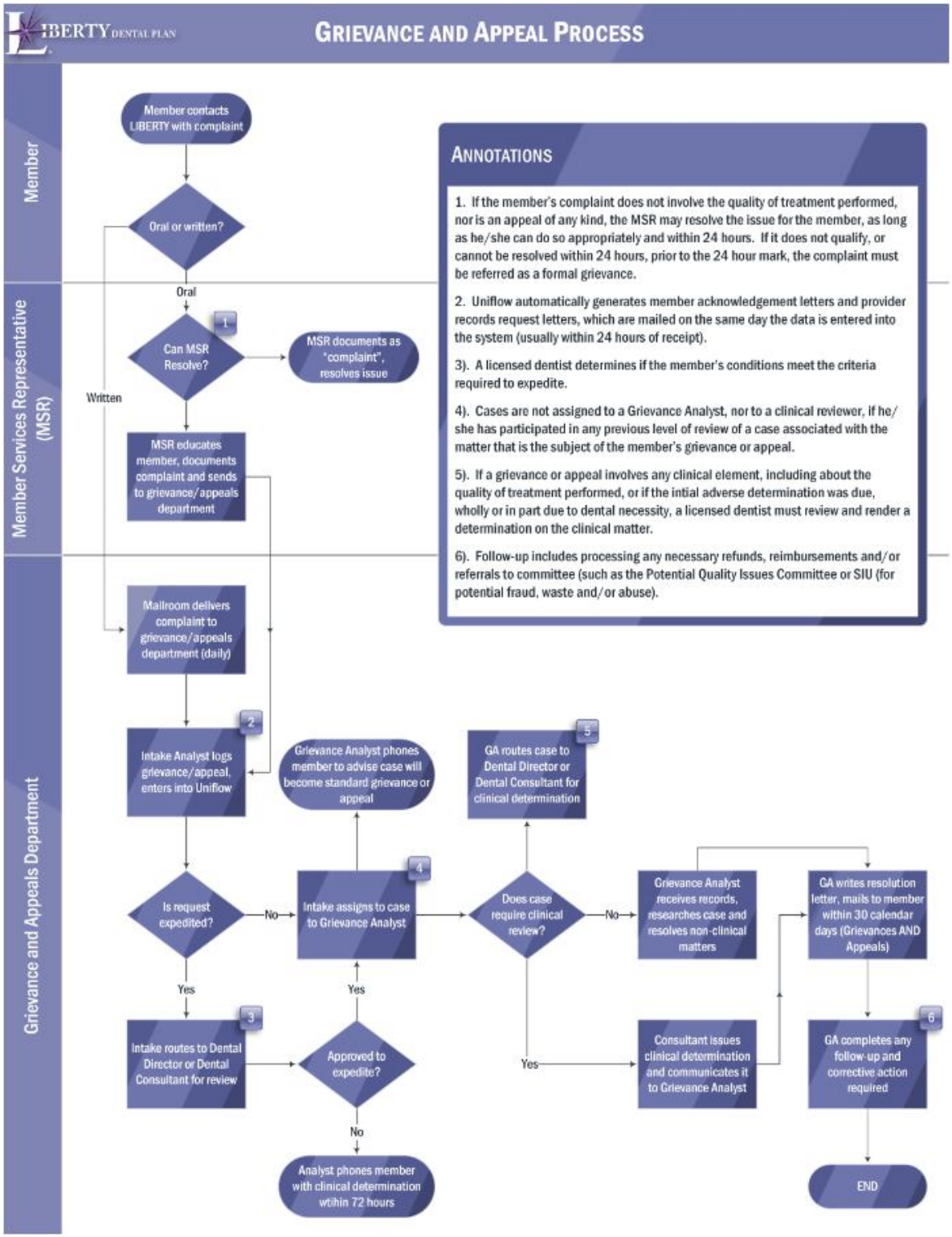
LIBERTY has established a robust grievance system to research and respond to grievances, appeals, and provider disputes in a prompt and fair manner. Through this grievance system, LIBERTY also ensures that our members are "made whole" if it is found that they were inappropriately charged from a contracted provider by reinstating the member's benefit or financially reimbursing the member. We provide a letter that

explains the outcome and payment to our members. If a member files a grievance regarding receiving substandard treatment, we work with the member to ensure the member received the appropriate care and investigate what further action needs to take place with the provider. The grievance system addresses provider disputes as well, and through manual review, referrals to committee and reporting, it serves as a major contributor to projects and initiatives designed to improve service.

LIBERTY's grievance and appeals process is a documented set of rules that encompasses researching, resolving and responding to member grievances and appeals, including expedited review of urgent grievances and facilitation of the state fair hearing process for members wishing to escalate their grievances. On a national level, LIBERTY's Grievance and Appeals Department collaborates with health plans and states on member grievances and appeals, providing research, investigation, and ultimately, a written recommended resolution on every dental case. These partnerships have allowed LIBERTY to select the best practices from across the country and implement efficient, streamlined processes that apply the quick standard turnaround times to the various deadlines associated with grievances, appeals, and provider disputes. In 2016, we had approximately X beneficiaries in the CA Medicaid program and resolved an average of 28 cases per month with an average resolution time of 27 days. Further, LIBERTY has built a reliable and thorough member grievance processing and tracking system using customized tracking software and processes to ensure that grievances, appeals, and requests for hearings are triaged to the appropriate staff, that staff are properly trained and supervised, that all members receive written acknowledgements, grievance resolution timelines are met, and grievance resolution letters meet the requirements of the RFP.

Our flowchart in Figure 3.9.16-1 below depicts the high-level steps involved in addressing grievances and appeals.

FIGURE 3.9.16-1. GRIEVANCE AND APPEAL FLOWCHART



Members, and providers on behalf of members, may submit grievances or appeals orally or in writing. Written grievances and appeals are acceptable whether communicated via a complaint form, letter, email, fax, or online submission.

When a grievance and/or appeal is received orally by our call center, a Member Services Representative first ensures that any urgent needs are appropriately addressed. Next, the MSR documents the member's concerns in our core MIS system—a common, "single-source" system that houses data accessed by multiple departments and serves as an electronic repository to hold all scanned documentation relating to grievance and appeals cases. The core system is highly customizable, and the Member Complaint Workflow within the MIS contains drop-down lists and custom fields to promote accurate, consistent data entry. After the MSR finishes documenting the member's concerns, the documentation is instantly routed to a special queue in the Grievance and Appeals Department. If a grievance is received by mail, the member's grievance is routed directly to the Grievance and Appeals Department and bypasses the MSR process.

As soon as a grievance is received in the Grievance and Appeals Department, an Intake Analyst logs it in the grievances and appeals log (our current grievance and grievance log), and the Grievance and Appeals log assigns the grievance a system-generated tracking number, marking the creation of an electronic case file. At this time, the system also automatically generates a written acknowledgement of receipt of the grievance to the complainant. During this process, the Intake Analyst will identify any requests for fair hearings, as well as expedited appeals, even if not specifically requested as such. Analysts are trained to identify when, based on the documentation provided by the member, taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. Such requests are immediately routed to a Dental Director (or licensed dentist designee) for review and to determine if it meets the criteria required to approve expedited review. If approved by the Dental Director (or licensed dentist designee), the case proceeds with the expedited timeframe for disposition, which will not exceed 72 hours for review and resolution. Upon resolution of an expedited grievance or appeal, the member is contacted by phone and advised of the resolution. If it is identified that the appeal request does not meet the criteria described above, the member will be immediately contacted and advised that the appeal will be converted to a standard appeal, with a resolution to be issued within 30 calendar days from the day of receipt of the initial request. This verbal notification will be followed with a written determination within 2 calendar days.

At the time a grievance is logged, LIBERTY automatically generates records request letters, which are then faxed and/or mailed to all dental providers named in the grievance. Once the records request has been generated, the case is assigned to a Grievance Analyst. LIBERTY ensures that all individuals who make decisions grievances and appeals are not involved in any previous review or decision about the action. All dentist reviewers who decide an appeal of a denial based on dental necessity (or lack thereof), or render any determination that involves review of a clinical nature, have the appropriate expertise in treating the member's condition or disease, and will also have not contributed to any previous plan decisions or grievances relating to the subject of the member's dissatisfaction.

Our team of 11 Grievance Analysts collectively possesses over 60 years of qualifying experience in the review and resolution of complaints, healthcare administration, and/or dental office experience. Several of LIBERTY's Grievance Analysts are RDAs (Registered Dental Assistants), possess specialty (orthodontic) certification for dental assisting, and as a minimum requirement for the role, have worked in dental office management, front office administration and/or as treatment coordinators. LIBERTY's Dental Directors and Dental Consultants are all licensed dentists in good standing, maintaining their licensure with regular continuing education and recredentialing.

If a grievance, or a member appeal, involves anything clinical in nature, or a determination based wholly or in part on dental necessity, the Grievance Analyst will route the case to a Dental Director or Dental Consultant to issue a determination on the clinical matter. Once this clinical determination is returned, the Grievance Analyst will compose a thorough resolution letter in language that is easily understandable. As an opportunity to standardize processes, LIBERTY will aim to resolve all Nevada Medicaid member grievances and appeals as expeditiously as the member's condition requires, or within 30 calendar days, meeting the requirement of the DHCFP.

Using data from the grievance and appeals system to improve operational performance.

Grievances and appeals are reported internally to various Quality Management (QM) Committees and, ultimately, to our Board of Directors. The most common types of grievances involve the situation when a provider does not administer the member's plan correctly, charges in excess of allowed amounts, or incorrectly advise members on their covered benefits. In these cases, we may impose a corrective action, such as requiring the provider to issue a refund to the member or to LIBERTY. We also will engage the Provider Relations staff to educate the provider on the issue identified. If we recognize a grievance trend within our provider network, we will work with Provider Relations to develop educational materials, such as provider bulletins or newsletters. In

the case that a grievance is filed against a LIBERTY staff member, we will conduct one-on-one focused education with the staff member to improve the quality of interaction they are having with the member and to resolve member grievances. When grievance data is linked to communicating the wrong information to our members, we use it as an educational opportunity to better train our staff.

Member grievances that are resolved against a provider are referred to our Potential Quality Issues ("PQI") Committee. The PQI Committee consists of representatives from our Quality Management ("QM") and Provider Relations Departments, as well as clinical staff. The PQI Committee reviews cases in detail on a monthly basis and determines whether the case represents a quality issue with the treatment provided to the member. In these instances, LIBERTY will take corrective action, which may include holding the provider responsible for the full amount of the cost to have the member's treatment completed by another provider. Providers receiving multiple PQI's are subject to additional corrective action, including suspension of new enrollments and potentially, termination. All PQIs are tracked and trended and are reviewed by the Committee quarterly.

Recipient Suggestions and Assessment of Recipient Satisfaction

It is LIBERTY's charge to improve our members' overall oral health through various education, outreach and follow up initiatives. We solicit feedback and recommendations from members through multiple different approaches.

Member Feedback

We utilize member satisfaction surveys to help evaluate our policies and processes. Our Member Satisfaction Surveys are adapted from the CAHPS survey. LIBERTY will administer the CAHPS survey in Nevada to a statistically random sample of members to capture the following measures: Getting Needed Care, Getting Care Quickly, How Well Providers Communicate, Customer Service and Global Ratings. We will use the CAHPS results to determine whether members have access to needed care and if they are happy with the care and the coordination we provide. We utilize data collected from the CAHPS surveys to augment our internal processes, including care coordination and member services, as well as to develop educational material that is distributed to our network providers through provider newsletters. Please see the example of a member satisfaction survey tool that we currently use in Attachment 9. We have found outbound call campaigns for member satisfaction to be more successful than mailings; therefore, we routinely conduct satisfaction surveys following a member call. The importance in gathering and analyzing member satisfaction is demonstrated through our outbound call outreach unit. We believe there is value in contacting the members by phone allowing the Member Services Representatives to ask questions regarding the member's

experience at the dental office and to verify that services were rendered in accordance with the treatment plan presented and approved by the member. Members are selected based on utilization records. This avenue allows for discussion with the member to pinpoint areas of satisfaction and concern. The telephone survey also includes an assessment of our customer service. Unfavorable results are shared with the management team for immediate action. Negative survey results regarding a provider are forwarded to our Provider Relations Department to initiate corrective action. In 2015, 93% of those surveyed said they were satisfied with our Member Services Department, and 92% of them would refer family or friends to LIBERTY.

In the 1st quarter of 2016, our California plan made 1,121 outgoing calls to complete

Utilizing Member Surveys for Quality Improvement

Daily survey results are tracked in in the MIS system for trending and reporting purposes. Internal changes are identified and applied to improve member experience and satisfaction. Quarterly survey results, are reported to the Quality Management and Improvement (QMI) Committee for analysis and corrective action when results are unfavorable. We conduct a focused review and analysis of offices identified with less than adequate member satisfaction scores, and implement strategies to outreach and counsel providers in how to improve. For example, in office wait times has been an area of concern in recent surveys; results have not met the established member satisfaction survey goals of 85% or greater. We have conducted a barrier analysis, and have reviewed relevant data including grievances. If the concerns with wait times are substantiated through data analysis, combined with the member feedback, the Network Manager is notified to conduct counseling with the provider in question. We often receive positive comments from our members about our network providers and our own staff. Satisfaction surveys with positive results and comments about a particular office are forwarded to our Dental Care Management team for potential consideration for the Center of Excellence program or other incentives to help recognize outstanding dental offices and positive feedback.

We will continue to explore new avenues for generating feedback and discussion. We will develop direct lines of communication, including a team dedicated solely to ensuring coordination is handled as quickly and efficiently as possible, with all entities that hold a stake in serving members and identifying and responding to members' oral health needs. We will develop close working relationships with Heritage Health MCOs and other state agencies, contractors, tribes, etc., establishing singular points of contact and ensuring effective and efficient communication lines, to resolve any and all coordination of care issues as they arise.

Our QMI Committee, will continue to serve as a forum for discussion and evaluation of the Member Satisfaction Survey. Key representatives from almost every department attend these meetings. Committee members engage in lively discussions that result in collaborative projects and initiatives that are initiated, validated or driven by member feedback. Other opportunities to review member input include, but are not limited to, member call center communications.

Confidentiality of Patient Information

With the advent of new, faster, and more efficient means of communications between health plans, hospitals, and doctors through Electronic Data Interchange (EDI), LIBERTY recognizes that there are concerns about ensuring that member information remains confidential and the member's privacy is protected. LIBERTY is committed to ensuring that member-identifiable information or data are only reviewed by the professionals who treat members, review and study the quality of care members receive, and those who pay for and administer the services received. LIBERTY is always striving to meet the latest standards and improve the security of confidentiality-protection systems. In addition to adhering to state and federal laws and regulations pertaining to confidentiality of individually identifiable information, LIBERTY utilizes the National Committee on Quality Assurance standards throughout the organization.

In order to ensure the protection of confidential information, LIBERTY has established a Confidentiality and Privacy Global Policy for staff members, contracted providers and personnel, and agents of LIBERTY to adhere to when handling individually-identifiable member material, data, or information. This document not only outlines the organization's policies and procedures for ensuring the confidentiality of patient information and records, but it details how these policies and procedures will be enforced. The Confidentiality and Privacy Global Policy covers a number of topics in detail, but a few are summarized below.

Patient Care Offices/Sites

LIBERTY ensures patient care offices/sites implement mechanisms to guard against the unauthorized or inadvertent disclosure of confidential information to persons outside the vendor via provider contracts, which explicitly state expectations about the confidentiality of member information and records. Confidentiality and release of information policies are also contained in the Provider Manual.

Participating Providers are required to maintain the confidentiality of all Member dental records and related treatment information in accordance with State and Federal Law. Providers must also establish procedures and safeguards so that no confidential information pertaining to LIBERTY Members are used or disclosed, other than for purposes directly connected with the administration of the LIBERTY Dental Plan.

In the treatment setting, all dental records and other personal health information must be kept in a secure place. Measures will be taken to ensure that all documents are covered (i.e., have coversheets, file folders containing medical records will be kept closed when document is not in use) to prevent access to confidential materials.

Finally, LIBERTY requires any internal or external participants in any organization business endeavors or community initiatives to sign a confidentiality Agreement Statement that documents:

1. The user's understanding of data confidentiality.

2. The user's commitment to assume responsibility for the data they access.

3. The user's commitment to report any security violations.

4. The user's commitment to use data only as permitted for the proper performance of his or her job, subject to sanctions or dismissal.

Data Shared with Personnel

All LIBERTY employees are required to attend a structured Orientation Program (upon hire), which includes all aspects of maintaining confidentiality of all sensitive information along with specific instructions on the use and importance of Computer Password Security. This information is further reinforced via periodic additional associate training sessions, newsletter features, and the Employee Handbook, which is provided when hired and is subsequently updated as needed.

All personnel are instructed to treat identifiable health care data as confidential upon employment. In addition, they are required to sign a confidentiality statement acknowledging their understanding and commitment to data confidentiality. The exceptions to this commitment are in instances in which:

1. It is required by law, or pursuant to a hearing request or on the recipient's behalf

2. 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

3. It is necessary to protect the health or safety of an individual

On an annual basis, LIBERTY Dental Plan managers and/or supervisors provide employees with continuing education on data confidentiality through the employee appraisal process. Employees are required to renew their confidentiality statement at this time. This is accomplished through a signature acknowledgment on the employee's

annual performance appraisal form. LIBERTY Dental Plan managers are accountable for compliance with these standards.

Disclosure of Recipient Records

Dental information regarding a member may only be released after LIBERTY has obtained appropriate prior written authorization from the member or the member's parent/legal guardian/conservator, or a valid court order or court-authorized subpoena requesting such records has been received by the company. 'Appropriate written authorization' means permission granted in accordance with Section 56.11 or 56.21 of the Confidentiality of Medical Information Act.

Current law allows release of dental records to the following parties without specific member/parent/legal guardian/conservator authorization. Written request must be received by the Corporate Dental Records Department, who will process such records and perform the release of records to the following parties:

A. Peer review organization reviewers (may be released)

B. Public Health Departments (may be released)

C. Licensing or accreditation surveyors (may be released)

D. County coroner (may be released)

E. Claims payers, only as is sufficient to verify that the billed services were in fact provided. (may be released)

F. To law enforcement agencies pursuant to a lawfully issued search warrant, and only upon advice and consent of the LIBERTY Dental Plan Legal Affairs or Risk Management Departments. (MUST be released)

G. Subpoena duces tecum, only upon advice and consent of the LIBERTY Dental Plan Legal Affairs or Risk Management Departments. (MUST be released)

H. Arbitration order, only upon advice and consent of the LIBERTY Dental Plan Legal Affairs or Risk Management Departments. (MUST be released)

I. When otherwise specifically required by law.

3.9.17 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.

To ensure all Nevada Medicaid recipients have the highest level of access and availability, LIBERTY has established standards that meet or exceed current State access and availability requirements (see the results in Table 3.9.17-1 below from our commercial network in Nevada). Our provider agreement requires the contracting provider to abide by standards that include procedures designed to monitor and evaluate access, availability, and continuity of care. In order to achieve these standards, all LIBERTY providers agree to comply with the policies and procedures outlined in our Provider Agreement and Provider Manual, which include standards for availability, accessibility, and timeliness of care.

TABLE 3.9.17-1. NEVADA COMMERCIAL NETWORK STANDARDS

LIBERTY Nevada Commercial Network Standards			
Category	**Benchmark**	**Standards**	**% within standards**
Hygiene Appointment	98%	30 days	**99.2%**
Initial Appointment	98%	30 days	**100.0%**
Routine Appointment	98%	30 days	**100.0%**
24 Hour Emergency	98%	24 hours	**100.0%**
In-Office Wait	98%	30 minutes	**100.0%**

Standards of Accessibility And availability

We are committed to ensuring our recipients receive timely access to care. Providers are required to schedule appointments for eligible recipients in compliance with standards of accessibility and availability as defined in the applicable program orientation brochure.

Additionally, LIBERTY has established the dedicated, internal position of Access & Availability (A&A) Coordinators within our Quality Management (QM) department. The A&A Coordinators work intimately with our internal operational departments to communicate, monitor, and enforce LIBERTY's access and availability standards. The A&A Coordinators also work closely to monitor the performance of a designated Member Services team that is trained specifically to perform our "secret shopper" call surveys as described below.

The A&A Coordinators track and trend provider compliance and report their findings directly to our Dental Director as well as our QM committee.

The following standards in Table 3.9.17-2 have been established for appointment availability for general dentists and specialists. All of the standards below either meet or exceed the current Nevada DHCFP dental requirements.

TABLE 3.9.17-2. APPOINTMENT AVAILABILITY STANDARDS

Appointment Type	Appointment Standards
Initial, Preventive, and Routine Care:	***Dental examinations and prophylaxis shall be scheduled at the earliest appointment available or within six weeks.***
Specialists Initial Consultations:	***Initial consultations for specialty services shall be scheduled for a period of 15-20 minutes, not to exceed 4 per hour. Consultations shall include a review and assessment of the patient including radiographs, study models, periodontal pocket measure chart, orthodontic records or other dental documentation, as appropriate. Specialist appointments shall be scheduled at the earliest appointment available or within 30 business days.***
Follow-up care:	***Follow-up appointments shall be made immediately after the patient has been seen. For routine appointments, where no further service is required, the recall appointments shall be noted in the dental office automated system for a 6-month post-card notification of the appointment, for review. Emergency follow-up appointments shall be scheduled within one week's time from the date of intervention to assess the patient's progress and/or, in case of emergency surgery, removal of sutures.***
Urgent/Emergency Care:	***Urgent and/or emergency dental services shall be performed within a 24-hour period. If there is a requirement for specialty referred, a verbal request for authorization is made of the Dental Director or his/her assignee, followed by a written request faxed from the general dentist to the Dental Director to support the approval. This documentation is integrated into the patient file once the Dental Director signs the document and returns it to the provider.***

Appointment Type	Appointment Standards
Standards for Waiting Time:	Patients are to be seen as scheduled, however, should delays occur, the in-office wait-time is not to exceed 30 minutes. Exceptions to this practice requires that the clinic staff notify the patient of any delay, give an approximate timeframe for the resolution of the delay and give the patient an option as to whether or not he/she would care to wait further or re-schedule the appointment.

We require that each contracting dentist offer an appointment to recipients in a prompt and compliant manner with the goal of maintaining and improving our recipient's dental health. If an appointment needs to be re-scheduled, the LIBERTY provider shall ensure that it is promptly rescheduled in a manner that is appropriate with recipients' needs. Under normal circumstances, LIBERTY's objective is that each contracting dentist will schedule the first available appointment for a recipient. While we have established requirements and standards, all of which meet or exceed the current Nevada DHCFP dental requirements, we also have established goals that are communicated to each provider. Table 3.9.17-3 below is a table which compares LIBERTY's access and availability standards to our goals:

TABLE 3.9.17-3. APPOINTMENT AVAILABILITY GOALS

Type of Care	Standard	Performance Goal
Initial Appointment	Within 6 weeks	First available appointment within standard
Routine Appointment (non-emergency)	Within 6 weeks	First available appointment within standard
Preventive Dental Care Appointment	Within 6 weeks	First available appointment within standard
Specialist Appointment	Within 30 Business Days	First available appointment within standard
Emergency Appointment	24 hours a day/7 days a Week	First available appointment within standard

In addition to appointment availability standards, LIBERTY maintains access standards by implementing policies and procedures for maintaining an adequate network of providers in accordance with applicable state and federal standards and guidelines. For example, Table 3.9.17-4 shows LIBERTY's provider network standards in three of the other state Medicaid programs in which it administers the benefits. The access standards in these states are similar to Nevada's requirements and when awarded a contract, LIBERTY will update these standards to accommodate Nevada.

TABLE 3.9.17-4. PROVIDER NETWORK STANDARDS

State	Standard
CA	One (1) FT provider per 1,500 enrollees (including Medicaid, commercial, and fee-for-service).
FL	One (1) FT provider per 1,500 enrollees (including Medicaid, commercial, and fee-for-service). The ratio may be increased by 500 enrollees for each FT licensed dental hygienist up to a maximum of two (2) per FT dentist.
NJ	At least two (2) physicians eligible as PCPs are within 10 miles or 30 minutes driving time or public transit time (if available), whichever is less, of 90 percent of the carrier's covered persons.

We have been successful in maintaining our required ratio of providers to recipients in States that we administer the Medicaid program. In the event that we have a need to increase capacity of our network providers to exceed the requirement of one FTE per 1,500 recipients, we will submit a detailed explanation to the DHCFP for approval. We will include our detailed plan to ensure that recipients are still receiving the standard access, quality of care, and not impacted by the increase capacity request.

We contract with Endodontists, Oral Surgeons, Periodontists, Pediatric Dentists, Orthodontists, and Prosthodontists. We are largely focused on contracting with additional pediatric dentists with expanded hours to ensure access to care for young children that may have difficulty in receiving treatment at a PCP.

We continually develops and initiates specialty recruitment strategies to ensure we have coverage for all specialty types whenever we have membership growth in a region or city, changes in our PCP network, needed improvements in accessibility and

appointment times are identified, or our specialty referral staff has identified specific needs in our specialty network.

Standards Monitoring

Understanding the critical role that oral health plays in concert with one's general health, and thus overall quality of life, LIBERTY takes accessibility to care very seriously. We require that each contracting dentist offer an appointment to each recipient as promptly as is appropriate and required to maintain and improve our recipient's dental health. To ensure that our recipients have the required access to care, we monitor offices through numerous methods, including but not limited to the following (each is described in detail below the bulleted list):

- ***GeoAccess Reports***
- ***Review of Input from Internal Response Unit***
- ***Member Utilization Trends and Out-of-Network Utilization Trends***
- ***Facility Site Review/Audit Calls***
- ***Recipient Complaints/Grievance Trending***
- ***Recipient Dental Exception (BDE) Tracking/Trending***
- ***"Secret Shopper" Call Tracking***
- ***Timely Access Reports***
- ***Provider Utilization Report Enforcement***
- ***Review of Quality Improvement Activities Related to Appointment Standards***
- ***Provider Relations Meetings***

GeoAccess Reports

LIBERTY produces GeoAccess reports monthly to ensure that our network is adequate for the recipients and meets the DHCFP requirements. We plot the member census against existing provider locations and analyze the impact of changes. This enables us to identify where additional contracting is needed to keep the network compliant with the DHCFP requirements. Using our strategies to identify additional providers for dental provider recruitment (such as competitors' networks, out of network providers, nomination requests, and the State's website), we continuously recruit providers to ensure that we continue to maintain our access standards, appointment standards, ratio of members to providers, and changes in cultural and linguistic needs of the population.

Review of input from of Internal Response Unit (IRU): LIBERTY created our Internal Response Unit (IRU) within the Member Services Department for the purpose of supporting our providers and members in resolving escalated cases and ensuring

continuity of care. The IRU is staffed by Customer Care Specialists who are trained in all aspects of the call center, and possess the skills required to perform case coordination activities. Our IRU team is on the front line of recipient and provider issues and able to quickly recognize when we have an issue in our network. If an issue is identified, the IRU will immediately contact the Provider Relations staff with the network concern. The IRU will also assist the recipient with finding an immediate solution for the network issue. Additionally, the IRU will meet with the Provider Relations monthly to discuss any other access, availability, and capacity trends they recognize.

Member utilization trends and out-of-network utilization trends

LIBERTY reviews any changes in member utilization trends for a particular specialty or an increase in out-of-network utilization, which can indicate that there is an access issue for our members.

Facility Site Review/Audit Calls

Initially, during new provider orientations and service calls, the Network Manager will ask the offices their standard appointment wait times and in-office wait times. If there are discrepancies with LIBERTY standards or State requirements, our Network Managers use these discussions as education opportunities to train them on what is expected and required. During our annual audit calls, as well as during the orientations and service calls/visits, the office staff is asked the average wait time for patients. Our Network Manager will use the average wait time given and update the provider file within our MIS system, using our Provider Service Report (PSR). We run quarterly reports outlining all offices that were surveyed on their in-office wait time.

Additionally, our Network Managers survey the entire network annually. We use a random selection process and provide quarterly reports to track and monitor the network's compliance with these standards. Examples of the audit call script for urgent care calls and routine calls are below:

- ***For urgent care calls, the audit caller will tell the provider staff that they have a broken tooth that hurts, and their face is swollen; or their filling came out and the tooth hurts.***
- ***For routine calls, the audit caller will tell the provider staff that they need to make an appointment for their child who has never been to a dentist or last went to the dentist 3 years ago.***
- ***During all calls, the audit callers will verify which dental providers are providing treatment in the office.***

If the appointment is provided within the appropriate time frame, the staff will be congratulated and notified that they passed the audit. If an appointment is not provided

within the timeframe, the staff will be notified that they did not pass the audit and an education plan will be initiated to educate the provider and staff on the appointment availability guidelines. Further Actions with these offices may include:

- ***Verbal re-education.***
- ***Halt referrals to office, resurvey in X time frame (e.g. 1 month, 3 months, 6 months).***
- ***Corrective Action Plan (CAP) requested. A CAP letter to be sent to office and written response requested. Corrective action plans can include such items as:***
  - ***Staff education on appointment availability requirements,***
  - ***Posting the requirements in the office,***
  - ***Modifying emergency protocols of office,***
  - ***Hiring additional staff/hygienist, etc.***

We also use our appointment audits to identify issues in our network. For example, if a provide office phone number is disconnected or the phone is not answered, this may indicate the provider changed office hours or providers may have changed. After some investigation into these matters, the Network Manager may visit the office, mail a letter, or terminate a provider if necessary. We will provider quarterly provider availability audit reports to the DHCFP.

LIBERTY reviews the offices of contracting primary care dentists prior to finalizing the credentialing/contracting process, and on an on-going, calendared basis. We attempt to conduct a review on the first anniversary of the date on which the contracting dentist was authorized to provide dental services to recipients in that office and semi-annually thereafter. If necessary, and if there are quality assurance concerns, the Dental Director may require additional reviews at any time.

As part of each review, the Plan verifies office staffing (e.g., the number of dentists, dental auxiliaries, hygienists available to recipient in the office), office hours (including after-hours availability and availability for emergencies), appointment availability (for initial appointments, routine appointments, and preventive dental care appointments), waiting time for scheduled appointments, patient capacity, as well as foreign languages spoken by recipients of the office staff and the office's physical accessibility (e.g., location, handicap accessibility). At the end of the review, LIBERTY will conduct an exit interview with the primary care dentist to discuss the findings made by our Dental Director during the review.

After the exit interview, the Dental Director reviews the summary findings and will determine whether the office meets all required standards and norms. The Dental Director then sends a letter to the primary care dentist stating one of three results:

- ***a) The office met or exceeded all LIBERTY guidelines;***
- ***b) The overall review was acceptable, but the office did not meet certain guidelines; or,***
- ***c) The office failed to sufficiently meet the LIBERTY's guidelines.***

In situations involving either item (b) or (c), above, the Dental Director's letter specifies any corrective actions the contracting dentist must take. The letter also includes a time frame for the completion of any corrective actions. If necessary, the Dental Director may schedule a follow-up review to determine whether a primary care dentist has successfully implemented the corrective actions required.

Recipient Complaints/Grievances Trending

Under our grievance procedures, LIBERTY tracks complaints made by recipients regarding access. Our A&A coordinator receives monthly reports describing the number of complaints/grievances received for each dental office by category (e.g., appointment wait; quality of care), and reviews them to identify specific and systemic problems and for trending purposes. The findings are communicated to the Dental Director, who then determines any necessary corrective actions.

We also monitor complaints from recipients to assess whether network providers are meeting availability and wait time standards. If we find a consistent trend from recipients about a specific provider, our Grievance and Appeals or Member Service Department notifies the provider's assigned Network Manager. The Network Manager then schedules a counseling session with the provider to discuss the specific complaint. During the counseling, the Network Manager asks the provider to verify the issue, provides education on the importance of meeting those standards, and describes the consequences if the provider continues to be non-compliant. A summary of the meeting is documented in our PSR.

A follow-up service call or visit is scheduled with the provider within 60 or 90 days after the counseling session (depending on the severity of the concern) to evaluate whether the provider has improved their performance. If the provider has made little or no improvement in meeting the access standards, we may suspend assignment of new recipients to the provider. If our monitoring shows that the provider continues to violate our access standards, our next step is to begin the process to terminate our relationship with the provider.

Recipient Dental Exception (RDE) Tracking/Trending

LIBERTY has established a new policy and procedure to ensure all (if any) Recipient Dental Exception requests are tracked and trended once received. LIBERTY will track the information gathered from each request, including specific demographic information of the recipient (e.g., zip code and language spoken) as well as the office information from each request. Analysis of the trending of this data will allow us to quickly identify barriers to access due to regional issues or cultural/linguistic reasons. It will also allow LIBERTY to identify office specific barriers and/or access and availability issues.

"Secret Shopper" Call Tracking

As a method of reviewing actual times recipients wait to get an appointment, LIBERTY conducts "secret shopper" calls to our primary care dentist offices. LIBERTY utilizes a subset of our Member Services department, trained specifically in the soft skills necessary to accomplish successful "blind" call surveys. Calls are made during different times of the day, including after hours to ensure the entire scope of services are surveyed.

Acting as a recipient's parent/guardian who is requesting an appointment, the caller inquires as to appointment accessibility for initial examinations, preventive dental care appointments, hygiene treatment, routine care, and emergency care. The caller also inquires as to appointment wait times for both general dentistry and specialist appointments. A report summarizing the results of the calls are prepared under the direction of the A&A coordinator and are reviewed by the Dental Director, who then determines any necessary corrective actions. If the need for corrective actions is identified, the Dental Director forwards the information to our Provider Relations department for immediate feedback to the office.

Timely Access Report

On a monthly basis, either during our established facility site reviews or standard service calls, LIBERTY collects timely access information from our providers. Timely access reports are provider specific reports which detail the actual amount of time recipients waited to get an appointment. The information gathered in these reports is verified using the above methods, including recipient complaint/grievance trending and "secret shopper" call tracking.

Provider Utilization Report

As a means of tracking access through data submitted by the providers, LIBERTY generates a Provider Utilization report monthly. This report instantly displays the utilization percentage for every office in the program. Offices with a utilization percentage below five percent (annualized, this equates to a utilization percentage

below 60 percent) receives a letter and a phone call from our Provider Relations team reminding them to submit all encounters and of their obligation to provide timely access and availability to all recipients.

Quality Improvement Activities for Access and Availability

On a monthly basis, the Quality Management department reviews reports identifying any Primary Care Dentists or Specialists that are not meeting appointment standards as a result of initial onsite facility reviews, provider service calls and recipient grievances. In addition to these reports, office transfer and exempt grievance logs are analyzed to identify and access and availability issues resulting from cultural or linguistic issues. All identified issues are forwarded to the Provider Relations department to address with the providers and appropriate action is taken according to the severity of the issue. Corrective Action Plans are determined by the Dental Director for offices that have been identified with potential barriers to care.

Along with the above mentioned methods, LIBERTY monitors the progress and success of any and all Quality Improvement activities that relate directly to access and availability. The combination of these monitoring methods allows LIBERTY to quickly identify any barriers to access and availability that might exist within our contracted provider network. When barriers are identified with any of our general or specialty providers, LIBERTY immediately begins the recruitment process of additional providers to improve access.

Provider Relations Meetings

LIBERTY conducts regional monthly Provider Relations meetings, which reviews input from all of the above sources. The meeting is joined by all operations areas including the Member Services Department, the Claims Department, the Grievance and Appeals Department, Provider Relations Department, Network Managers, Dental Directors, and Dental Consultants. During these monthly meetings, we collaborate to review information from all of the departments to identify where appointment availability and wait times may be an issue and determine a strategy to improve on those issues. We will provide appointment availability and wait time reports to the DHCFP on a regular basis.

Enforcement

Provider compliance of access and availability standards is monitored through the Peer Review Committee. Offices with Corrective Action Plans (CAPs) generated from facility site reviews are placed on a shortened audit schedule and are visited by Quality Assurance Consultants to evaluate compliance with access and availability standards. The shortened audit schedule can vary from thirty to ninety days, depending on the severity of the issue identified. The Committee monitors the offices that have been

issued a CAP and gathers any additional reporting elements applicable to ensure a provider has maintained compliance with access and availability standards. The provider offices that have not shown improvement are then escalated to the Quality Management and Improvement Committee for further action. If it is determined that an office is not meeting and/or exceeding our access and availability standards, the following actions may be taken as appropriate:

- ***Counseling***
- ***Office placed on track and trend report***
- ***Office closed to new enrollment***
- ***Recruitment of alternate office***
- ***Move part of or all enrollment to an alternate location***
- ***Reduced reimbursement***
- ***Termination***

If the contracting dentist fails to implement any corrective actions or continues to fail to meet LIBERTY's guidelines with regard to any of the matters discussed above, the Dental Director may close the contracting dentist office to new enrollment, place the contracting dentist on probation, and/or terminate the dentist's participation in LIBERTY's network.

3.9.18 Dental Record Standards

3.9.18.1 Accessibility and Availability of Dental Records

A. 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.

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

LIBERTY's Provider Contract requires that providers comply with HIPAA regulations in regard to Dental Records and Confidentiality. The Provider Contract also outlines requirements with respect to the availability of Dental Records. These standards are further reiterated in the Provider Manual. Upon award of the contract in Nevada, we will update our Provider Contract and Provider Manual to include language specific to the DHCFP requirements, where applicable. LIBERTY's Provider Contract and Provider Manual are comprehensive and have been written to ensure HIPAA compliance and adequate dental record availability 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. We are committed to ensuring that network providers comply with all the requirements as set forth in this RFP.

Ensuring HIPAA Compliance

LIBERTY takes pride in administering our dental plan in an effective and innovative manner while safeguarding our recipients' Protected Health Information (PHI). As such, we are committed to complying with HIPAA requirements and standards as they relate to accessing dental records.

LIBERTY requires all dental providers to comply with HIPAA laws, rules, and regulations and reminds network providers that, by virtue of the signed Provider Contract, providers agree to abide by all HIPAA and Quality Management Program requirements. Providers must further agree that recipient PHI may be shared with LIBERTY per the requirement in the HIPAA laws which enables sharing of such information for treatment, payment, and health care operations, as well as for peer review and quality management and improvement requirements of health plans. There is no need for special recipient authorizations when submitting recipient PHI for these purposes.

LIBERTY has appointed a Privacy Officer to develop, implement, maintain, and provide oversight of our HIPAA Compliance Program, as well as assist with the education and training of our employees on the requirements and implications of HIPAA. As a health care provider and covered entity, providers and their staff must follow HIPAA guidelines regarding PHI.

Dental Records Availability

LIBERTY's Provider Contract also requires that recipient dental records be kept and maintained in compliance with applicable state and federal regulations. Complete dental records of active or inactive patients must be accessible for a minimum of 10 years, even if the facility is no longer under contract with a LIBERTY network. Dental records for children should be maintained up to 10 years beyond the age of majority.

In addition to availability, our Provider Contract requires that dental records be comprehensive, organized, and legible. All entries should be in ink, signed, and dated by the treating dentist or other licensed health care professional who performed services. Patient records should be available to dental practitioners at each encounter.

Finally, contracted dentists must make available copies of all patient records to the Plan upon request. Records may be requested for grievance resolutions, second opinions, or for state and/or federal compliance. The dentist must make records available at no cost to the Plan or the patient, and non-compliance may result in

disciplinary actions, up to and including transfer of current enrollment and/or closure to new enrollment. Continued non-compliance may result in termination by the Plan.

3.9.18.2 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:

A. 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:
   1. Patient Identification Information – Each page on electronic file in the record contains the patient's name or patient ID number;
   2. 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;
   3. 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;
   4. 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;
   5. Diagnostic information;
   6. Medication information;
   7. Identification of Current Problems – Significant illnesses, Dental conditions and health maintenance concerns are identified in the Dental record;
   8. 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;
   9. 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;
   10. Emergency care; and
   11. Patient Visit Data – Documentation of individual encounters must provide at a minimum adequate evidence of.
       a. History and Physical Examination – Comprehensive subjective and objective information obtained for the presenting complaints;

       b. Plan of treatment;

       c. Diagnostic tests;

d. Therapies and other prescribed regimens;

e. 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;

f. Referrals and results thereof;
g. All other aspects of patient care, including ancillary services;

12. Entry Date – All entries must have date and time noted;
13. Provider Identification – All entries are identified as to author; and
14. Legibility – The record is legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.

LIBERTY expects contracted dentists to adhere to recognized standards of dental record-keeping including, maintaining accurate and legible treatment records which are consistent with generally accepted clinical guidelines and requirements, American Dental Association guidelines and state and/or federal law. As mentioned above, the Provider Contract requires that all dental records be comprehensive, organized, and legible. All entries should be in ink, signed, and dated by the treating dentist or other licensed health care professional that performed services.

All dental services, including those proposed, recommended, and/or performed, must be documented and consistent with professionally recognized standards of dental practice. In addition, patient information is collected and recorded, including a system-generated patient identification number. The following information is included in LIBERTY's standards for dental record-keeping.

Patient Information

Along with a patient ID number, all dental records must include:

- ***Personal information: name, sex, birth date, race, ethnicity, primary language, and marital status***
- ***Contact information: address, telephone number, cell phone number, e-mail address, name of employer, work address and telephone number, and other contact information such as social media addresses***
- ***Name and telephone number of person(s) to contact in an emergency***
- ***For minors, name of parent(s) or guardian(s) and telephone numbers, if different from above***
- ***Pertinent information relative to the patient's chief complaint and dental history, including problems or complications with previous dental treatment***

Medical History

There should be a detailed medical history form, signed and dated by the patient or patient's parent or guardian, comprised of questions which require a "yes" or "no" responses, minimally including:

- ***Patient's current health (and disability) status***
- ***Name and telephone number of physician and date of last visit***
- ***History of hospitalizations and/or surgeries***
- ***Emergency care***
- ***Patient visit data documenting individual encounters (i.e., plan of treatment, diagnostic tests, therapies and other prescribed regimens, referrals and results thereof, and all other aspects of patient care, including ancillary services)***
- ***For children, history related to prenatal care and birth and preventive services***
- ***History of abnormal (high or low) blood pressure***
- ***Smoking, alcohol, and substance abuse***
- ***Current medications, including dosages and indications***
- ***History of drug and medication use (including Fen-Phen/Redux and bisphosfonates)***
- ***Allergies and sensitivity to medications or materials (including latex)***
- ***Adverse reaction to local anesthetics***
- ***History of diseases:***
    - ***Cardio-vascular disease, including heart attack, stroke, history of rheumatic fever, existence of pacemakers, valve replacements and/or stents and bleeding problems, etc.***
    - ***Pulmonary disorders including tuberculosis, asthma and emphysema***
    - ***Nervous disorders***
    - ***Diabetes, endocrine disorders, and thyroid abnormalities***
    - ***Liver or kidney disease, including hepatitis and kidney dialysis***
    - ***Sexually transmitted diseases***
    - ***Disorders of the immune system, including HIV status/AIDS***
    - ***Other viral diseases***
- ***Musculoskeletal conditions, including the location and date of placement of any prosthetic joints***
- ***Pregnancy***
    - ***Document the name of the patient's obstetrician and estimated due date.***
    - ***Follow current guidelines in the ADA publication, Women's Oral Health Issues.***

- ***History of cancer, including radiation or chemotherapy***

Dental records must also include the dentist's notes following up on patient comments, significant medical issues, consultations, referrals, and specialist reports on the medical history form or in the progress notes.

Medical alerts for significant medical conditions are required to be uniform and conspicuously located on a portion of the chart used and visible during treatment and should reflect current conditions. The medical history should be updated at appropriate intervals, dictated by the patient's history and risk factors, and must be done at least annually and signed by the patient and dentist.

Finally, LIBERTY requires that dental records contain a dental history, distinct from medical history, which includes the following information:

- ***Reason for seeking current dental care (Chief Complaint)***
- ***History of previous oral surgery, orthodontics, periodontics, etc.***
- ***Problems with previous dental treatment***
- ***Complications from local anesthesia***
- ***Previous Risk Assessments***
- ***Recipient's dental goals***

3.9.18.3 Record Review Process

A. 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

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

LIBERTY Dental Plan has established guidelines and processes in place for reviewing dental records to assess the content for legibility, organization, completion, and conformance to the standards outlined above.

Upon acceptance to LIBERTY's network, offices will be added onto the Quality Assurance Review Program Schedule. The program is identified and determined by querying LIBERTY's network of general providers. Offices are identified and selected by an internal average benchmark set of dollars paid per provider. The remainders of offices who have met the set standards are then compared to the previous year's review schedule to ensure each office has a passing score of an on-site review performed within the last 12-month period. The offices that have not been reviewed or

have failed scores by LIBERTY within those 12 months are then added to the current year's schedule.

If the provider office is also a provider for another managed care plan and has had a review conducted by an accredited reviewer using the common review tool, LIBERTY may accept a copy of that review with an acceptable score performed within the previous 12 months in lieu of the initial review. Variance from the defined levels of acceptable performance determines both the frequency of subsequent quality reviews and the necessity for current corrective actions to remediate deficiencies.

The threshold criteria for the initial review of a contracted provider office is based on a combination of either the number of members and encounters the office experiences or the number of members and grievances reported. An initial review of a provider office is performed if the office has 50 assigned members and at least ten unique encounters or 150 assigned members within a 36-month period and two or more grievances in a consecutive 12-month period.

LIBERTY uses the Association of Dental Plans common review tool to assess the content of dental records. The tool will be used and performed by a calibrated reviewer applicable to each state. The review tool is designed to measure both attributes and deficiencies noted during the dental chart review. A licensed dentist, who is qualified by training and experience and is certified as a reviewer shall review patient charts to ensure completeness, comprehensiveness, and acceptable care.

When it is time for a review, LIBERTY will contact providers a month in advance to set a mutually agreeable date and time for the review to be conducted. The advance schedule notice may be disregarded if a site visit needs to be done due to a significant amount of concern of access or risk towards member's dental care or a number of complaints received.

Provider offices that have demonstrated review scores of 95% or above with no critical deficiencies on the Dental Chart Review will be reviewed every three years. However, offices with low review scores or for whom deficiencies are found, the period between reviews will be reduced as follows:

- ***74%-84% - one year reassess by Dental Consultant***
- ***85%-94% - two years reassess by Dental Consultant***

A chart review with a score below 84 % is a failed chart review and requires immediate correction of deficiencies in order to continue as a provider. The provider must demonstrate that corrective action to remediate deficiencies has been taken. Compliance shall be verified with a follow-up review of all deficient categories within

one year or less at the discretion of the Dental Director, and a re-review within that one year to verify continued compliance.

3.9.19 Utilization Review

3.9.19.1 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.

LIBERTY Dental Plan (LIBERTY) maintains a Utilization Management Program description and associated policies and procedures, currently in use with our existing Nevada groups that have been developed over several years and through involvement with our Dental Directors, Peer Review Committees and regional, state, and nationwide standards of dental care.

Our UM Program Description outlines the structure, accountability, scope and process used to make determinations based on benefit coverage and dental appropriateness of care. Our complete UM Program description can be found in Attachment 18.

3.9.19.2 Scope

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

LIBERTY's comprehensive Utilization Management (UM) program is designed to: ensure that dental services are delivered at the appropriate level of care, in a timely, effective and cost-effective manner; examine and improve the quality of dental care; and enhance the evaluation of practice patterns of oral healthcare delivery. Our UM program complies with applicable state and federal regulations, and incorporates National Committee of Quality Assurance (NCQA) guidelines American Dental Association (ADA) standards. To deliver the highest quality dental care for all members, LIBERTY's UM program methodology focuses on ensuring:

- ***Appropriate utilization of dental services.***
- ***Access to specialty care.***
- ***Availability of care.***
- ***Coordination of dental care.***
- ***Over and under-utilization***

Mechanisms to detect and document over- and under-utilization of dental services.

In the past year, we have developed a proprietary UM analysis tool that allows us to establish network normative patterns for every dental service category. LIBERTY's core MIS application is a single source application that houses all data in a single platform, creating a flexible, integrated system that provides both functionality and customization capabilities. We use various methods to identify and track Utilization Data from our core application. Our system houses Claims, Pre-Estimate, Check, Provider\Office, Group, Billing, Member communications, and all other supporting data. Our reporting tools enable us to pull data from the core system on a regular basis, using the existing datasets, which can then be exported and referenced for a variety of reporting needs. These include test and reporting environments, data warehouse, and custom applications that share data from the core system.

Our UM analysis tool automatically analyzes every network dental office against the established patterns of utilization and identifies both over and under-utilizing providers in each dental service category. The Dental Director or designee assesses over- and under-utilization and reports findings and recommended actions to the UM Committee. The UM committee reviews, analyzes, and assesses trends of providers. An analysis of annual utilization trends occurs in the month of January and involves review of the previous year. Assessment trends include, but are not limited to the following:

- ***Analysis of the utilization data (members eligible, members utilized, annual utilization rate, procedures per visit, procedures per member, average UCR per member, fees per member, capitation difference, etc.).***
- ***Analysis of utilization trends (diagnostic, preventive, restorative, endodontic, periodontic, oral surgery, etc.).***
- ***Analysis of procedure ratios (i.e.: crowns/fillings, root canals/extractions, etc.).***
- ***Analysis of provider trends.***
- ***Evaluation of member access and availability to service.***
- ***Evaluation of utilization related grievances.***
- ***Monitoring under-/adequate-/over-utilization.***
- ***Member satisfaction survey results.***
- ***Provider satisfaction survey results.***
- ***Denial and appeal rates.***
- ***Provider referral and specialist care patterns of practice.***
- ***Access to specialty care, ancillary services and appropriate preventive dental services.***

We generate encounter data tracking reports, such as individual provider report cards, as well as overall network procedure and prescribing patterns, on a quarterly basis. Reports are analyzed to:

- ***Evaluate accessibility to care.***
- ***Evaluate over- and under-utilization.***
- ***Evaluate appropriateness of treatment patterns.***
- ***Evaluate and identify trends.***
- ***Evaluate deviations from established criteria, policies and procedures, and current industry standards.***

Figure 3.9.19.2-1 contains a sample UM report from our Illinois plan on an individual provider's treatment and billing patterns as compared to the average for the population.

FIGURE 3.9.19.2-1. SAMPLE ILLINOIS UM REPORT

Minimum Members	Between 1 and 2 STDEV
30	More than 2 STDEV

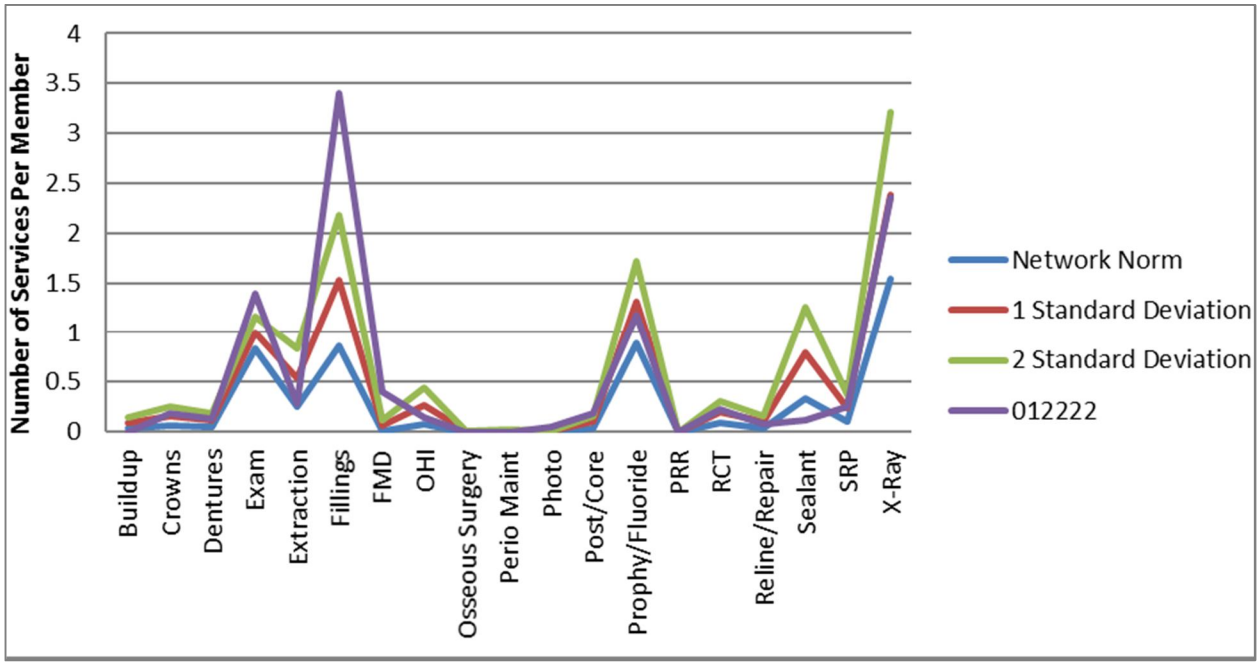
Services Per Member																			
Buildup	Crowns	Dentures	Exam	Extraction	Fillings	FMD	OHI	Osseous Surgery	Perio Maint	Photo	Post/Core	Prophy/Fluoride	PRR	RCT	Reline/Repair	Sealant	SRP	X-Ray	Total
0.188406	0.188405797	0.130435	1.391304	0.27536232	3.405797	0.405797	0.144928	0	0	0.043478	0	1.173913043	0	0.231884	0.072463768	0.115942	0.246377	2.362319	11.10145
0.257143	0.285714286	0.057143	0.885714	0.08571429	3.114286	0	0	0	0	0	0	0.628571429	0	0.2	0	1	0.457143	2.028571	9
0	0.114285714	0.057143	0.885714	0.14285714	3.857143	0	0	0	0	0	0	0.828571429	0	0	0	0.257143	0	2.628571	8.971429
0.214834	0.217391304	0.094629	0.936061	0.47826087	1.163683	0.02046	0	0	0	0.023018	0	0.578005115	0	0.283887	0.028132992	0.347826	0.358056	3.872123	8.930946
0	0.04	0.08	0.92	0.48	0.52	0	0	0	0	0	0	0.78	0	0	0.28	0.56	0.26	4.82	8.9
0	0	0	0.911765	0.44117647	0.147059	0	0	0	0	0	0	1.264705882	0	0	0	0	0	5.823529	8.617647
0	0	0	0.974684	0.20253165	0.759494	0	0.873418	0	0	0	0	1.715189873	0	0.082278	0	0.936709	0	1.202532	8.094937
0.277778	0.333333333	0.222222	0.638889	1.02777778	1.138889	0	0	0	0	0	0	0.805555556	0	0.166667	0	0.416667	0.555556	2.138889	8.083333
0.122449	0.112244898	0	0.744898	0.69387755	1.193878	0	0.367347	0	0	0	0	0.683673469	0	0.193878	0	0.755102	0.469388	2.05102	8.020408
0.5	0.5	0.066667	0.9	0.26666667	2.033333	0	0	0	0	0	0	0.633333333	0	0.4	0.066666667	0	0	2.233333	7.966667
0.09375	0.09375	0	0.953125	0.15625	2.625	0	0	0	0	0	0	0.75	0	0	0	0.921875	0	2.21875	7.84375
0.030303	0	0	0.848485	0.09090909	0.545455	0	0	0	0	0	0	1.212121212	0	0.030303	0	0.909091	0.424242	3.484848	7.818182
#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
0.184397	0.04964539	0.06383	0.815603	0.19858156	0.978723	0	0.588652	0	0.021276596	0	0	1.078014184	0	0.397163	0.021276596	0.716312	0.099291	2.156028	7.801418
0.05	0.025	0.0125	0.75	0.825	0.9625	0	0.025	0	0.025	0	0	0.6	0	0.1	0	0.85	0.2	2.7625	7.775
0.296875	0.265625	0.328125	0.71875	0.59375	1.625	0	0	0	0.015625	0	0	0.6875	0	0.265625	0.171875	0.421875	0.71875	1.4375	7.65625
0.146341	0.146341463	0.04878	0.829268	0.2195122	1.439024	0	0	0	0	0	0	1.073170732	0	0.268293	0.097560976	0.780488	0.097561	2.317073	7.560976
0	0	0	1.051724	0.06896552	2.327586	0.017241	0	0	0	0	0	1.396551724	0	0.017241	0	0	0.034483	2.37931	7.344828
0	0	0	0.909091	0.18181818	1.606061	0	0	0	0	0	0	1.757575758	0	0.121212	0	0.969697	0	0.818182	7.30303
0	0	0	1	0	0	0	0	0	0	0	0	1.971153846	0	0	0	2.423077	0	1.826923	7.221154
0.25	0.166666667	0	1	0.61111111	1.083333	0	0	0	0	0	0	0.5	0	0.194444	0.111111111	0	0.666667	2.444444	7.194444
0.237113	0.226804124	0	0.876289	0.01030928	0.886598	0	0	0	0	0	0	1.010309278	0	0.28866	0.020618557	0.082474	0.072165	3.123711	6.917526
0	0	0	0.950495	0.05940594	0.584158	0	0	0	0	0	0	1.683168317	0	0.059406	0	1.742574	0	1.336634	6.821782
0	0	0.037736	0.924528	0.11320755	0.867925	0	0	0	0	0	0	0.867924528	0	0.018868	0.094339623	0.981132	0.150943	2.584906	6.660377
0.023529	0.035294118	0.082353	0.917647	0.48235294	1.823529	0	0	0.023529412	0	0	0	0.764705882	0	0.011765	0.011764706	0.223529	0.082353	1.670588	6.658824
0.033333	0.033333333	0	0.933333	0.03333333	0.5	0	0	0	0	0	0	0.733333333	0	0.066667	0.066666667	0	0.266667	3.9	6.633333
0.027027	0.054054054	0.108108	0.837838	0.16216216	1.189189	0.135135	0	0	0	0	0	0.432432432	0	0.027027	0.054054054	0	0	3.486486	6.621622
0.010101	0.01010101	0	0.89899	0.11111111	0.777778	0	0	0	0	0	0	1.575757576	0	0.454545	0	0.989899	0	1	6.545455
0.010417	0.020833333	0.020833	0.635417	0.57291667	0.958333	0	0.364583	0	0.03125	0	0	0.833333333	0	0.041667	0	0.864583	0.166667	1.552083	6.4375
0.035088	0.035087719	0.122807	0.614035	0	2.280702	0	0	0	0	0	0	0.561403509	0	0.035088	0.333333333	1.052632	0.070175	1.122807	6.421053

The UM Tool allows us to develop customized corrective actions and counseling for every provider identified. Analysis and determination of corrective action is scheduled at least quarterly or more often as needed. The results of the UM analysis and identified over and under-utilizing providers are forwarded to our Dental Care Management

(DCM) team where custom corrective action plans and counseling are created. DCM also determines the severity of the corrective action and determines if immediate, more invasive action is required by our clinical staff. DCM also uses the UM analysis to make determinations about potential fraud, waste and abuse cases that are forwarded to our Special Investigations Unit (SIU) for further investigation and development of appropriate internal actions as well as fulfilling our regulatory reporting requirements to appropriate authorities as necessary.

In addition, our UM analysis tool automatically analyzes every network dental office against the established patterns of utilization and identifies both over and under-utilizing providers in each dental service category. The UM Tool allows us to develop customized corrective actions and counseling for every provider identified. See Figure 3.9.19.2-1 for an example.

FIGURE 3.9.19.2-1. UM TOOL AUTOMATED OUTPUT CHART – INDIVIDUAL OFFICE COMPARED TO NORMS BY SERVICE



Our system also can add custom logic to the claims adjudication process (Transforms), which allows us to identify unique pre-authorization and/or claim elements (e.g., at the procedure code, category of service and/or provider level) on claims for Nevada Medicaid. Custom logic provides the opportunity to evaluate for Fraud, Waste and Abuse (FWA) and other outliers. Through our automated custom evaluation logic, we can rapidly identify potential over- and under-utilization patterns.

To support the UM program, the pre-authorization and claims adjudication processes include automatic routing of flagged pre-authorization and claims for dental consultant review, and\or stamped with action codes or explanations for reporting purposes. The UM program uses automated and custom reports that are generated based on established data elements and criteria.

Innovative Approach to Provider Profiling

To assure that our providers are performing high quality services, LIBERTY engages in a comprehensive and unique utilization management model that incorporates extensive provider profiling. Utilizing our extensive claims history data base, each individual provider's performance is measured against average patterns and numerous benchmarks. We utilize a proprietary Provider Profiling tool which combines tracking and trending of data from numerous quality indicators to compare providers to their peers. When identifying utilization patterns and trends, we include multiple aspects of a member's experience to analyze provider patterns in a more meaningful way. The quality indicators include, but are not limited to, utilization, grievances and appeals, access, availability and member satisfaction data, for different categories of service and patient demographics.

The providers' grievance and appeal trends and any member service issues are also evaluated. Providers whose performance deviates over or under our statistically expected utilization are readily identified and reviewed. Corrective action plans are developed for the outlier providers including counseling by our dental directors and possibly desk audits and onsite reviews. Counseling and education normally results in providers changing their behaviors. Deviations can result in corrective action plans including office closure to new patients, limitation of referrals, implement more extensive pre-authorization, compensation restructure or termination if necessary. This effectively combines the process of evaluating medical necessity with the appropriateness of care and leads to better health outcomes. The over/under-utilization of services is reduced and members remain more engaged in the continuum of care. Assuring that the right care is provided not only results in the most appropriate and efficient care, but also the most cost effective care. As a result, we not only improve the health of our members, we also assure the most effective use of the funding. Attachment 11 illustrates the improvement in provider patterns and reduction in overall costs before and after LIBERTY counseling and education, and Figure 3.9.19.2-2 below provides a sample case study.

FIGURE 3.9.19.2-2. COUNSELING CASE STUDY

Case Example

A provider was identified as being an outlier due to higher than normal cost per member and aberrant patterns with fillings (mainly one surface "B" fillings) for adults which triggered a "red" flag". The provider did not do any crowns which is suspicious as crowns are a covered benefit – but unlike fillings, require pre-authorization. The provider would need to send an x-ray so the Dental Consultant could review for medical necessity. A counseling call was made with the provider and the Dental Director to discuss patterns on 6/1/2016 which resulted in a change of behavior in overall treatment patterns and a reduction in costs by 18%. This office will be re-evaluated in October to confirm provider's behavior has remained changed.

3.9.19.3 Pre-Authorization Review Requirements

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

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

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

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

E. 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;

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

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

H. Consistent with 42 CFR 438.210, 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

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

LIBERTY has long-established and effective policies, processes and procedures for conducting pre-authorizations for dental services. LIBERTY conducts all Utilization Review in-house by our Dental Director or by appropriately licensed, experienced dental professional LIBERTY staff members. Neither our Dental Director nor staff Dental

Consultants are compensated or incentivized additionally based on clinical review decision making. LIBERTY does not delegate any utilization management responsibility.

LIBERTY's Dental Director is responsible for all UM decisions, including those made by staff dental consultants. LIBERTY is committed ensuring that only qualified licensed dentists make utilization review determinations. Our pre-authorization team has an average tenure with LIBERTY of 5 years, and is experienced in reviewing high volumes of pre-authorizations. Table 3.9.19.3-1 below illustrates the volume of pre-authorizations which we process across all markets on a monthly and annual basis.

TABLE 3.9.19.3-1. VOLUME OF PRE-AUTHORIZATIONS PROCESSED MONTHLY AND ANNUALLY

Year	*Monthly Average Prior Auths*	*Annual Total Prior Auths*
2014	*14,510*	*174,121*
2015	*20,202*	*242,426*
2016	*21,985*	*197,866 (YTD, on track to hit 265,000)*

We tailor our pre-authorization policies where appropriate to each State Medicaid program, meeting all state and federal requirements for services. LIBERTY's pre-authorization policies and procedures are currently used with our existing Nevada groups and member. Thus, our prior authorization policies and procedures are written consistent with provision of medically necessary dental care with respect to community standards of practice. In addition, we stay connected to community standards of practice through our Provider Relations team and our Peer Review Committee comprised of providers throughout our Nevada Network. The following response conveys our approach to pre-authorizations.

LIBERTY determines which dental services require pre-authorization based on:

1) ***State requirements/federal guidance: We will honor state requirements regarding which procedures must be prior authorized. In addition, LIBERTY will consider any guidance from government regulators such as CMS.***
2) ***Clinical Standards of Practice: LIBERTY also applies clinical standards of practice from the ADA Clinical Practice Guidelines handbook, and utilizes our own clinical experts and market research to help make determinations on which services require pre-authorization.***
3) ***Utilization Review: We also factor in ongoing results of our own utilization review process to determine which services should be reconsidered for pre-authorization (either as an addition or subtraction to the list). On a quarterly basis, LIBERTY will perform a utilization review of all services for our Nevada plan. In situations where particular services might seem to be excessive or abused***

without pre-authorization occurring, we will consider changing the requirements for that procedure for the following plan year. When doing so, provider notification would occur prior to the effective date of the new plan year. We will re-evaluate this annually upon the release of the certified dental terminology (CDT) code updates. In reviewing utilization patterns LIBERTY also adjusts their claim system to identify and control PFWA billing patterns. The claims system is flexible and PFWA controls are able to be customized at the provider, office, group, plan and code levels. These types of system rules include but are not limited to considering members claims history for especially for procedures that do not have frequency limitations such an appropriate count of Periapical x-rays (PA's).

LIBERTY utilizes an electronic pre-authorization application to process all requests. Figure 3.9.19.3-2 below includes a screenshot of our application.

We monitor UM and encounter data to identify trends in utilization and/or prescribing patterns, and to monitor services that may need reevaluation of pre-authorization requirements. The example below in Figure 3.9.19.3-3 illustrates how we monitor and adapt our pre-authorization requirements based on consistent utilization data monitoring.

FIGURE 3.9.19.3-3. EXAMPLE OF UTILIZATION DATA MONITORING

After LIBERTY implemented our Medicaid product in Illinois, our Utilization Review team noticed a high number of D4355 claims – Full Mouth Debridement procedures for the state compared to similar markets in California and Florida. Upon further review, it appeared providers in the Illinois market often submitted the D4355 as an additional benefit to increase their payments. This procedure code originally did not have a requirement to pre-authorize. Shortly after LIBERTY recognized this trend, we added a pre-authorization requirement for the D4355 procedure. The result of this minor change resulted in D4355 utilization numbers decreasing by 50% within the first 3 months of the new benefit year, ultimately reducing unnecessary procedures and saving the state taxpayer dollars.

Our team of dental professionals is aware of and understands the importance of having all necessary clinical and diagnostic information when making UM determinations. If the claims team and/or dental professionals determine that additional information is required prior to making a utilization review determination, LIBERTY will contact the provider office by phone, fax and/or email multiple times.

Prospective Reviews

Upon receiving each request for pre-authorization, a prospective review is performed by our Pre-authorization and Referral Specialists. These individuals are trained Claims Processors who have a strong understanding of the benefit plans, but have also been cross-trained in Utilization Management Review. The Pre-Auth Specialist will review the authorization request to ensure the treatments being requested are covered benefits. We also review the enrollee's claims history to ensure benefit frequencies or limitations would not affect the outcome of a clinical determination. In addition, the Pre-Auth Specialist will ensure all associated attachments are included for a clinical determination to be made. In instances where services being requested are not covered, the Pre-Auth Specialist will issue a notification letter to the provider and member notifying them that the requested treatment is not a plan benefit. If additional documentation is required, a concurrent review will then take place by our Utilization Management team.

Concurrent Reviews

The Utilization Management team performing our concurrent reviews is comprised of a Dental Hygienist, Registered Dental Assistants and licensed dentists. These individuals work directly with our provider offices through the telephone, fax and email. Our UM team performs outreach to the provider offices when additional materials are required for a clinical determination such as radiographs, patient charts or study models. Since our UM team has established relationships with most offices, they are also the point of contact when immediate requests for treatment changes are identified and requested

by the treating provider. Oftentimes, decisions are made directly over the phone between the Dental Professional and our UM Team.

Retrospective Reviews

A retrospective review occurs when the claim is received. Treatment such as dentures, surgical extractions, crowns and bridges are again sent to our clinical review staff to ensure adequate quality of care was rendered. Any changes to a treatment plan of an authorization would also be subject to clinical review. If a clinical professional identifies a possible quality of care issue, that claim is then escalated to the Dental Director for that state or plan. The Dental Director will then reach out to the treating dentist to discuss the case and the treatment that was rendered, sharing his/her concerns until a resolution is determined. In some cases, that resolution might be a simple agreement and understanding between both parties, while in others the resolution may entail a change of treating providers.

Expedited Pre-authorization Reviews

Expedited pre-authorization requests are received in two ways:

- ***Via telephone:*** ***Provider offices will often call LIBERTY because they have the member in their office and the provider is willing to perform services at that moment. In those situations, our providers will contact LIBERTY's customer service line, where our Member Services Representatives can process an expedited pre-authorization determination immediately, and fax or email that authorization to the provider's office.***
- ***Via email and fax:*** ***The Claims Management department has a designated email box and fax line for expedited service requests. Both the email box and the fax lines are monitored every hour on the hour. New requests received are scanned (faxes) or attached (emails) into a pre-authorization request that is created in our system. The expedited request is processed and faxed or emailed back to the office and a hard copy is printed and mailed to the member within 48 hours.***

Pre-authorization Process for Non-Participating Providers

LIBERTY understands that in some situations, it is necessary to send a member to a non-participating provider. For example, the member lives in a rural area and the closest contracted provider is outside the geographical radius for the member to travel. In these situations, LIBERTY will authorize treatment at a non-participating provider's office. The non- participating provider is required to authorize the treatment plan. This process is assisted by our Member

LIBERTY is ensuring continuity of treatment for new enrollees with non-participating providers for a minimum 120-day timeframe.

Services department, who works with both the member and the non- participating provider. By reviewing and authorizing the services before they are rendered, LIBERTY ensures the provider is paid promptly and the member receives the necessary treatment.

Communication of Services Requiring Pre-authorization

The members who participate in the Nevada Medicaid program will be provided a copy of their Evidence of Coverage (EOC) upon request. The EOC will provide a breakdown of which services are covered and what the plan's limitations or exclusions are.

LIBERTY will communicate with its contracted providers through a documented Provider Desktop Reference Guide. This guide will outline the entire Nevada Medicaid program as managed by LIBERTY and will include which services are covered under the program, as well as which of those services will require pre-authorization.

Notification of Authorization Decisions

Notification for all pre-authorization requests are made to both the member and the provider via written notification. LIBERTY's electronic prior-authorization application is designed to generate both member and provider notification letters upon completion of the transaction. Written notification for a standard pre-authorization is mailed no later than 7 days from receipt of the pre-authorization. For expedited requests, written notification is mailed to both the member and the provider, but in addition, LIBERTY will fax a copy of the notification to the provider's office as well as try to verbally notify the member by making a phone call. Notifications by fax and phone call will occur within 48 hours of receipt.

In the 1st quarter of 2016 in our IL Plan, 100% of notifications were sent out within 24 hours of a decision.

LIBERTY has recently developed clear and concise language that, in simple terms, explains the reason for denial. All denials, especially those that are due to a lack of medical necessity, are explained to the recipient and provider with the previously noted language on an Explanation of Benefits letter. For benefit determinations, the notification clearly specifies the provision in the evidence of coverage that excludes the benefit. Denial notification also includes the member's right to file an appeal/grievance along with the grievance process, including timeframes for submitting a grievance. LIBERTY communicates our grievance and appeals process to members through their Evidence of Coverage and all UM decision letters. Liberty also includes the provider dispute process in our Provider Reference Guide. This process is also covered during new office orientations and at routine maintenance visits.

LIBERTY's goal is to resolve every grievance and appeal as timely as possible. Routine grievances and appeals are generally resolved within thirty calendar days and urgent/emergency grievances and appeals are generally resolved within 72 hours of receipt. Given our turnaround standards, we understand that different dental conditions require a different, more urgent resolution timeframe. While uncommon in dentistry, LIBERTY's grievance and appeals team and our Dental Director are trained to identify situations where a grievance and/or appeal require an expedited resolution timeframe. In these rare occasions, LIBERTY has responded the same day, often within a few hours of receipt.

Members are also advised of their right to seek a second opinion at no charge. When a referral is denied because the services fall within the scope of the provider, the member is instructed to return to his/her provider for treatment.

Monitoring and Measuring the Efficacy of our Pre-Authorization Processes

LIBERTY Retrospective Review Snapshot

In 2016, LIBERTY conducted a retrospective analysis of a provider's procedure patterns, followed by a consultation with the provider, which resulted in a change of behavior in overall treatment patterns and a reduction in costs by 18%.

LIBERTY assesses its Performance related to our UM program at least annually. LIBERTY identifies areas of dissatisfaction, sets priorities for improvement and evaluates the effectiveness of interventions. Where opportunities for improvement are identified, LIBERTY Dental initiates action to change its processes to meet its goals and to meet members' and providers' expectations.

Our commitment to measuring and facilitating access to preventive and restorative care leads to extensive work to identify and address under-utilization (care gaps, etc.). Our commitment to cost-effective use of the taxpayer's money leads to extensive work to identify and eliminate over-utilization, including fraud, waste and abuse (FWA), as well as unnecessary and overly aggressive procedures.

On at least a quarterly basis, we evaluate retrospective review patterns including, but not limited to, the following activities:

- ***Incorporating clinical and non-clinical sources of information to analyze patterns of care, based on patient age and demographics and by provider type and geography.***
- ***Comparing statistics with regional, product-based and national profiles.***

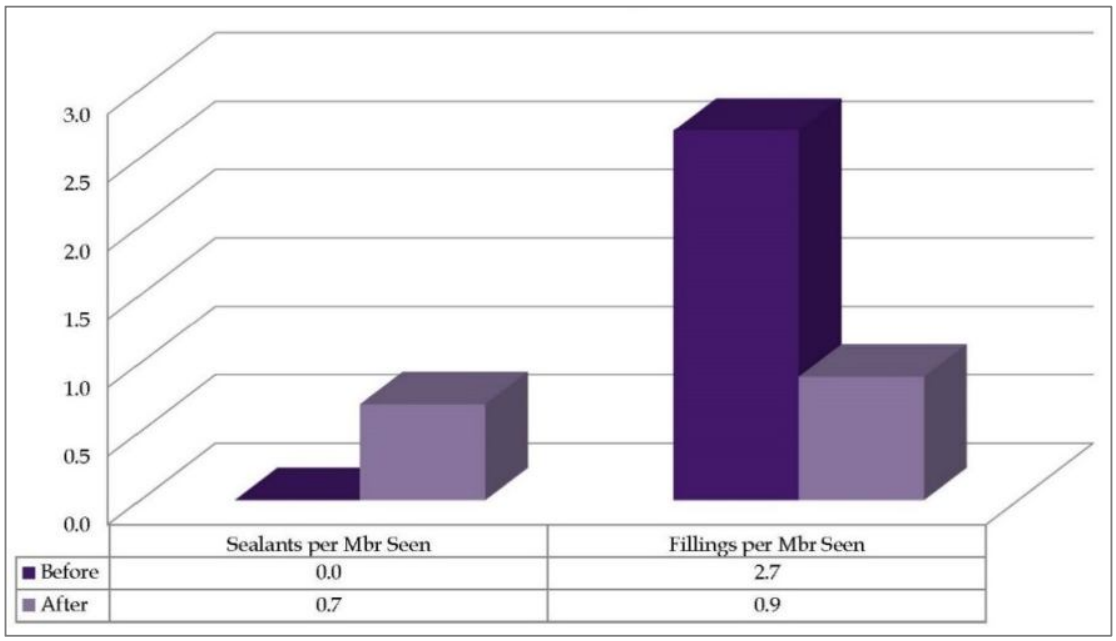
- ***Analyzing and establishing benchmarks and standards.***
- ***Providing clinical feedback and guidance from our Chief Dental Officer and State Dental Directors.***
- ***Focusing on managing the appropriateness of care (as defined by clinical criteria, professional standards of care, and based on each member's available dental benefits), for both services that are auto-adjudicated and services that are reviewed for medical necessity by licensed dental consultants.***
- ***Benchmarking provider's performance against other comparable providers, based on specialty and geography.***
- ***Management, tracking and trending of practice patterns based on utilization data.***
- ***Analyzing clinical patterns and developing action plans as appropriate.***

LIBERTY has proprietary UM tools used to evaluate dental offices on an ongoing basis. These tools evaluate raw utilization data and establish network normative utilization patterns and identify providers that and over and under-utilizing.

In addition, our tools provide separate analysis by dental service category and by dental code. This allows LIBERTY to identify and focus on specific trends and patterns allowing us to craft a custom approach not only to identify outlier dental offices, but to develop custom corrective actions plans with code-by-code comparisons for the specific dental office compared to their peers in the network. Figure 3.9.19.3-4 below illustrates improvement in a particular provider's service patterns for sealants and fillings pre-and post-counseling on utilization.

Provider Corrective Action Plans include discussion and counseling calls, as well as routine and focused desk and on-site reviews, which are accomplished professionally, effectively and efficiently through our single source system.

FIGURE 3.9.19.3-4. PROVIDER SERVICE PATTERN IMPROVEMENT POST-COUNSELING



Following the counseling call, the provider in question increased preventive sealant treatments from 0.0 to 0.7 per member, and decreased the number of fillings from 2.7 to 0.9 per member.

The UM Committee monitors over and under-utilization of services, identifies treatment patterns for analysis and ensures that utilization decisions are made in a timely manner which accommodate the urgency of the situation and minimizes any disruption in the provision of care. The Dental Director is charged with preparation of a quarterly report containing analysis of utilization data and authorization turn-around-times for individual providers to be reviewed by the QMI Committee.

Retrospective Review Success Stories

Example #1

A provider originally showed aberrant patterns with the number of fillings and potential patterns of FWA due to the surface patterns. We scheduled a call with the provider and the Dental Director to discuss utilization patterns and to provide additional education regarding plan covered benefits. Almost a year after the counseling call, the provider continues to follow good practice patterns: sealants are within normal range, restorations per member are closer to the norm, overall cost per member has decreased and patterns appear consistent. While this provider will continue to be

closely monitored, our counseling and education efforts appear to have changed this provider's behavior.

Example #2

LIBERTY reviewed utilization patterns to ensure proper treatment planning and medical necessity of sealants and fillings. As a result a provider was identified as an outlier due to a pattern of high usage of fillings and no sealants. A counseling call was made with the provider and LIBERTY's Dental Director to discuss the filling patterns as well as provider education regarding sealants and their effectiveness. Subsequently, the provider had a change in behavior that resulted in lower cost per member and higher sealant activity.

Collection of Data

LIBERTY Dental collects data related to member and provider satisfaction with the utilization management process through a variety of mechanisms. Sources of satisfaction data include but are not limited to the following:

- ***Member satisfaction surveys are routinely administered to assess member experience and satisfaction with elements of the utilization management process, including the ability to get needed care. Analyses are conducted at the plan and medical group levels. A sample Member Satisfaction Survey is included in Attachment 9.***
- ***LIBERTY Dental's member grievance process allows tracking and analysis of member complaints, appeals and inquiries specific to the utilization management process.***
- ***Provider satisfaction surveys provide an assessment of staff and contracted practitioners' satisfaction with LIBERTY's utilization management process, including usefulness of resources and adequacy of the provider network. A sample Provider Survey is included in Attachment 10.***
- ***Review of practitioner and provider feedback offered through venues such as Joint Operating Committee meetings, provider services site visits, provider/departmental reviews and direct communication with LIBERTY utilization management staff provides additional satisfaction data.***

Analysis, identification of opportunities and development of action plans

LIBERTY Dental acts to change processes to meet performance goals and member and provider expectations. The Utilization Management Committee (UMC) will conduct a review of LIBERTY's performance analyzed against established metrics and goals. Analyses include assessment against performance goals (where appropriate), review of trends over time and assessment of root causes of identified variances. The UMC will

identify areas of dissatisfaction requiring intervention, develop and implement an action plan and monitor and evaluate outcomes. The UMC evaluates re-measurement data and determines if problem resolution has occurred.

Feedback to Members and Providers

The results are communicated to members and providers, including opportunities for improvement and subsequent interventions via member and provider newsletters and the LIBERTY Dental website.

3.9.20 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.

3.9.20.1 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.

Management Information Systems (MIS) and information technology (IT) infrastructure are at the core of LIBERTY's business operations and systems structure. Through our platforms and integrated solutions, LIBERTY offers Nevada Medicaid a seamless system that integrates payer-provider collaboration, claims and encounters processing and payment, fraud prevention, care management, eligibility and enrollment management, utilization and quality management, provider relations, and member services.

In 2006, LIBERTY foresaw the need to build capacity and to offer seamless integration to ultimately provide better care to our recipients and support our providers in

transforming the way they deliver care. At this pivotal point, LIBERTY developed a strategic Information Technology Plan for how it would support its business moving forward. Consequently, we migrated to a new MIS platform, which offers an integrated application to support business functions across our systems. Today, while all the recommendations in the plan have been met, LIBERTY is constantly re-evaluating this system, determining if actions have resulted in their intended results, and measuring outcomes.

Our core of IT platform offers cutting edge solutions with market leading, innovative, and configurable health benefit administration. Our MIS application delivers a comprehensive system with a unified infrastructure that controls the whole process from start to finish. In the 10 years that LIBERTY has been on our core application suite, the system has gone through annual upgrades and releases to meet both our clients'—and LIBERTY's own—functionality needs. We constantly re-evaluate our core needs and current functionality, introducing additional systems and applications to support our business and vision. Some recent results of these monitoring efforts include:

- ***Developing Claims Transforms – customizable XML that can be added to the core adjudication logic either for short term projects or for outlier detection for possible fraud, waste, and abuse.***
- ***Enhancing the workflow processes, including adding access to events or workflows within all core screens to allow for quicker call tracking and the routing of information between departments for follow-up.***
- ***Redesigning the database structure to optimize performance and scalability for both current and long term needs.***
- ***Streamlining claims, estimate, and referral processes, which has allowed us to grow our claims intake handling and processing without increasing the need for additional staff.***
- ***Creating an individual billing platform that has allowed us to enter the various state and federal exchanges.***
- ***Modifying Office, Provider, and Vendor Online Portals to provide more tools and access to data to better treat our membership—in 2010 only 7% of claims submission came through the web, where today we are averaging 26%.***

In 2010, LIBERTY adopted a core MIS data warehouse, which has allowed for expanded reporting capabilities and additional process automation. The application is now on an SQL.NET platform that stores the data for all aspects of claims processing.

Many applications that make up the MIS application suite share the same databases and image server that store the data, documents, and images. These include:

- ***Meditrac*** ***for claims, provider, group, and enrollment management. This also houses the tools to both build and manage the benefit plans, as well as the tools to help manage the claims processes.***
- ***HIPAA Gateway*** ***for transaction management of the EDI files processing.***
- ***Uniflow*** ***for member services and workflow management.***
- ***MIS Administrator*** ***for application security management. It also houses the tools for transaction management for the non EDI files to import data through batch and automated processes.***
- ***Online Website and Portals*** ***for recipient and provider engagement.***
- ***Scanning Assistant*** ***for document and attachment scanning.***
- ***Medimart*** ***for data warehousing.***
- ***Perfect Claim*** ***for paper claim data capture.***

MIS Components for Care Coordination

Uniflow

Uniflow is the primary tool currently used by our Member Services Team. It was designed to allow Member Services to have easy access to a variety of data elements that are specific to their needs on just a few screens. It also contains the Workflow/Event tracking that is used to track member call reasons and data, as well as communication within the application. This allows for requests for information to be routed and tracked within the application and tied to a recipient or other entity (e.g., Office, Provider, or Claim).

We also use Uniflow to track the grievance intake and resolutions in conjunction with our custom grievance database. This allows for reminders, routing, and/or timelines to be set, as well as letter creation and other automated functions within the system. Letters can be customized to meet DHCFP's requirements.

MIS Administrator

MIS Administrator is the administrative tool to control security within the MIS applications. The "Tools" section in our MIS houses report templates, as well as the modified reports that LIBERTY creates that are mapped throughout the system for the various reporting requirements (e.g., EOB, Pre-Estimates, PCP Transfer letters, and Checks/Explanation of Payments [EOP]). Also under "Tools" are the various batch loads that allow us to enter data in bulk, and add automation to the process.

Online Website and Portals

LIBERTY provides many online solutions to support membership, groups, and providers. These are all HIPAA compliant, secure, and user friendly. The data within the portals tie directly to the core database, Medimart, which allows for accurate data available in

real-time for member and provider portals. This ensures that as LIBERTY makes updates to our data, users have access immediately to that information.

Our website, https://www.libertydentalplan.com/, also offers many tools to assist recipients and providers without the need to access our secure portals. For recipients, the website can also be used to get more information about specific programs that are managed by LIBERTY, as well as links to our group specific sites. The website also provides health tips, links to important documents such as claims forms, and search for providers. Finally, through the website recipients can file grievances or simply reach out to contact LIBERTY directly. Many recipients also utilize our phone app (see Figure 3.9.20-1 below), which is a mobile-friendly way to access these features.

The website is useful for providers as a way to access many of the tools that LIBERTY has available to them, such as the provider portal (see Figure 3.9.20-4, secure email to contact us, and EDI claims submission.

FIGURE 3.9.20-2 PROVIDER PORTAL SCREENSHOT

Member Portal

The member portal (Figure 3.9.20-3) allows recipients to create a secure logon and access their PHI (e.g. prior claims and usage history). Since the portal links directly to LIBERTY's core database, all information is always up to date. Recipients can review their claims, estimates, and referrals that have been submitted on their behalf, as well as view and print the documents that are associated with them. They can also check their schedule of benefits and print a copy, or check utilization and identify when they are next eligible for treatment.

The member portal also allows recipients to search for a provider to gain access for treatment. It includes Provider/Office information such as handicap access, openness to new patients, office hours, and other information that allows recipients to make an educated choice before choosing their provider. The portal also allows recipients to request a new ID Card and/or print a temporary card. They can review all demographic information that we have on them to ensure it is accurate, and there are links to contact us if it is not. We also can provide documents that are specific to a user for outreach purposes, as well as training and other informational documentation that serves the recipient.

Finally, we have tools for recipients to conduct a comprehensive "Self-Health" evaluation that covers both their overall health and dental health. Once completed it

gives them a score and access to material that can lead to better health. All of this functionality allows recipients to have 24/7 access to their information. This tool is incredibly valuable to our recipients, and 100,000 members (recipients) currently have logins to the portal.

Office/Provider Portals

These portals, enabled by the web service iTransact, are used by our providers to gain access to information necessary to treat our recipients. They can view/submit claims, estimates, or referrals, as well as check claim status. They also can print this information or resubmit it if necessary through the portals. They have the ability to check eligibility for a recipient or multiple recipients at a time and manage their users and see who should have access or needs to have their access removed. Currently 26% of all claims submissions come through our secure portals directly to LIBERTY in real-time. Once an office submits a claim, it is available to LIBERTY as well as to recipients on the Member Portal. Providers have access to online materials and manuals 24/7 (except for short periods of scheduled maintenance).

In addition to the provider portal, we recognize the value and need of encrypted email as a way to ensure that sensitive information remains private. In accordance with security laws, such as HIPAA and the Gramm-Leach-Bliley Act, LIBERTY encrypts all email containing sensitive information to protect our private and confidential electronic communications. We use secure encryption, such as Proofpoint Encryption™ and PGP Encryption software, to protect the sensitive information we share electronically. Proofpoint Encryption™ can detect PHI in outbound email and auto-encrypt those messages. Any emails composed by an employee are scanned to detect PHI. When detected, the information is automatically encrypted at rest and in motion. Before the

end-user can open the email, it first requires authentication. We also have the capability to set up a client-specific end-to-end Transport Layer Security (TLS) tunnel for the safe, encrypted data transfer without the end user requiring authentication to access the information. These data are secure across transmission.

3.9.21 IQAP Documentation

3.9.21.1 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.

We document all QMI improvement initiatives, process and procedures, defines goals, objectives, specific activities, responsible parties and targeted timeframes for completion or resolution of activities in the QMI Work Plan. The Work Plan is developed annually with National Committee for Quality Assurance (NCQA) best practice standards simulated for dental services and built upon the evaluation, recommendations and findings of the previous year's Work Plan.

Our Work Plan focuses on the accessibility, availability, appropriateness, continuity, effectiveness, and timeliness of dental care as well as the safety of service delivery environment. The Work Plan encompasses the following distinct functions that mirror applicable NCQA components for the delivery of care:

- ***Policy and Procedure Review***
- ***Annual QMI Evaluation and Report Summary***
- ***Annual QMI Work Plan***
- ***Identification of Quality Issues and Trends***
- ***Measurement Monitoring***
- ***Focused Quality of Care Studies***
- ***Provider Network Monitoring***
- ***Provider Profiling***
- ***Standards for Clinical Criteria & Guidelines/Practice Parameters***
- ***Corrective Action Plans***
- ***Corrective Action Plans***
- ***Educational Activities***

Detailed descriptions of the activities associated with the above functions can be found in our Quality Program Description.

On an annual basis, a QMI Work Plan is developed under the direction of the Chief Dental Officer/Dental Director to assist with the following tasks:

- ***Documentation of the next year's goals and objectives for planned projects and activities, including clinical and non-clinical programs, initiatives and measurement activities.***
- ***Required effort to accomplish stated goals and objectives.***
- ***Identification of tasks and subtasks according to a work breakdown structure.***
- ***Allocation of resources, task planning and scheduling.***
- ***Monitoring and control of task progression.***
- ***Preparation of the Annual QMI Evaluation and Report.***

Our Work Plan focuses on the accessibility, availability, appropriateness, continuity, effectiveness, and timeliness of dental care as well as the safety of service delivery environment. The Work Plan encompasses distinct functions that mirror applicable NCQA components for the delivery of care.

3.9.21.2 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.

LIBERTY's QMI Work Plan and Annual Quality Program Description are updated annually and are readily available to DHCFP, as well as any other governmental agency upon request. We maintain ongoing documentation of all quality of care studies, QMI reports, protocols, policies and procedures, standards, worksheets and meeting minutes which can be provided upon request.

3.9.22 Coordination of Quality Assurance (QA) Activity with Other Management Activity

3.9.22.1 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.

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

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

C. 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.

LIBERTY Dental Plan's Quality Improvement Program (QMI) is a comprehensive approach to Quality Assurance. The QMI Program encompasses an array of well-defined processes and functions that are critical to the oversight and delivery of dental services. Each QA activity is executed with the goal of maintain or improving the overall health of members. LIBERTY examines monitors and revises processes within the QMI Program to ensure the highest quality of care.

Our QMI Program collaborates with other management functions and activities providing streamlined oversight of quality assurance activities across multiple areas. We collaborate with other quality and network management activities through the following mechanisms:

- ***Policy and Procedure Review***
- ***Annual QMI Evaluation and Report Summary***
- ***Annual QMI Work Plan***
- ***Identification of Quality Issues and Trends***
- ***Measurement Monitoring***
- ***Focused Quality of Care Studies***
- ***Provider Network Monitoring***

- ***Utilization Management***
- ***Educational Activities***

Policy and Procedure Review

LIBERTY ensures quality of care and services through policies and procedures that direct day-to-day operations. All policies and procedures are reviewed, at a minimum, annually by the Policy and Procedure Committee at the direction of the Dental Director. New policies and procedures are written and adopted through the P&P Committee on an ongoing basis. Revisions of existing policies and procedures are completed as processes are updated and presented to the appropriate committee bodies for approval.

Annual QMI Evaluation and Report Summary

The Dental Director and Quality Management staff evaluates the QMI Plan annually to appraise the effectiveness of the previous year's clinical and non-clinical initiatives, including but not limited to the following:

- ***Adherence to QMI standards, policies and procedures***
- ***Development of quality initiatives that support data-driven decision-making and support continuous ongoing measurement and re-measurement of clinical and non-clinical effectiveness***
- ***Member and Provider satisfaction;***
- ***Development and implementation of programmatic improvements to clinical and non-clinical processes, based on results from ongoing measurement;***
- ***Results of focused quality of care studies and other quality initiatives***
- ***Effectiveness of corrective action plans.***

Approximately three months prior to the end of each contract year, LIBERTY reviews the QMI Plan to identify issues and potential revisions, incorporating the concerns and feedback from staff, customers, members and providers. The Quality Management and Improvement (QMI) Committee is presented with the evaluation report, which is reviewed to formulate recommendations for continuous process improvement revisions. After the revisions have been approved, they are formally presented to the Board of Directors for review and acceptance. All approved and accepted revisions are incorporated into the Work Plan, and distributed to employees and plan partners, as appropriate.

The QM Department also prepares an annual report that summarizes the previous year's quality activities. The Dental Director and QM Coordinator will prepare the first draft of the annual report. The report will summarize the overall effectiveness of the previous year's Work Plan. Once finalized, it is reviewed by the dental director and presented to the QMI for first-level review and approval. The Annual QMI Evaluation and Report includes but is not limited to the following:

- ***Results and outcomes of internal performance***
- ***Focused quality of care studies***
- ***On-Site visits***
- ***Effectiveness of provider reviews***
- ***Potential Quality of Care Issues***
- ***Grievances and Appeals***
- ***Member/Provider Satisfaction Survey results***

Annual QMI Work Plan

On an annual basis, the QM Department develops a QMI Work Plan to assist with the following tasks:

- ***Documentation of the next year's goals and objectives for planned projects and activities, including clinical and non-clinical programs, initiatives and measurement activities***
- ***Required effort to accomplish stated goals and objectives;***
- ***Identification of tasks and subtasks according to a work breakdown structure***
- ***Allocation of resources, task planning and scheduling***
- ***Monitoring and control of task progression***
- ***Preparation of the Annual QMI Evaluation and Report***

The overall goal of the QMI Work Plan is to support program improvement of clinical and non-clinical processes based on the previous year's findings from ongoing assessments. The completed Work Plan, which is approved by the Dental Director and, the QMI Committee and accepted by the Board of Directors. This allows an opportunity for evaluation and coordination of QMI activities throughout LIBERTY.

Identification of Quality Issues and Trends

Though the identification potential quality issues is every employee's responsibility, the QM Department serves as the primary source of data related to the quality of services provided. A utilization management analyst generates quarterly reports to assist in the identification of trends specifically, under-utilization and/or over-utilization of services. Quality issues and trends are also identified by QM staff through input from other Departments during scheduled staff meetings and the review of member and provider

grievances, and satisfaction survey result. The QM/UM Work Group ensures immediate feedback on issues related to quality of care, access & availability, grievances and identifying potential sentinel events proactively.

Measurement Monitoring

We assess clinical and non-clinical aspects of quality activities and performance improvement by monitoring and evaluating performance using objective quality indicators of which identify required measures and corresponding opportunities for improvement. The quality indicators are used in the development, assessment and modification of the QMI Program. LIBERTY also complies with standards developed by NCQA and the American Dental Association to ensure that measures reflect best practices of dental health care. Automated reports are generated from LIBERTY's management information system, along with satisfaction survey results, to evaluate dentally appropriate measures. As directed by the Dental Director the QM Coordinator ensures that all aspects of monitoring and evaluation meet applicable state and federal privacy/confidentiality laws and that reports of such activities are delivered to the QMI Committee, health plan partners and regulatory agencies, as required.

We conduct annual member and provider satisfaction surveys. Other opportunities to implore member and provider input include, but are not limited to, the following:

- ***Member Call Center calls***
    - ***Correspondence sent to our Member Services Department***
    - ***Grievance and appeal actions***
    - ***Outreach activities***
- ***Provider Call Center calls***
    - ***Training seminars***
    - ***Visits to provider offices***
    - ***Local/regional meetings***
    - ***Participation in dental associations and other dental organizations.***

Focused Quality of Care Studies

We conduct focused quality of care studies on a regular basis to evaluate clinical outcomes of dental service delivery. LIBERTY's proactive approach to quality of care benefits everyone and focused quality of care studies play an integral role in improving the oral health outcomes. The Dental Director and the QA Coordinator are actively involved in each study's development, analysis and interpretation. LIBERTY performs

such studies in accordance with the Centers for Medicare & Medicaid Services' guidelines.

Provider Network Monitoring

We have extensive experience in developing and maintaining provider networks that offer members the full scope of each plan's benefits, as well as adequate access to those benefits. Our approach for monitoring each aspect of service delivery includes:

- ***Each provider's completion of a Participating Provider Agreement***
- ***Distribution of a LIBERTY Provider Handbook to each provider***
- ***Each applying dentist's completion of a provider profile form, which gives us the information needed to conduct a first-level assessment of the dentist's qualifications***
- ***A comprehensive credentialing process that adheres to NCQA standards***
- ***Targeted structural and/or process audits of providers who have been identified through utilization analysis and grievance and satisfaction data as having potential quality issues***
- ***Random structural reviews that assess the provider's physical facility, as well as the provider's office protocols regarding emergencies, booking appointments, sterilization and related procedures***
- ***Chart audits that assess the provider's process of care and conformity with professional dental practice, appropriate dental management and quality of care standards***
- ***Re-credentialing of each network provider every three years, consistent with NCQA standards.***
- ***A formal provider dispute resolution process***
- ***Establishing provider quality improvement goals in areas in which the provider or provider network does not meet LIBERTY's standards or improvement goals.***
- ***Developing and implementing incentives, both financial and non-financial incentives, to motivate Providers to improve performance on profiled measures.***

Utilization Management

Our Utilization Management (UM) program ensures access to care while maintaining quality and cost effectiveness. One of our primary responsibilities is to conduct

utilization reviews to determine whether treatments meet each plan's criteria and generally accepted standards of care. Licensed dentist review prior authorizations and claims to determine whether to authorize, modify or deny dental services based on review of radiographs, if required, and other information provided by the treating dentist.

Other UM activities include:

- ***Establishing dental necessity criteria;***
- ***Establishing thresholds for acceptable utilization levels;***
- ***Implementing mechanisms to evaluate over-utilization and under-utilization;***
- ***Determining sanctions for provider noncompliance;***
- ***Identifying potential quality issues and referrals to the QIC;***
- ***Conducting structural reviews of newly enrolled providers' offices, along with targeted onsite reviews;***
- ***Conducting peer review of UM activities through the evaluation of utilization reporting, appeal requests and provider profiling and***
- ***Reporting to the QIC and dental director regarding overall UM program effectiveness.***

The process of waste, abuse and fraud detection provides an excellent example of how the UM program operates within the QM Department. Suspected cases of waste, abuse or fraud often originate in the QM Department because, organizationally, the Department is tasked with monitoring provider and member activity to detect inconsistencies with sound medical practices, the potential for increased resource consumption resulting from reimbursement for unnecessary dental care and under-utilization and/or over-utilization trends.

Educational Activities

We convey information to providers, members and staff to help ensure their understanding of clinical and administrative issues. The Provider Relations Department coordinates and implements training sessions and continuing education seminars for providers. The Member Service Department creates and disseminates preventive health education brochures to members and trains Call Center Representatives of each program's requirements to foster knowledgeable interaction with members and providers on the telephone.

The QM Department tracks these educational activities because they are an integral component of many quality improvement initiatives; such as with member and provider satisfaction surveys results which are used identify topics for future educational activities.

3.9.23 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.

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

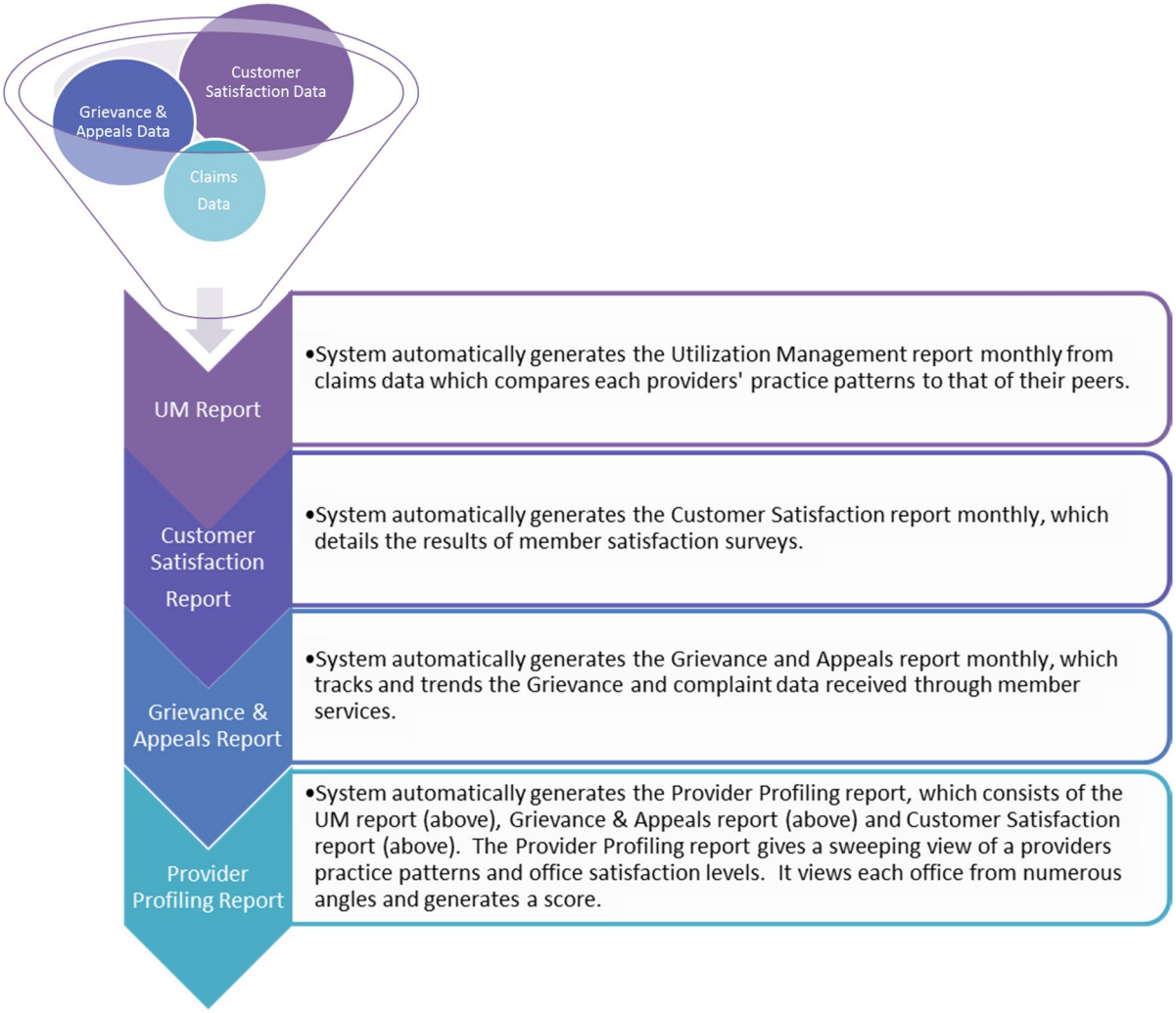
3.9.23.2 Data or studies must be submitted by the required due date, and be accurate and complete.

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

We have extensive experience collecting, analyzing, and uniformly reporting various data types, including, but not limited to, utilization, cost, quality assurance, recipient/provider satisfaction and grievance/appeals data. LIBERTY currently serves over 2 million Medicaid recipients nationwide, and through this experience, we have developed strategies and systems to effectively and efficiently report on a wide range of data sets. Our systems allow us to create custom reports for our government agency clients to capture State, Federal, and contractual reporting requirements.

Our MIS system contains all business and clinical data within its comprehensive, single-source database. Using the existing data sets, all relevant information can be exported and referenced using various reporting software. In regards to generating standard quality and utilization reports, this subsystem is 100 percent automated (Figure 3.9.23-1).

FIGURE 3.9.23-1. QUALITY IMPROVEMENT (QM/QA/UM) SUBSYSTEM



The applications most used by our analysts are Microsoft Reporting Services (SQL), Microsoft Access, and Microsoft Excel. Our systems provide for customizable reporting frequencies allowing us to adhere to DHCFP's desired reporting schedules. Our automated reporting capabilities ensure we will meet DHCFP's contractual requirements on all specified reports.

Data collected on our Nevada recipients will be provided to DHCFP in accordance with the contract, performance measures, and reports. These data and studies will be submitted by the required due date in an accurate and complete fashion.

3.9.24 Dispute Resolution

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

3.9.24.1 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.

3.9.24.2 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.

Provider Question and Dispute Resolution Process

We provide a fast, fair, and cost-effective provider dispute resolution process whereby providers can have their questions answered and dispute decisions made by LIBERTY to deny or modify any requested service.

We will educate providers on their right to access the provider complaint system through multiple means. LIBERTY's Nevada Medicaid provider network will receive live, in-person training and regular written communication advising them of their right to access the provider complaint process. We will review the provider complaint submission process with providers during initial orientation. Additionally, information on the process can be found on our website and on iTransact, our Provider Portal. Providers may also request hard copy instructions on submitting a complaint at any time, which also includes informal "inquiries."

In the case of these provider inquiries, LIBERTY's Provider Relations team will be available to assist providers in a variety of areas. The provider will have access to their assigned Network Manager via phone, mail, and email to express concerns or file a complaint. When the provider is clearly appealing an adverse determination or a complaint that requires a more thorough investigation, providers are directed to submit their complaints in writing to LIBERTY's Grievance and Appeals Department. For out-of-network providers, we provide information on inquiries and grievances consistent with our network providers.

LIBERTY experiences a relatively small amount of provider appeals. Thus far in 2016, we have handled an average of four provider appeals per month in our California Medicaid network with an average resolution time of 26 days.

We process provider complaints with the same urgency and in a similar manner as member grievances and appeals, ensuring that all provider complaints and appeals are properly logged in a single source database followed by the issuance of a written acknowledgement letter to the provider. Each complaint, grievance, and

appeal will be reviewed in accordance with contractual requirements, guidelines, and all applicable state and federal regulatory requirements. In the case of appeals, cases will be assigned to a different reviewer than the one involved in the initial determination. We will resolve all provider complaints and appeals with a written determination to the provider within 30 calendar days of receipt. The Manager of Grievances/Appeals oversees the receipt and processing of all provider complaints and appeals to ensure that each case is resolved in a timely manner.

To ensure timely processing of a payment when a claim is appealed and we overturn its initial denial, we have developed a highly collaborative process between departments that involves regular training and review, as well as accountability. Our Grievance and Appeals Department investigates the matter and issues a determination. The Claims Department reviews the resolution from the Grievance Department and processes or reprocesses the item in question. Depending on the outcome, LIBERTY's Finance Department will be called upon to either issue payment (or additional payment, including interest, when applicable), or possibly recover funds if a provider was paid incorrectly.

Our Evidence of Payment letters to providers will include our phone number, email address, and physical address. We also have the flexibility of customizing the letters for Nevada Medicaid. In addition, LIBERTY will have a member of our Grievance and Appeals team dedicated to receiving and processing provider grievances.

Dispute Resolution Timeframe

Providers can submit written and verbal inquiries and grievances through multiple avenues, including through their Network Manager, through the provider services hotline, or online through the provider portal. Tracking of provider grievances is performed by the Grievance and Appeal team working in conjunction with Provider Relations and our IT department. Providers receive a written acknowledgement letter within 5 calendar days. The acknowledgement letter is typically generated and mailed on the same day it is initially entered into our system. LIBERTY has a standard turnaround time of 30 days to respond in writing to provider complaints and appeals with an appropriate determination and resolution, well within the 90 calendar day requirement of the Nevada DHCFP.

Provider Dispute Tracking

We will track all provider complaints in our core MIS application as well as in manually maintained spreadsheets. These files, which contain information on the nature of each provider dispute, the date filed, the dates and nature of actions taken, and final dispute resolution, allow for custom reporting, which is reviewed on an ongoing basis for trends

or patterns by our Provider Relations and Grievance and Appeal Departments. At least quarterly, provider grievance data is presented and discussed with our Quality Management Improvement Committee. We review the provider complaint data to identify opportunities to decrease the number of denial decisions that are reversed during the provider appeal process. In California we reduced the number of provider complaints by conducting clinical reviewer calibrations, focused training on internal processing guidelines, ongoing provider training by Network Managers, and through information shared in Provider Newsletters. As shown in Figure 3.9.24-1, the number of provider complaints has decreased by 27% in the last 12 months. Figure 3.9.24-2 demonstrates that over half of the provider disputes appeals indicate that our initial decision was correct.

FIGURE 3.9.24-1. THE DOWNWARD TREND OF LIBERTY PROVIDER COMPLAINTS IN CALIFORNIA IN THE LAST YEAR

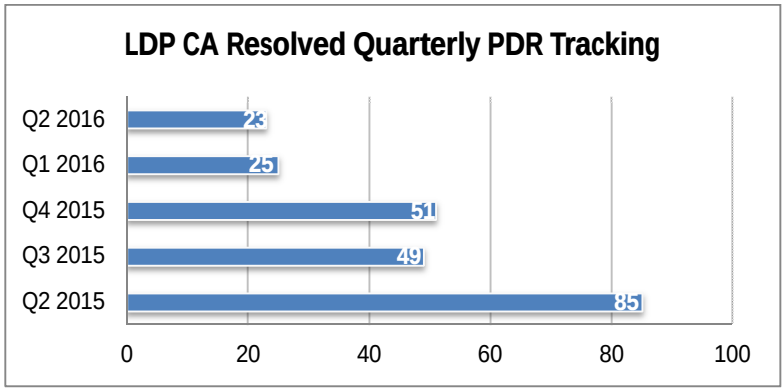
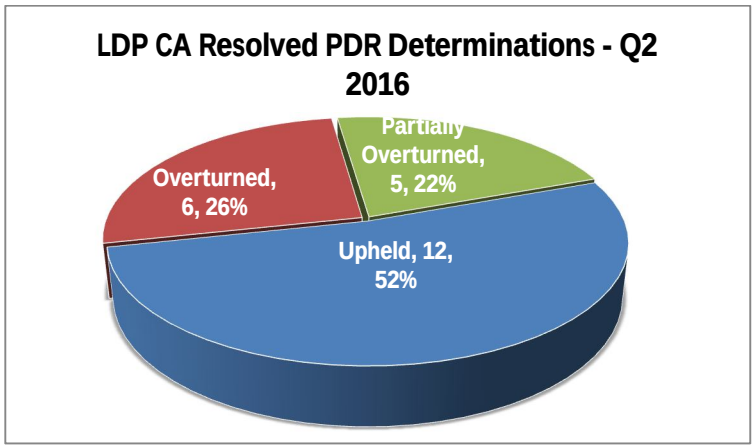


FIGURE 3.9.21-2. RESOLVED PDR DETERMINATIONS IN Q2 2016



Provider complaint outcomes will be tracked and reported to the Quality Management and Improvement Committee. If a determination from a provider complaint demonstrates the need for additional counseling or follow-up from the Provider Relations Department, the Grievance and Appeal Department will forward a request for follow-up to the provider's assigned Network Manager. The Network Manager will follow up with the provider within 30 calendar days to ensure the completion of any necessary training, counseling, or re-orientation. Upon the completion of the training, the Network Manager provides the Grievance and Appeals Department with a completed Provider Service Report (PSR) as supporting documentation. In addition, resolutions to provider grievances will be maintained in the MIS system where Provider Relations Department can review and upload the completed PSR forms after any necessary actions have been completed.

3.10 STATE QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY

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3.10 STATE QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY

3.10.1 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:

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

3.10.1.2 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.

3.10.2 The purpose of this quality strategy is to:

3.10.2.1 CFR 438.Section E – State Responsibilities

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

B. 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;

C. Ensure that the vendors comply with standards established by the DHCFP;

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

E. 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

F. 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.

3.10.2.2 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.

A. The Strategy incorporates procedures that:
   1. Assess the quality and appropriateness of care and services furnished to all of the DHCFP dental program recipients enrolled with the vendor;

2. 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;
3. 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;
4. 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;
5. That designates the performance measures and levels developed by CMS in consultation with States and other relevant stakeholders;
6. Designates an information system that supports the initial and ongoing operation and review of the DHCFP's quality strategy;
7. 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

8. 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.

We understand and will comply with the requirements of section 3.10 through 3.10.2.2.

LIBERTY has reviewed the purpose of the state's Medicaid and Nevada Check Up Managed Care Quality Assessment and Performance Improvement Strategy set forth in section 3.10.2, as well as the procedures incorporated therein. LIBERTY's Quality Management and Improvement (QMI) goals and initiatives align with those of the State, and the QMI Program that LIBERTY has developed encompasses policies, procedures and infrastructure that will allow LIBERTY to comply with State's requirements.

LIBERTY has a longstanding history of working with State regulatory agencies to successfully demonstrate, during regularly scheduled surveys, that LIBERTY meets or exceeds the State's quality requirements. LIBERTY's most recent routine survey in California, the nation's largest Medicaid market, resulted in zero deficiencies.

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3.11 FISCAL REQUIREMENTS

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3.11 FISCAL REQUIREMENTS

3.11.1 Vendor Fiscal Standards

The State of Nevada Division of Insurance (DOI) regulates the financial stability of all certified vendors. The vendor must comply with all DOI standards in addition to the PAHP standards described in this section.

LIBERTY Dental Plan of Nevada, Inc. has and will continue to comply with all Nevada Division of Insurance financial stability, solvency, and equity statutes and regulations, as well as all PAHP described below.

3.11.2 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.

3.11.2.1 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.

3.11.2.2 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.

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

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

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

We understand and will comply with the requirements listed in sections 3.11.2.1 through 3.11.2.3 related to deposit requirements.

3.11.2.4 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.

We understand and will comply with DHCFP's requirement to maintain the performance security deposit after the contract term for a length of time determined by DHCFP.

3.11.3 Vendor Liability

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

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

A. The vendor's debts, in the event of the vendor's insolvency;

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

C. 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

D. 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.

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

LIBERTY has existing and operational relationships with the subcontractors we plan to contract with in Nevada. Due to our long relationship with these subcontractors providing services in numerous other Medicaid markets throughout the country, they are fully aware of, and compliant with, our strict policy requiring contracts with subcontractors and downstream vendors to adhere to all the same conditions and obligations as those LIBERTY is bound to in our contracts with state and federal entities. Specifically, our contracts with these subcontractors already include the Nevada DHCFP required provision that recipients must not be held liable for any of the following:

- ***The subcontractor's debts, in the event of the subcontractor's insolvency;***
- ***For services provided to the recipient in the event the subcontractor fails to receive payment from the state or LIBERTY for such services;***

- ***subcontractor fails to receive payment from the state, subcontractor or LIBERTY for such services; or***
- ***Payments to a provider who furnishes covered services under a contractual, referral, or other arrangement with the subcontractor in excess of the amount that would be owed by the recipient if the subcontractor had directly provided the services.***

LIBERTY's contracts with our subcontractors also require that they continue services to recipients during insolvency pursuant to the Center for Medicare and Medicaid State Medicaid Manual (SMM) 2086.6.B.

Finally, LIBERTY's Delegation Oversight Committee is responsible for formal, ongoing oversight of the functions we have delegated to these subcontractors, including verifying, at least annually, that they are aware of and continue to adhere to these obligations.

3.11.4 Payment of Claims

3.11.4.1 The vendor shall be responsible for paying all claims for properly accessed and, if necessary, authorized covered services provided to enrolled recipients on dates of service when they were eligible for coverage unless the services are excluded under the DHCFP 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.

3.11.4.2 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.

3.11.4.3 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.

3.11.4.4 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.

3.11.4.5The 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.

3.11.4.6 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.

3.11.4.7 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.

3.11.4.8 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.

3.11.4.9 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.

3.11.4.10 The vendor shall accurately pay claims with ninety-five percent (95 %) of claims paid

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

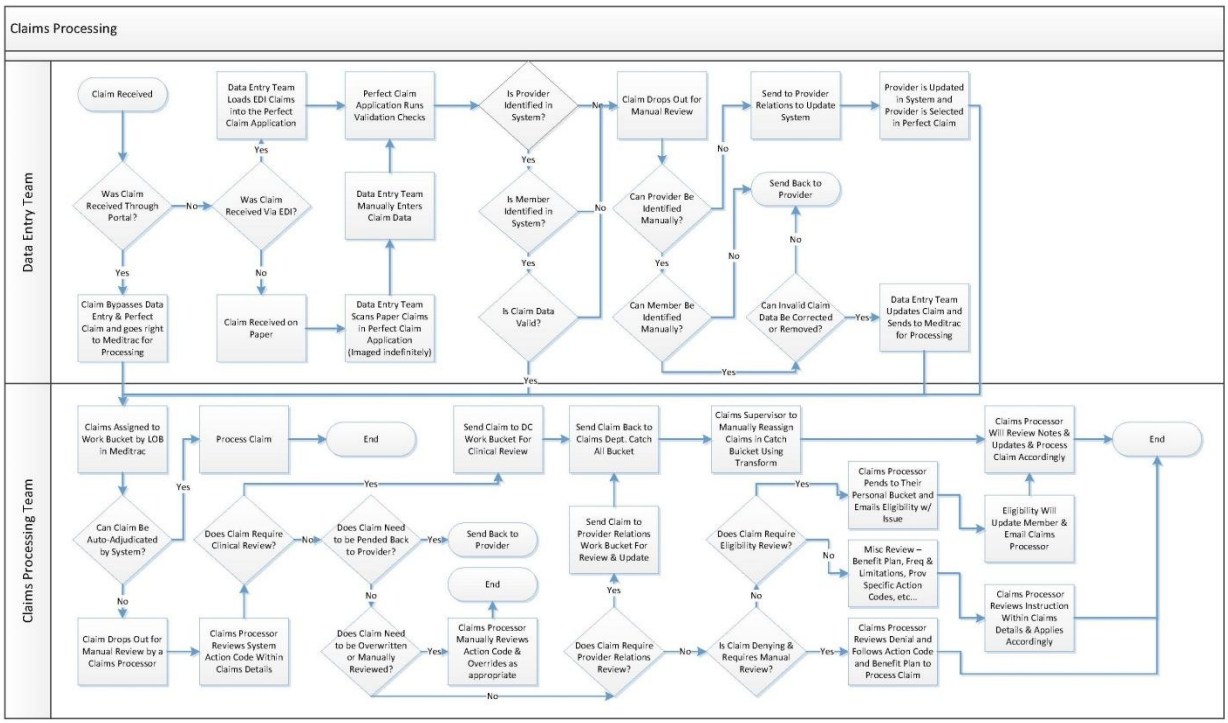
3.11.4.12 The vendor shall provide the DHCFP with information prior to implementation of any changes to the software system to be used to support the claims processing function as described in the vendor's proposal and incorporated by reference in the contract.

3.11.4.13 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).

We understand and fully agree to comply with sections 3.11.4.1-3.11.4.13

LIBERTY's Claims Management department is committed to providing timely, accurate and efficient claims processing in order to service our members and providers. See Figure 3.11.4-1 for our claims processing workflow.

FIGURE 3.11.4-1. CLAIMS PROCESSING WORKFLOW



LIBERTY leverages both innovative technology and years of experienced professional expertise to develop and maintain dynamic solutions to claims adjudication. As outlined below, our adjudication application and workflow manager is designed to be flexible and adaptable, yet stable and consistent. In addition, our staff of 75 employees, who's average tenure is 5 years with the organization, receive, track and work claims through the adjudication process ensuring accurate and uniform results. Our average turnaround time for clean claims is 97.9% processed within 15 days while 100% within 30 days. We receive 56% of our claims through electronic data interchange (EDI) while another 23% are input through our provider portal. The remaining 21% is still received through the mail on paper claim submissions.

Our adjudication system houses logic modules that are specific to each contract's benefit schedule. These logic modules drive efficient processing by allowing us to pre-determine the results with each CDT procedure code that is submitted. Preventive and diagnostic procedures. for example, would be subject to the benefit plan's limitations

and exclusions while treatment such as extractions, dentures and crowns would be subject to clinical review by a licensed dentist for medical necessity. These types of rules and edits are set up and thoroughly tested before the first claim is ever received. Claims that do not auto-adjudicate stop for manual processing with instructions to the processor which we call Action Codes. Action Codes tell a processor why something did not auto-adjudicate and what step to follow next. For example, a claim might stop for a processor to review because conflicting procedures were submitted on the same day. In this case, the processor or dental consultant would review the documentation provided and either deny the less comprehensive procedure or allow both procedures as an exception based on medical necessity. Our adjudication system also has built in edits that deny duplicates, stop the unbundling of procedure codes, flag claims over a certain dollar threshold, and can connect multiple claims with the same member, provider and date of service when treatment is billed on separate claims. We also have edits and rules that can be placed on providers, provider offices, and provider organizations. Rules can be placed on particular fee schedules, procedure codes within a fee schedule, or on a group of procedures (such as extractions or dentures). The flexibility of the application allows LIBERTY to really dive into provider billing patterns and work to promote a consistent and clean claim submission/claim payment process. LIBERTY understands the requirement to pay all claims necessary for covered services for eligible members. We will commit to adjudicating and paying claims accordingly in accordance with all state and federal regulations in a timely and accurate manner.

LIBERTY has Claims Management staff in three offices across the country. Claims processing for DHCFP will be handled out of our Las Vegas, Nevada location. Our Nevada location currently processes claims and pre-authorizations for 3 state Medicaid programs with 27 employees and has capacity for additional staff members. Our Nevada location currently handles over 75,000 claims per month for our Florida, Illinois, and New Jersey Medicaid programs as well as commercial groups local to Nevada.

Coordination of Benefits

Coordination of Benefit (COB) information is captured and stored through multiple methods at LIBERTY. Our eligibility load captures a member's primary insurance information if available. LIBERTY has the capability to store this information during eligibility feeds within the member's profile, and our claims adjudication application will read that information to drive coordination of benefits. When a claim is being adjudicated, our application will stop the claim for a Processor to review with a notification that the member has primary insurance coverage. The claim would then be pended and forwarded to the primary insurance carrier.

A second method for capturing COB information is on a submitted claim. Often claims are submitted with information or indicators that there is another liable party. This comes on the claim form itself or on an attachment. When this information is identified, LIBERTY will flag that claim for verification of COB. A Claims Coordinator will research that claim by reaching out to the member or the provider who submitted the claim to identify whether there has another insurance and whether coordination of benefits needs to occur. Upon receiving confirmation, the Claims Coordinator will update the member's profile in LIBERTY's system so that moving forward, the Coordination of Benefits process will take place automatically. The claim is then pended and forwarded to the primary insurance carrier for processing.

Upon receipt of a claim that has already been paid by a primary provider, LIBERTY's adjudication application has a specific COB screen for handling Coordination of Benefits. A Claims Processor will update the COB screen with the billed charges, amount paid by primary party, amount allowed and the remaining balance to be paid will be calculated automatically. This streamlines COB processing and ensures consistent, accurate payment results.

Submission of Claims by Network and Out-of-network Providers

Our adjudication system allows for two tiered timely filing guidelines which can allow one filing limit for in-network providers (180 days) and allows for a second filing limit for out-of-network providers (365 days). We accept standard ADA claims forms as well as non-standard claim forms as long as all of the pertinent information required to process the claim is included. When the claim is received, either electronically or on paper, it is date stamped for record keeping purposes. That date received is also input into our adjudication system for reporting purposes. The date the claim is closed as well as the date the payment is issued is also stored in our system for reporting and turnaround time verification.

LIBERTY's claims adjudication system and payment processing system run on the same platform. This streamlines the process as an "all in one" solution. Once claims are completed and closed, they get posted to our Finance department. Every morning, our Finance department begins to generate check runs for pending claims payments. If there are claims that are past the 30 day timeframe, our adjudication application will automatically calculate interests and apply that interests to the claim payment. Our payment accuracy for 2016 is 99%.

LIBERTY Dental Plan is always looking to improve its core MIS software and applications. The enhancement process is part of the "Life Cycle" of our MIS systems. Releases are scheduled a few times during the year to ensure we are keeping up to date with our system capabilities and compliance needs. We will work with DHCFP to establish a

mutual approach to the notification process of these releases, and the release schedule. All enhancements and the full release go through various testing cycles before eventually getting scheduled for release to Production. This includes, but not limited to: Enhancement, Functional, Department, and Regression testing. Only after all parties sign off, and change management approves are items scheduled for release. Additionally, upon release of enhancements, all claims processing manuals are updated to reflect any changes or modifications which were caused by enhancement.

3.11.4.14 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:

A. Is identified in the Medicaid State plan;

B. 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;

C. Has a negative consequence for the recipient;

D. Is auditable;

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

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

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

LIBERTY is fully aware of and compliant with the 2011 CMS final rule implementing the requirements of Section 2702 of the ACA, specifically requiring states to implement non-payment policies for provider preventable conditions (PPCs) in the Medicaid population. The goal of this regulation is consistent with LIBERTY's own values of ensuring high quality services to Medicaid recipients. Thus, our current policies and procedures are consistent with, and therefore, readily equip us to 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 NV DHCFP criteria:

1. ***Is identified in the Medicaid State plan;***
2. ***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;***

3. ***Has a negative consequence for the recipient;***
4. ***Is auditable;***
5. ***Includes, at minimum, wrong surgical or other invasive procedure performed on a patient;***
6. ***Surgical or other invasive procedure performed on the wrong body part; and***
7. ***Surgical or other invasive procedure performed on the wrong patient.***

In addition, our PPC protocols require us to adhere to any state or federal reporting requirements, and require our participating providers to report the following information to LIBERTY within five days of the occurrence of a relevant PPC event:

- ***Member name and member ID number.***
- ***A description of the event.***
- ***Dates of services and occurrence of the event.***
- ***Attending physician(s).***
- ***Facility***

Since, in the dental context, PPC are less prevalent, we understand and are prepared to properly respond to such events.

3.11.5 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.

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

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

We maintain and will provide the DHCFP with any financial documentation requested to demonstrate our financial reserves and administrative ability to carry out contractual obligations. Please refer to document "4.01.11.13 2015 Independent Audit Report LDP Nevada" for our quarterly and annual financial reports.

3.11.6 Third-Party Liability (TPL)

3.11.6.1 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.

3.11.6.2 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.

3.11.6.3 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.

3.11.6.4 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.

3.11.6.5 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.

3.11.6.6 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.

3.11.6.7 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.

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

3.11.6.9 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.

In compliance with Title 42, CFR Part 433, Subpart D, LIBERTY has a standard operating procedure to identify and recover funds for which a third party is liable. These procedures see that costs for treatment services otherwise payable by LIBERTY are either avoided or otherwise recovered from a liable party using post-payment recovery. Member educational materials, including the Member Handbook, remind members of their responsibility to report other health insurance, including employer sponsored insurance and/or Medicare. Providers are also educated on third party liability policies, including notification to LIBERTY Dental Plan. The following insurance information is outlined as potential sources for TPL:

- ***Private health insurance***
- ***Employment related health insurance***
- ***Automobile insurance***
- ***State Workers' Compensation***

The early identification of possible third party liability cases greatly increases our ability to effectively research and pursue recovery of dental related expenses paid. The following techniques are used by LIBERTY staff to gather TPL information:

Internal Identification – Employees identify and refer possible TPL case specifics to the Claims Management Team or Claims Coordinators. All appropriate LIBERTY employees are trained to be aware of TPL considerations and forward notification of possible TPL information to the Claims Coordinators, Supervisors or Managers. Examples of these employees would be:

- ***Claims Staff***
- ***Utilization Review Department***
- ***Member Services***
- ***Account Management***

Provider Response – Provider offices may disclose primary insurance or TPL information regarding members which will lead to further investigation by the Claims Coordinators. Examples of this type of communication might be made to the following teams:

- ***Member Services***
- ***Dental Outreach Unit***

- ***Provider Relations***

Recipient Disclosure – Recipients may disclose TPL information while contacting our Member Services department. Our Member Services department will ask for additional insurance coverage upon taking calls from recipients. Possible TPL information is forwarded to the Claims Coordinators for verification. Examples of this kind of disclosure could be made to the following:

- ***Member Services***
- ***Internal Response Unit (IRU)***

State Provided TPL Reports or Notifications – LIBERTY will seek out and obtain any state related materials providing TPL information and work to match that information with Medicaid recipients.

In addition to the above processes, LIBERTY will send out annual survey cards to recipients of the Nevada Medicaid program in an effort to obtain updated insurance coverages from recipients. We will also leverage our Member Portal to conduct these surveys. All TPL information received and verified will be updated in the Member profile and utilized when processing claims to avoid expenditures. Historical TPL information will be stored at a minimum of 72 months in accordance with state and federal rules.

TPL information will be provided to DHCFP in the format and medium requested by DHCFP. LIBERTY agrees to cooperate, in the manner requested, with DHCFP and within the established timeframes related to TPL reporting. LIBERTY's adjudication application contains a feature within the workflow which allows user to create events. For each collection attempt and event can be created which can be pulled for reporting purposes. Events will be date and time stamped and will show the number of attempts made for collection efforts. Successful collections will also have a workflow event created as well as a financial transaction, all of which can be pulled and reported to monitor progress and to measure the success of the process. On an annual basis, LIBERTY commits to working with our Compliance department to ensure all updated rules and regulations pertaining to TPL for Medicaid, state, and federal agencies are met and in line before the start of the next calendar year.

LIBERTY understands that it is required to take all reasonable measures to identify third party resources which may have a legal, fiscal, or contractual liability as a result of medical assistance furnished to a Medicaid recipient. Where third party liability is known or reasonably expected, LIBERTY will deny the claim and require the provider to bill and collect from the primary liable party. In cases where we have made payment without taking reductions for third party benefits, LIBERTY undertakes measures to collect directly from third parties. To initiate third party recoveries, post-payment reports will be

run checking for recipients with TPL versus claims paid without COB. Those claims identified will be parsed out and targeted for recovery upon completion of investigation and validation of third party liability coverage dates. Recovery letters will be generated itemizing the services believed to be overpaid and followed up by collection calls. LIBERTY understands the importance of cost avoidance and cost recovery and commits to DHCFP to make every effort possible to ensure Nevada Medicaid is the payer of last resort.

3.11.7 Subrogation

3.11.7.1 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.

3.11.7.2 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.

3.11.7.3 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.

Subrogation is the substitution of one party for another when one party has a legal claim against another party. LIBERTY is subrogated to the rights of a Medicaid recipient against any third party arising out of injury, disease, or sickness. This means that LIBERTY is allowed to recover from any other payer the cost of our providing dental benefits to a Medicaid recipient. In general, we have the right to recover the cost of a recipient's dental care, to the extent of what LIBERTY has paid, from anyone the recipient has the right to recover from, or to substitute for the recipient and seek to recover our payment.

For example, if Medicare or employer sponsored insurance is involved, LIBERTY will pay for the services rendered to a recipient as the primary payer (i.e., in those cases where LIBERTY is unaware of the existence of the other insurance). If payment for the treatment rendered is subsequently made by Medicare or the employer sponsored insurance carrier directly to the dental office, whom was also paid for the same services by

LIBERTY, our policy requires the provider to notify LIBERTY of the overpayment. We will then request a refund of the overpayment from the dental office, as applicable. Furthermore, the Medicaid recipient is also required to assist and cooperate fully with LIBERTY in our efforts to secure such rights.

LIBERTY will utilize all tools, both internal and external as provided by DHCFP, to recover costs. This includes researching for casualty claim submissions as required. These activities will be tracked and monitored for reporting purposes to DHCFP. Tracking is maintained within our adjudication system utilizing a function called workflow events. An event is created with every action taken for recovery. Each event is date and time stamped with a clear label and detail outlining the action. We will generate reports for DHCFP to measure our success. LIBERTY will put forth a best effort to commit to exceeding collection targets for the time period prescribed by DHCF.

3.11.8 Reserving

As part of its accounting and budgeting function, the vendor will be required to establish an actuarially sound process for estimating and tracking incurred but not reported (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.

The Company calculates IBNR and claims payable every month, using industry standard claims lag triangle IBNR models. These encompass two years' paid claims data for better assessment of completion factors in developing a more accurate estimate for the claims reserve, along with member counts for each month. The claims reserves are initially calculated by the Company's FP&A department. They are then submitted to the Controller for review and revisions where necessary. After this step, the reserves go to the CFO for final review and approval, and are then recorded to the Company's books. In addition, all claims reserves are reviewed and certified annually by an independent actuary at the end of the fiscal year. This includes an assessment of the Company's reserving processes. The actuary's annual certification is appended to this RFP.

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

3.11.9.1 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.).

3.11.9.2 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.

3.11.9.3 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.

3.11.9.4 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.

3.11.9.5 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.

LIBERTY has a longstanding, strict policy against contracting with any offshore vendor and ensuring that payments for items or services covered under our government programs, including Nevada Medicaid should we be awarded the DHCFP contract, are not made to financial institutions or entities located outside the U.S. ("Foreign Corporations"). Similarly, our policies and procedures strictly prohibit our providers from making payments for items or services covered under our government programs to Foreign Corporations. Our policies and procedures, which will be made available to DHCFP, make it clear that this prohibition extends to payments to telemedicine providers and pharmacies outside of the U.S.

Given our extensive experience in Medicaid programs, LIBERTY is fully aware that Section 6505 of the ACA requires that Nevada's Medicaid program "shall not provide any payments for items or services provided under the State plan or under a waiver to

any financial institution or entity located outside of the U.S.," and we have a variety of measures in place to ensure full compliance with this requirement. For example:

- ***We do not use Foreign Corporations, such as bank accounts or business agents, located outside of the U.S. when making payments for services or items provided under government programs, like Nevada Medicaid.***

- ***At least annually, we educate all staff involved in procurement, contracting, and other LIBERTY areas which engage in selecting or contracting with financial institutions or entities, regarding this prohibition.***

- ***At least annually, we perform a sample audit of payments to validate none have been made to Foreign Corporations. Our policy requires us to immediately report any such inadvertent payment to the appropriate oversight agencies, including the DHCFP, should we be awarded the Nevada contract and, to promptly make any required reimbursements of such payments.***

Provider Compliance

Our provider contracts, provider manual, and provider educational materials make clear LIBERTY's prohibition against providers making payments for items or services provided under government programs to Foreign Corporations. In addition, our policies and protocols are carefully designed to ensure our providers do not make payments to Foreign Corporations. For example:

- ***We will not credential or contract with any provider located outside of the U.S.***
- ***We require providers to attest that they are not affiliated with Foreign Corporations, and will not make payments to Foreign Corporations, as part of the credentialing process and annually thereafter.***
- ***We deny payment when billing or paying entities associated with out of country addresses or bank accounts.***

3.12 GRIEVANCES, APPEALS AND FAIR HEARINGS

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3.12 GRIEVANCES, APPEALS AND FAIR HEARINGS

3.12.1 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.

3.12.1.1 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.

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

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

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

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

D. The failure to provide services in a timely manner; or

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

3.12.1.3 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.

A. This information must include:

1. The recipient's right to file grievances and appeals; the requirements and timeframes for filing;

2. The availability of assistance with filing;

3. 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;

4. The toll free number to file oral grievances and appeals; and

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

3.12.1.4 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.

3.12.1.5 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.

3.12.1.6 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.

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

Grievance, Appeals, and State Hearings

LIBERTY appreciates the importance of advocating for our Medicaid members and ensuring their rights are honored, including the right to file grievances and submit appeals. LIBERTY has established a robust grievance system to research and respond to grievances, appeals, and provider disputes in a prompt and fair manner. Through this grievance system, LIBERTY also ensures that our members are "made whole" if it is found that they were inappropriately charged by a contracted provider (by reinstating the member's benefit or reimbursing the member). If a member files a grievance regarding substandard treatment, we work with the member to ensure the member receives the appropriate care, and we will investigate what further action needs to take place with the provider.

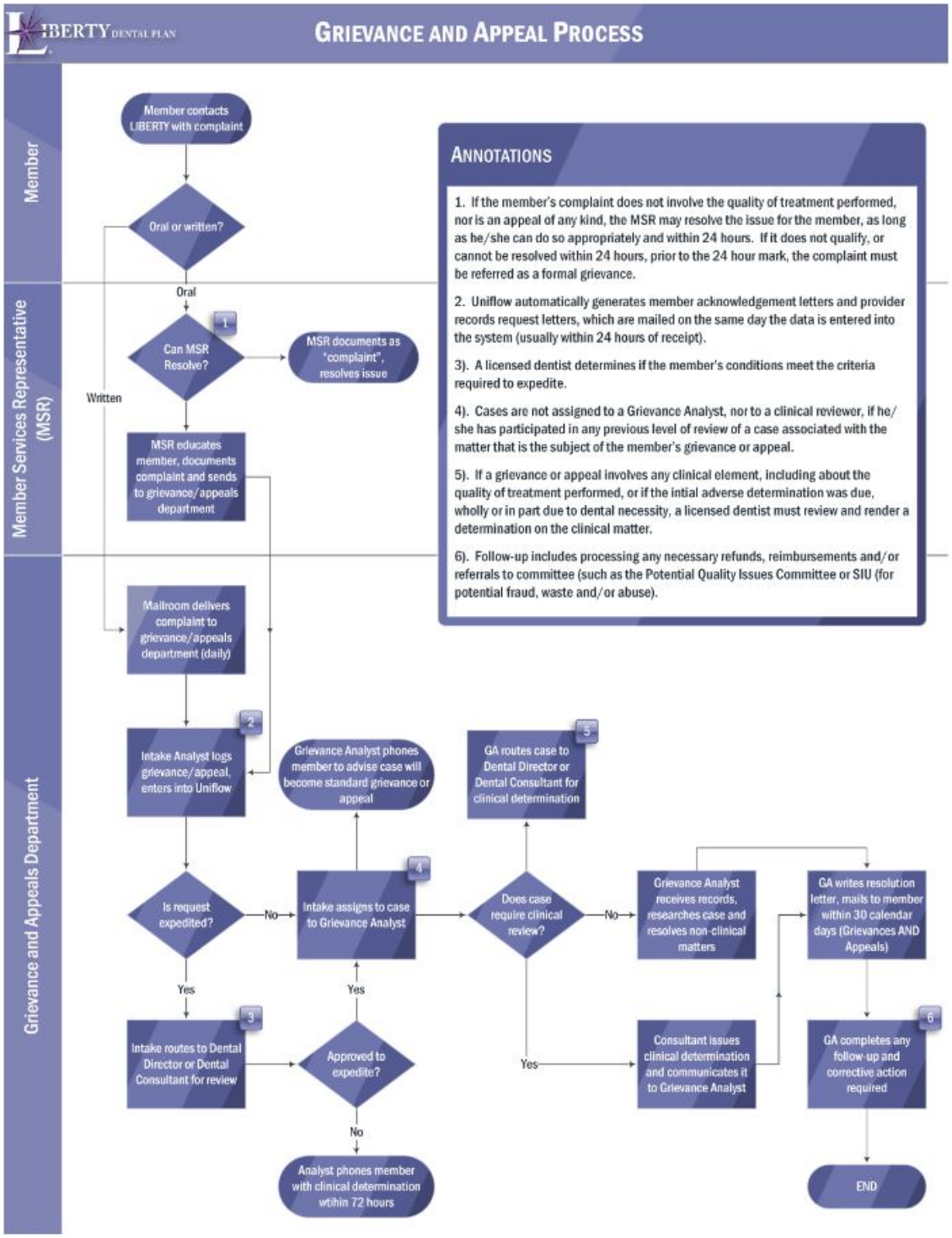
In our California Medicaid (Medi-Cal) program in 2016, we have resolved an average of 28 cases per month with an average resolution time of 27 days. This modest case stream given the enrollment volume we serve (currently more than 575,000 Medi-Cal enrollees) is indicative of the high level of member satisfaction we are achieving.

LIBERTY's grievance and appeals process is a documented set of rules that encompasses researching, resolving and responding to member grievances and appeals, including expedited review of urgent grievances and facilitation of the state fair hearing process for members wishing to escalate their grievances. Members are informed of their right to access the grievance process at the time of enrollment. Our definitions of a grievance and an appeal are in alignment with the State definition. LIBERTY's existing systems capture all required documentation to allow full compliance with all the reporting requirements of the DHCFP.

Grievance and Appeal Process

Our flowchart in Figure 3.12.1-1 below depicts the high-level steps involved in addressing grievances and appeals.

FIGURE 3.12.1-1. GRIEVANCE AND APPEAL FLOWCHART



When contacting the Member Services Department for assistance, Nevada Medicaid members will have access to staff, programs and services designed to facilitate the convenient expression of dissatisfaction and requests for assistance. Member Services Representatives (MSRs) are trained to identify and document all expressions of dissatisfaction as a "complaint". From there, they are trained to immediately recognize whether it is the type of complaint they can resolve for the member on their own, or if the complaint is of a type, or contains a qualifying element, that would require the matter to be referred as a formal verbal grievance or appeal. Such matters will receive the attention of an experienced Grievance Analyst and a licensed dentist, if needed.

Members, providers on behalf of members, or other authorized representatives, such as parents and/or legal guardians, may submit grievances or appeals orally or in writing. Written grievances and appeals are acceptable whether communicated via a complaint form, letter, email, fax, or online submission.

When a grievance and/or appeal is received orally by our call center, a Member Services Representative ("MSR") first ensures that any urgent needs are appropriately addressed. Next, the MSR documents the member's concerns in our core MIS system—a common, "single-source" system that houses data accessed by multiple departments and serves as an electronic repository to hold all scanned documentation relating to grievance and appeals cases. The core system is highly customizable, and the Member Complaint Workflow within the MIS contains drop-down lists and custom fields to promote accurate, consistent data entry. After the MSR finishes documenting the member's concerns, the documentation is instantly routed to a special queue in the Grievance and Appeals (G&A) Department. If a grievance is received by mail, the member's grievance is routed directly to the Grievance and Appeals Department and bypasses the MSR process.

As soon as a grievance is received in our G&A Department, an Intake Analyst enters the relevant information into the grievances and appeals log. This system assigns the grievance a system-generated tracking number, marking the creation of an electronic case file. At this time, the system also automatically generates a written acknowledgement of receipt of the grievance to the complainant. During this process, the Intake Analyst will identify any requests for fair hearings, as well as expedited appeals, even if not specifically requested as such.

Analysts are trained to identify when, based on the documentation provided by the member, taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. Such requests are immediately routed to a Dental Director (or licensed dentist designee) for review and to determine if it meets the criteria for an expedited review. If approved by

the Dental Director (or licensed dentist designee), the case proceeds with the expedited timeframe for disposition, which will not exceed 72 hours for review and resolution. Upon resolution of an expedited grievance or appeal, the member is contacted by phone and advised of the resolution. If it is identified that the appeal request does not meet the criteria described above, the member will be immediately contacted and advised that the appeal will be converted to a standard appeal, with a resolution to be issued within 30 calendar days from the day of receipt of the initial request. This verbal notification will be followed with a written determination within two calendar days.

At the time a grievance is logged, LIBERTY automatically generates records request letters, which are then faxed and/or mailed to all dental providers named in the grievance. Once the records request has been generated, the case is assigned to a Grievance Analyst. LIBERTY ensures that all individuals who make decisions on grievances and appeals were not involved in any previous review or decision about the action. All dentist reviewers who decide an appeal of a denial based on dental necessity (or lack thereof), or render any determination that involves review of a clinical nature, have the appropriate expertise in treating the member's condition or disease, and will also have not contributed to any previous plan decisions or grievances relating to the subject of the member's dissatisfaction.

If a grievance, or a member appeal, involves anything clinical in nature, or a determination based wholly or in part on dental necessity, the Grievance Analyst will route the case to a Dental Director or Dental Consultant to issue a determination on the clinical matter. Once this clinical determination is returned, the Grievance Analyst will compose a thorough resolution letter using language that is easily understandable. As an opportunity to standardize processes, LIBERTY will aim to resolve all Nevada Medicaid member grievances as expeditiously as the member's condition requires, or within 30 calendar days, exceeding the requirement of the DHCFP's requirement of "90 calendar days from the date of receipt of the grievance." LIBERTY will resolve all Nevada Medicaid member appeals within "30 calendar days from the date of receipt of the appeal" in compliance with the contract requirements.

Information Provided to Members

As part of LIBERTY's commitment to ensuring Nevadans will have full, convenient access to the grievance and appeals process, LIBERTY will leverage our familiarity with regulatory and client requirements from across the country to offer easy access to the grievance process with multiple points of contact and submission methods, as well as transparent processes that encourage open communication and feedback.

LIBERTY will immediately comply in writing with the provision of notification requirements. Among the "Member Rights and Responsibilities" in the Member Handbook will be instructions on how to file a grievance and submit an appeal (including how to request a State Fair Hearing). This information will be provided to members in accordance with all DHCFP requirements, and will appear in member handbooks, as well as the "Member" page of LIBERTY's website.

Additionally, LIBERTY will advise members of their right to file a grievance or appeal on the provision of all notices of adverse determination. LIBERTY will include required notifications on all Explanations of Benefits. LIBERTY also plans to implement a fillable grievance form. Members may download the form from LIBERTY's website, request for a copy to be mailed to them via the toll-free member phone line, or ask their dental provider for a copy. In addition to the provision of the fillable form for download from LIBERTY's website, LIBERTY will also allow members to submit their grievance and/or appeal directly from the website by completing the online form and clicking "submit". The member's grievance or appeal is immediately routed to LIBERTY's Grievance and Appeals Department for processing.

LIBERTY's Provider Relations Department will incorporate member grievance and appeals training into providers' orientation agendas and their Provider Reference Guide. LIBERTY communicates with providers regularly, and will publish frequent reminders of the importance of ensuring their patients have access to LIBERTY's grievance system through Provider Newsletters and Provider Alerts.

Staffing

The Manager of Grievances/Appeals oversees the receipt and processing of all member and provider complaints and appeals to ensure that each case is resolved in a timely manner. Our team of 11 Grievance Analysts collectively possesses over 65 years of qualifying experience in the review and resolution of complaints, healthcare administration, and/or dental office experience. Several of LIBERTY's Grievance Analysts are RDAs (Registered Dental Assistants), possess specialty (orthodontic) certification, and as a minimum requirement for the role, have worked in dental office management, front office administration and as treatment coordinators. LIBERTY's Dental Directors and Dental Consultants are all licensed dentists in good standing, maintaining their licensure with regular continuing education and recredentialing.

When recruiting, we set a minimum standard for the number of years of experience applicants to the Grievance Analyst role must possess with experience working in an operations role at healthcare service plan or experience working in a dental clinical setting.

In addition to possessing the required clinical and/or plan experience, grievance analysts must be able to present clearly, concisely, and professionally in oral and written communication. During the interview process, we require and analyze a writing sample, as well as test applicants in their communication skills. Although these standards may prolong the recruiting process, communication skills required to work in this unique position are vital for success. Upon hiring a new Grievance Analyst, we conduct an intensive training and orientation period. The training includes a thorough explanation and hands-on experience of all aspects of our grievance system and processes. When a newly hired Grievance Analyst is fully trained, we assign them a limited grievance caseload. The usual training period for a new Grievance Analyst is 4-6 months.

Reporting, Tracking, and Auditing

LIBERTY has built a reliable and thorough member grievance processing and tracking system using customized tracking software and processes to ensure that grievances, appeals, and requests for hearings are triaged to the appropriate staff, that staff are properly trained and supervised, that all members receive written acknowledgements, grievance resolution timelines are met, and grievance resolution letters meet the requirements of the RFP. Our tracking and reporting systems allow us to fully comply with the requirements outlined by DHCFP. We will provide monthly and quarterly reports to the State as outlined in Attachment T. LIBERTY will comply with an annual audit of the appeals process by DHCFP.

3.12.2 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).

3.12.2.1 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.

3.12.2.2 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.

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

A. 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;

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

C. The services were ordered by an authorized provider;

D. The authorization period has not expired; and

E. The recipient requests continuation of benefits.

3.12.2.4 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:

A. The recipient withdraws the appeal;

B. 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;

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

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

3.12.2.5 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.

3.12.2.6 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.

3.12.2.7 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.

3.12.2.8 For tracking purposes, an oral appeal or grievance is differentiated from a routine telephone inquiry by the content of the inquiry.

Upon contract award, LIBERTY will provide DHCFP with written Nevada-specific policies and procedures for our grievance and appeals system and process, including provisions regarding the State Fair Hearing process. Further, we will work with DHCFP to secure approval for any required or recommended material changes in our grievance and appeals system.

We will allow recipients and providers acting on behalf of the recipient to file an appeal within 90 calendar days from the date of notice of action. LIBERTY will comply with the State's requirements on continuing a recipient's benefit while the appeal is in process and pending.

We will educate our members on filing grievances and appeals process through multiple means, including through our member portal, website, and Member Handbook, in addition, we will develop a process with DHCFP to easily receive any grievances or appeals filed directly to DHCFP.

Members, and providers on behalf of members, may submit grievances or appeals orally or in writing. Written grievances and appeals are acceptable whether communicated via a complaint form, letter, email, fax, or online submission. LIBERTY can easily adopt DHCFP's timely filing requirements as set forth above, and will comply with all DHCFP's tracking and reporting requirements.

3.12.3 Authorization and Notice Timeliness Requirements

3.12.3.1 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.

3.12.3.2 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.

Our current authorization and notice timeliness standards comply with all DHCFP's requirements. LIBERTY's authorization department processes standard requests using the date of receipt and the recipient's health status to prioritize the authorization inventory to ensure that decisions are provided as expeditiously as each recipient's health requires and within the states established timeline. The supervisor of the authorization department runs inventory reports throughout the day which allows for close tracking and adjustments for all inventories, and ensures timely processing. Our front-end scanning system ensures that all relevant information pertaining to the authorization is routed to a licensed dental consultant in an efficient manner. If an authorization is received and does not contain sufficient clinical documentation or lacks any other information required to make a decision, LIBERTY's UM Outreach staff will contact the provider and/or recipient/guardian via telephone in an effort to gather the missing information and make a decision without a delay. If the outreach staff has attempted but not obtained the information required to make the decision, LIBERTY will request an extension if it is deemed to be in the best interest of the recipient. Our MIS system allows for customization of recipient and provider notifications including but not limited to extension notices and right to appeal notices.

We accept authorization requests via telephone, fax, secure e-mail, LIBERTY's web portal, electronic via EDI and paper by mail. Upon receipt, each authorization is reviewed for evidence of a need and/or request from a provider for an expedited decision. Each authorization is treated individual depending on information received and information in the member's dental history. Authorizations requiring expedited review are routed to the clinical or administrative staff as necessary to ensure that a timely decision is made, no later than 72 hours after the time of receipt.

If an authorization is received and does not contain sufficient clinical documentation or lacks any other information required to make a decision, LIBERTY's UM Outreach staff will contact the provider and/or recipient via telephone in an effort to gather the missing information and make a prompt decision. If the outreach staff has attempted, but not obtained the information required to make the decision, LIBERTY will request an extension if it is deemed to be in the best interest of the recipient. If it is deemed not to be in the best interest of the recipient, a licensed dental consultant will make a decision within the expedited timeframe by using information received with the request and/or information in the member's dental history. The LIBERTY MIS system allows for customization of recipient and provider notifications including, but not limited to, extension notices and right to appeal notices.

3.12.4 Notice of Action

3.12.4.1 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.

Our MIS system allows for customization of recipient and provider notifications including the written Notice of Action letters as required by the state's Medicaid program. Our policy is to notify the recipient and the provider in writing no later than 24 business hours after the Notice of Action is generated. We may also notify the recipient and/or provider via telephone prior to the written notification.

3.12.4.2 The notice must meet all of the following requirements:

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

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

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

LIBERTY is accustomed to providing translated recipient notifications in the state established prevalent non-English languages. LIBERTY's single source information system houses the recipients primary written and spoken language. Upon the Notice of Action being generated from the system, the recipient's primary written language is considered and if the primary written language is one of the state-established prevalent non-English languages the letter is generated in the appropriate language as specified.

Recipients and providers may also access LIBERTY's web portal and our Member Service call center which will provide additional assistance including coordinating dental appointments for all recipients including special needs recipients such as visually impaired or those with limited reading proficiency.

LIBERTY's UM and Operational Audits teams have developed and continue to monitor all denial rationale that is applied to the Notice of Actions in effort of providing easily understood denial rationale to both recipients and providers.

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

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

B. The reasons for the action;

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

D. The recipient's right to request a State Fair Hearing after the recipient has exhausted the vendor's internal appeal procedures;

E. The procedures for exercising the recipient's rights to appeal;

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

G. 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;

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

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

J. 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.

LIBERTY is accustomed to providing written Notice of Actions as required by CMS and state Medicaid programs. Our system has a variety of customizable features that allow us to ensure that each Notice of Action that is generated at minimum includes all state specific criteria including but not limited to;

- ***Action taken and reason for action***
- ***Recipient and provider appeal rights specific to the state Medicaid program***
- ***State Fair Hearing rights and procedures for the right to appeal***
- ***Circumstance(s) under which the expedited resolution is available and how to request***
- ***Recipient's rights to have the benefits continued if the appeal is filed***
- ***The recipient's right to self-representation or to use legal counsel, a relative, a friend, or other spokesman***
- ***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.***

3.12.4.4 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.

LIBERTY will provide 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.

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

A. In the death of the recipient;

B. 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);

C. The recipient's admission to an institution where he is ineligible for Medicaid services;

D. The recipient's address is unknown and mail directed to him has no forwarding address; or

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

LIBERTY will provide notice for all of the above circumstances. The notification and any documentation referring to the notification are housed in LIBERTY's information system in the member and/or authorization file.

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

LIBERTY will provide the Notice of Action on the date of action for all denials of payment.

3.12.4.7 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.

LIBERTY's service authorization supervisor and outreach staff closely work on all service authorizations, placing outreach calls to the provider and/or recipient in an effort to collect all pertinent information required to make timely decisions for both expedited and standard authorization requests. If a decision cannot be made within the required

timeframes, LIBERTY will provide a notice of denial on the day that the timeframe expires.

3.12.4.8 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.

LIBERTY will provide recipients with a written resolution notice and ensure that the notice includes the results of the process and the date that it was completed. In addition, our oral notification process includes a minimum of three oral notification attempts for each request. Written notifications are housed in LIBERTY's information system via PDF and oral notifications are housed in our MIS system attached to the member's authorization and/or claim.

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

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

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

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

Notices for appeals not resolved wholly in favor of the recipient will include the right to a State Fair Hearing, how to request a Fair Hearing, the right to receive benefits and how to request benefits while the hearing is pending. The notice will also include a statement explaining that the recipient may be held liable for the cost of those benefits if the hearing decision upholds the vendor's action.

3.12.5 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:

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

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

3.12.5.3 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.

A. 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.

B. 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.

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

A. 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;

B. Acknowledge receipt of each grievance and appeal;

C. 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

D. 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:

1. An appeal of a denial that is based on medical necessity;
2. A grievance regarding the denial of an expedited resolution of an appeal; or
3. A grievance or appeal that involves clinical issues.

3.12.5.5 The process for appeals also requires:

A. 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;

B. 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;

C. 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

D. 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.

3.12.5.6 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:

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

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

C. 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.

3.12.5.7 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.

3.12.5.8 The vendor is required to maintain records of grievances and appeals, which

the DHCFP will review as part of the Division's quality strategy.

3.12.5.9 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.

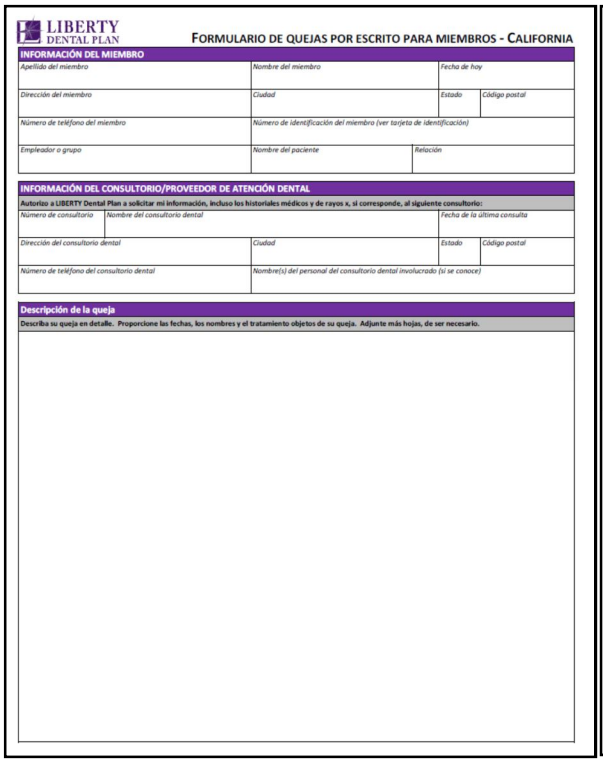
LIBERTY's current grievance and appeals processes and resolution timelines align with the requirements of the DHCFP. LIBERTY resolves all grievances as expeditiously as the member's condition requires, or within 30 calendar days, which is well within DHCFP's requirement of "90 calendar days from the date of receipt of the grievance." LIBERTY will resolve all Nevada Medicaid member appeals within "30 calendar days from the date of receipt of the appeal" in compliance with the contract requirements.

Assistance for Members

LIBERTY's Member Services Representatives are trained to not only appropriately resolve minor concerns for members, but also to offer the grievance and/or appeal process when it is the most appropriate recourse. This includes offering assistance in the grievance/appeal filing process, as well as educating members on language assistance and other services that are available to them, free of charge.

LIBERTY makes all member resources available in established threshold languages. As shown in Figure 3.12.5-1, all grievance and appeals forms are available in English and Spanish on our member website, and there are also instructions in multiple languages on how to access language services in many other languages. For example, if due to a language barrier, a member experiences difficulty in expressing the nature of their complaint or grievance on the phone, LIBERTY's MSRs are trained to engage the services of a language vendor who can assist. Language assistance services include assisting members in expressing their grievances verbally in addition to providing instruction on completing a grievance form or letter if they choose to submit their concerns in writing. LIBERTY will also provide assistance for alternative formats, such as TTY/TTD services.

FIGURE 3.12.5-1. EXAMPLES OF OUR GRIEVANCE FORMS AVAILABLE IN ADDITIONAL LANGUAGES



LIBERTY DENTAL PLAN

FORMULARIO DE QUEJAS POR ESCRITO PARA MIEMBROS - CALIFORNIA

INFORMACIÓN DEL MIEMBRO

Apellido del miembro	Nombre del miembro	Fecha de hoy	
Dirección del miembro	Ciudad	Estado	Código postal
Número de teléfono del miembro	Número de identificación del miembro (ver tarjeta de identificación)		
Empleador o grupo	Nombre del paciente	Relación	

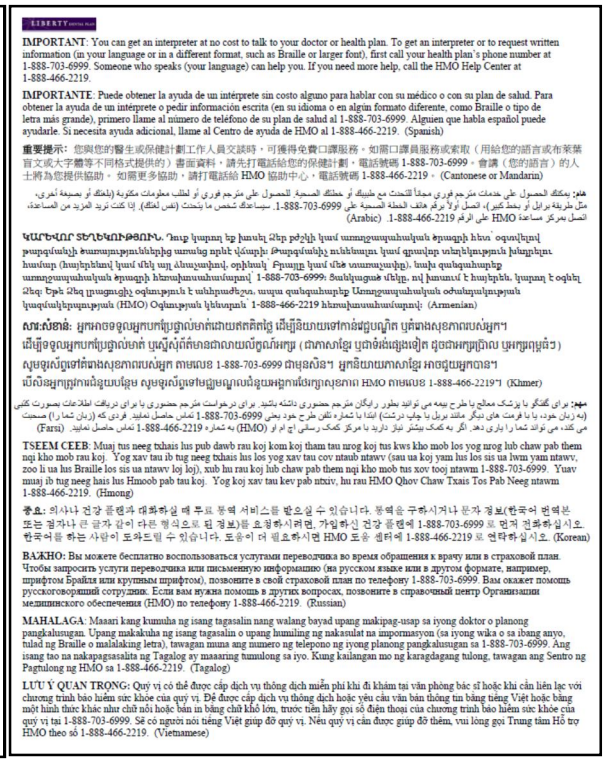
INFORMACIÓN DEL CONSULTORIO/PROVEEDOR DE ATENCIÓN DENTAL

Autorizo a LIBERTY Dental Plan a solicitar mi información, incluso los historiales médicos y de rayos x, si corresponde, al siguiente consultorio:

Número de consultorio	Nombre del consultorio dental	Fecha de la última consulta	
Dirección del consultorio dental	Ciudad	Estado	Código postal
Número de teléfono del consultorio dental	Nombre(s) del personal del consultorio dental involucrado (si se conoce)		

Descripción de la queja

Describa su queja en detalle. Proporcione las fechas, los nombres y el tratamiento objetos de su queja. Adjunte más hojas, de ser necesario.



IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health plan. To get an interpreter or to request written information (in your language or in a different format, such as Braille or larger font), first call your health plan's phone number at 1-888-703-6999. Someone who speaks (your language) can help you. If you need more help, call the HMO Help Center at 1-888-466-2219.

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su plan de salud. Para obtener la ayuda de un intérprete o pedir información escrita (en su idioma o en algún formato diferente, como Braille o tipo de letra más grande), primero llame al número de teléfono de su plan de salud al 1-888-703-6999. Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame al Centro de ayuda de HMO al 1-888-466-2219. (Spanish)

重要提示：您與您的醫生或保健計劃工作人員交談時，可獲得免費口譯服務。如需口譯員服務或索取（用給您的語言或布萊葉盲文或大字體等不同格式提供的）書面資料，請先打電話給您的保健計劃。電話號碼 1-888-703-6999。會講（您的語言）的人士將為您提供協助。如需更多協助，請打電話給 HMO 協助中心，電話號碼 1-888-466-2219。 (Cantonese or Mandarin)

هام: يمكنك الحصول على خدمات مترجم فوري مجاناً للتحدث مع طبيبك أو خطتك الصحية للحصول على مترجم فوري أو لطلب معلومات مكتوبة (بلغتك أو بصيغة أخرى، مثل طريقة برايل أو بخط كبير)، اتصل أولاً برقم هاتف الخطة الصحية على 1-888-703-6999. سيساعدك شخص ما يتحدث (نفس لغتك). إذا كنت تريد المزيد من المساعدة، اتصل بمركز مساعدة HMO على الرقم 1-888-466-2219. (Arabic)

ԿԱՐԵՎՈՐ ՏԵՂԵԿՈՒԹՅՈՒՆ. Դուք կարող եք խոսել ձեր բժշկի կամ առողջապահական ծրագրի հետ՝ օգտվելով թարգմանի ծառայություններից առանց որևէ գնի: Թարգմանիչ ունենալու կամ գրավոր տեղեկության խնդրելու համար (հայերենով կամ մեկ այլ ձևաչափով, օրինակ՝ Բրայլը կամ մեծ տառաչափը), նախ զանգահարեք առողջապահական ծրագրի հեռախոսահամարով՝ 1-888-703-6999: Ցանկացած մեկը, ով խոսում է հայերեն, կարող է օգնել Ձեզ: Եթե Ձեզ լրացուցիչ օգնություն է անհրաժեշտ, ապա զանգահարեք Առողջապահական օժանդակության կազմակերպության (HMO) Օգնության կենտրոն՝ 1-888-466-2219 հեռախոսահամարով: (Armenian)

សារៈសំខាន់: អ្នកអាចទទួលអ្នកបកប្រែផ្ទាល់មាត់ដោយឥតគិតថ្លៃ ដើម្បីនិយាយទៅកាន់វេជ្ជបណ្ឌិត ឬគម្រោងសុខភាពរបស់អ្នក។ ដើម្បីទទួលអ្នកបកប្រែផ្ទាល់មាត់ ឬស្នើសុំព័ត៌មានជាលាយលក្ខណ៍អក្សរ (ជាភាសាខ្មែរ ឬជាទម្រង់ផ្សេងទៀត ដូចជាអក្សរប្រ៊ីលី ឬអក្សរធំជាដើម) សូមទូរស័ព្ទទៅតាមលេខសុខភាពរបស់អ្នក តាមលេខ 1-888-703-6999 ជាមុនសិន។ អ្នកនិយាយភាសាខ្មែរ អាចជួយអ្នកបាន។ បើសិនអ្នកត្រូវការជំនួយបន្ថែម សូមទូរស័ព្ទទៅមជ្ឈមណ្ឌលជំនួយអង្គការសហព្យាសុខភាព HMO តាមលេខ 1-888-466-2219។ (Khmer)

مهم: برای گفتگو با پزشک معالج یا طرح بیمه می توانید بطور رایگان مترجم حضوری داشته باشید. برای درخواست مترجم حضوری یا برای دریافت اطلاعات بصورت کتبی (به زبان خود، یا با فرمت های دیگر مانند بریل یا چاپ درشت) ابتدا با شماره تلفن طرح خود یعنی 1-888-703-6999 تماس حاصل نمایید. فردی که (زبان شما را) صحبت می کند، می تواند شما را یاری دهد. اگر به کمک بیشتر نیاز دارید با مرکز کمک رسانی اچ ام او (HMO) به شماره 1-888-466-2219 تماس حاصل نمایید. (Farsi)

TSEEM CEEB: Muaj tus neeg txhais lus pub dawb rau koj kom koj tham tau nrog koj tus kws kho mob los yog nrog lub chaw pab them nqi kho mob rau koj. Yog xav tau ib tug neeg txhais lus los yog xav tau cov ntaub ntawv (sau ua koj yam lus los sis ua lwm yam ntawv, zoo li ua lus Braille los sis ua ntawv loj loj), xub hu rau koj lub chaw pab them nqi kho mob tus xov tooj ntawm 1-888-703-6999. Tuav muaj ib tug neeg hais lus Hmoob pab tau koj. Yog koj xav tau kev pab ntxiv, hu rau HMO Qhov Chaw Txais Tos Pab Neeg ntawm 1-888-466-2219. (Hmong)

중요: 의사나 건강 플랜과 대화하실 때 무료 통역 서비스를 받으실 수 있습니다. 통역을 구하시거나 문자 정보(한국어 번역본 또는 점자나 큰 글자 같이 다른 형식으로 된 정보)를 요청하시려면, 가입하신 건강 플랜에 1-888-703-6999 로 먼저 전화하십시오. 한국어를 하는 사람이 도와드릴 수 있습니다. 도움이 더 필요하시면 HMO 도움 센터에 1-888-466-2219 로 연락하십시오. (Korean)

ВАЖНО: Вы можете бесплатно воспользоваться услугами переводчика во время обращения к врачу или в страховой план. Чтобы запросить услуги переводчика или письменную информацию (на русском языке или в другом формате, например, шрифтом Брайля или крупным шрифтом), позвоните в свой страховой план по телефону 1-888-703-6999. Вам окажет помощь русскоговорящий сотрудник. Если вам нужна помощь в других вопросах, позвоните в справочный центр Организации медицинского обеспечения (HMO) по телефону 1-888-466-2219. (Russian)

MAHALAGA: Maaari kang kumuha ng isang tagasalin nang walang bayad upang makipag-usap sa iyong doktor o planong pangkalusugan. Upang makakuha ng isang tagasalin o upang humiling ng naksulat na impormasyon (sa iyong wika o sa ibang anyo, tulad ng Braille o malalaking letra), tawagan muna ang numero ng telepono ng iyong planong pangkalusugan sa 1-888-703-6999. Ang isang tao na nakapagsasalita ng Tagalog ay maaaring tumulong sa iyo. Kung kailangan mo ng karagdagang tulong, tawagan ang Sentro ng Pagtulong ng HMO sa 1-888-466-2219. (Tagalog)

LƯU Ý QUAN TRỌNG: Quý vị có thể được cấp dịch vụ thông dịch miễn phí khi đi khám tại văn phòng bác sĩ hoặc khi cần liên lạc với chương trình bảo hiểm sức khỏe của quý vị. Để được cấp dịch vụ thông dịch hoặc yêu cầu văn bản thông tin bằng tiếng Việt hoặc bằng một hình thức khác như chữ nổi hoặc bản in bằng chữ khổ lớn, trước tiên hãy gọi số điện thoại của chương trình bảo hiểm sức khỏe của quý vị tại 1-888-703-6999. Sẽ có người nói tiếng Việt giúp đỡ quý vị. Nếu quý vị cần được giúp đỡ thêm, vui lòng gọi Trung tâm Hỗ trợ HMO theo số 1-888-466-2219. (Vietnamese)

In addition to training on identifying and documenting member grievances, MSRs receive special training on cultural sensitivity and linguistic needs. These factors will be taken into consideration when assisting members who require special attention. LIBERTY's Health Education and Cultural Competency program is a constantly growing initiative designed to promote and monitor, among other measures, the fair and equal provision of services, printed materials and other communication that takes into consideration a member's preferred language. LIBERTY has identified a list of documents that are considered "vital" and are to be automatically provided to beneficiaries if LIBERTY has record of their linguistic preference. It is LIBERTY's goal to never let a member's cultural or linguistic requirements or special needs be a barrier to accessing the same services or rights LIBERTY offers to all our beneficiaries.

Handling Grievances and Appeals

At the time a grievance is logged, LIBERTY automatically generates records request letters, which are then faxed and/or mailed to all dental providers named in the grievance. Once the records request has been generated, the case is assigned to a Grievance Analyst. LIBERTY ensures that all individuals who make decisions on grievances and appeals are not involved in any previous review or decision about the

action. All dentist reviewers who decide an appeal of a denial based on dental necessity (or lack thereof), or render any determination that involves review of a clinical nature, have the appropriate expertise in treating the member's condition or disease, and will also have not contributed to any previous plan decisions or grievances relating to the subject of the member's dissatisfaction.

If a grievance, or a member appeal, involves anything clinical in nature, or a determination based wholly or in part on dental necessity, the Grievance Analyst will route the case to a Dental Director or Dental Consultant to issue a determination on the clinical matter. Once this clinical determination is returned, the Grievance Analyst will compose a thorough resolution letter in language that is easily understandable. We will aim to resolve all Nevada Medicaid member grievances and appeals as expeditiously as the member's condition requires, however, no later than 30 calendar days from receipt.

Appeals Process

All oral appeal inquiries will be logged by our Member Service Representatives and transferred to our Grievance and Appeals Department. We will inform members of their right to present evidence and review the case files.

Tracking and Reporting

LIBERTY will provide tracking and reporting of all appeals and grievances to DHCFP.

Quality Improvement

Grievances and appeals are reported internally to various Quality Management (QM) Committees and, ultimately, to our Board of Directors. The most common types of grievances involve the situation when a provider does not administer the member's plan correctly, charges in excess of allowed amounts, or incorrectly advise members on their covered benefits. In these cases, we may impose a corrective action, such as ordering the provider to issue a refund to the member or to LIBERTY. We also will engage the Provider Relations staff to educate the provider on the issue identified. If we recognize a grievance trend within our provider network, we will work with Provider Relations to develop educational materials, such as provider bulletins or newsletters. In the case that a grievance is filed against a LIBERTY staff member, we will conduct one-on-one focused education with the staff member to improve the quality of interaction they are having with the member and to resolve member grievances. When grievance data is linked to LIBERTY's staff communicating inaccurate information to our members, we use it as an educational opportunity to better train our staff and minimize the likelihood of a recurrence.

Member grievances that are resolved unfavorably against a provider are referred to our Potential Quality Issues ("PQI") Committee. The PQI Committee consists of representatives from our Quality Management ("QM") and Provider Relations departments, as well as clinical staff. The PQI Committee reviews cases in detail on a monthly basis and determines whether each case is a quality issue related to the treatment provided to the member or represents a systemic issue with the specific provider. In these instances, LIBERTY will take corrective action, which may include holding the provider responsible for the full cost to have the member's treatment completed by another provider. Providers receiving multiple PQI's are subject to additional corrective action, including suspension of new enrollments and/or termination from the network. All PQIs are tracked and trended and are reviewed by the Committee quarterly.

3.12.6 State Fair Hearing Process

3.12.6.1 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.

3.12.6.2 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).

3.12.6.3The 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.)

Our grievance and appeals process is a documented set of rules that encompasses researching, resolving and responding to member grievances and appeals, including expedited review of urgent grievances and facilitation of the state fair hearing process for members wishing to escalate their grievances. Among the "Member Rights and Responsibilities" in the Member Handbook will be instructions on how to request a State Fair Hearing. We also include information on how to request a State Fair Hearing on our website and on our member portal. LIBERTY will participate in all State Fair Hearings at our own expense and recognizes that we are bound by the decision of the Fair Hearing Officer.

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

3.12.7.1 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:

A. 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;

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

C. The services were ordered by an authorized provider;

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

E. The recipient requests an extension of benefits.

3.12.7.2 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:

A. The recipient withdraws the appeal;

B. 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;

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

D. The time period of service limits of a previously authorized service has been met.

3.12.7.3 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).

3.12.7.4 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.

We will formally document policies and procedures that comply with the required provisions and continue benefits during the appeals and State Fair Hearing Process in compliance with these requirements. LIBERTY acknowledges that if the State Fair Hearing Officer reverses a decision to deny authorization of services, and the recipient

received the disputed services while the appeal was pending, LIBERTY must pay for those services.

3.12.8 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.

3.12.8.1 General Requirements

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

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

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

3.12.8.2 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:

A. Denial or limited authorization of a requested service;

B. Reduction, suspension or termination of a previously authorized service;

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

D. Demand for recoupment;

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

F. The denial for disenrollment for good cause.

We will provide a fast, fair, and cost-effective provider dispute resolution process whereby providers can dispute decisions made by LIBERTY to deny or modify any requested service. We will seek written approval of all our written provider grievance and appeals policies and procedures upon implementation and following implementation whenever our policies and procedures are updated.

We will educate providers on their right to access the provider grievance system and State Fair Hearing process through multiple means. LIBERTY's Nevada Medicaid provider network will receive live, in-person training, and regular written communication advising them of their right to access the provider grievance process. We will review the provider complaint and grievance submission process with providers during initial orientation. Additionally, information on the process can be found on our website and on iTransact, our Provider Portal. Providers may also request hard copy instructions on submitting a complaint at any time, which also includes informal "inquiries". In the case of these provider inquiries, LIBERTY's Provider Relations team will be available to assist providers in a variety of areas. The provider will have access to their assigned Network Manager via phone, email, and regular mail to express concerns or file a complaint. When the provider is clearly appealing an adverse determination or a complaint that requires a more thorough investigation, providers are directed to submit their grievances in writing to LIBERTY's Grievance and Appeals Department. For out-of-network providers, we provide information on inquiries and grievances consistent with our network providers.

LIBERTY experiences a relatively small amount of provider appeals. Thus far in 2016, we have handled an average of 4 provider appeals per month in our California Medicaid network with an average resolution time of 26 days. This modest volume is consistent with our efforts, as a dentist-owned organization, to operate in a manner that fully understands and successfully serves the needs of the dental provider community at the "front-end".

LIBERTY will process provider grievances and appeals with the same urgency and in a similar manner as member grievances and appeals. We ensure that all provider complaints and appeals are properly logged in a single source database followed by the issuance of a written acknowledgement letter to the provider. Each complaint, grievance, and appeal is reviewed in accordance with contractual requirements, guidelines, and all applicable state and federal regulatory requirements. Appeals cases will be assigned to a different reviewer than the one involved in the initial determination. We will resolve all provider complaints and appeals with a written determination to the provider within 30 calendar days of receipt. The Manager of Grievances/Appeals

oversees the receipt and processing of all provider complaints and appeals to ensure that each case is resolved in a timely manner.

To ensure timely processing of a payment when a claim is appealed and we overturn its initial denial, we have developed a highly collaborative process between departments that involves regular training and review, as well as accountability. Our Grievance and Appeals Department investigates the matter and issues a determination. The Claims Department reviews the resolution from the Grievance Department and processes or reprocesses the item in question. Depending on the outcome, LIBERTY's Finance Department will be called upon to either issue payment (or additional payment, including interest, when applicable), or possibly recover funds if a provider was paid incorrectly.

Our Evidence of Payment letters to providers will include our phone number, email address, and physical address. We also have the flexibility of customizing the letters for Nevada Medicaid. In addition, LIBERTY will have a member of our Grievance and Appeals team dedicated to receiving and processing provider grievances.

LIBERTY will issue a final decision within 90 days calendar days after the grievance is filed and within 30 days after an appeal is filed. Once a provider has exhausted LIBERTY's internal appeals process, we will notify the provider of their right to file a State Fair Hearing.

Submission of Provider Grievances

Providers can submit written and verbal inquiries and grievances through multiple avenues, including through their Network Manager, through the provider services hotline, or online through the provider portal. Tracking of provider grievances is performed by the Grievance and Appeal team working in conjunction with Provider Relations and our IT department. Providers receive a written acknowledgement letter within 5 calendar days. The acknowledgement letter is generally generated and mailed on the same day it is entered into our system. In Nevada, LIBERTY will apply a standard turnaround time of 30 days to respond in writing to provider complaints and appeals.

Tracking of Provider Grievances

LIBERTY will track all provider complaints and grievances in our core MIS application as well as through our manually maintained spreadsheets. These tools allow for custom reporting which is reviewed on an ongoing basis for trends or patterns by our Provider Relations and Grievance and Appeal Departments. Provider complaint, grievance, and appeals outcomes will be tracked continuously and reported to the Quality Management and Improvement Committee on a quarterly basis. If a determination from a provider complaint demonstrates the need for additional counseling or follow-up

from the Provider Relations Department, the Grievance and Appeal Department will forward a request for follow-up to the provider's assigned Network Manager. The Network Manager will follow up with the provider, within 30 calendar days, to ensure the completion of any necessary training, counseling, or re-orientation. Upon the completion of the training, the Network Manager provides the Grievance and Appeals Department with a completed Provider Service Report (PSR) as supporting documentation. In addition, resolutions to provider grievances will be maintained in the MIS system where Provider Relations Department can review and upload the completed PSR forms after any necessary actions have been completed. We will review the provider complaint data to identify opportunities to decrease the number of denial decisions that are subsequently appealed and approved as part of the provider appeal process.

In California, we reduced the number of provider complaints by conducting internal licensed dental consultant clinical reviewer calibrations, focused training on internal processing guidelines, ongoing provider training by Network Managers, and through information shared in Provider Newsletters. As shown in Figure 3.12.8-1 the number of provider complaints has decreased by 27% in the last 12 months. Figure 3.12.8-2 demonstrates that over half of the provider disputes appeals indicate that our initial decision was correct.

FIGURE 3.12.8-1. THE DOWNWARD TREND OF LIBERTY PROVIDER COMPLAINTS IN CALIFORNIA THE LAST YEAR

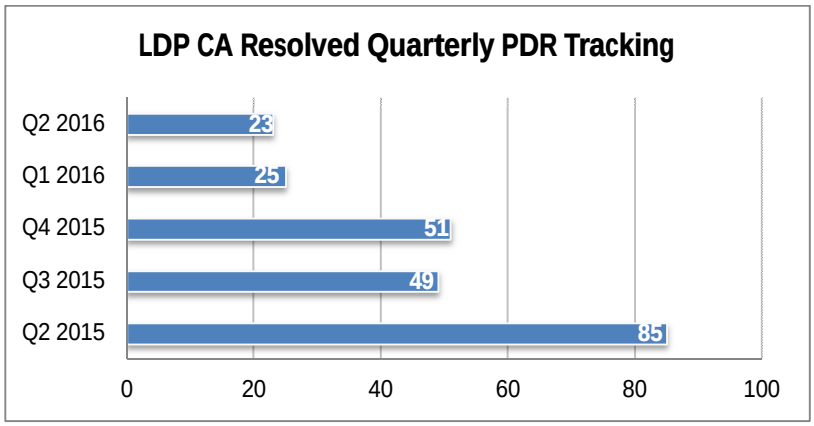
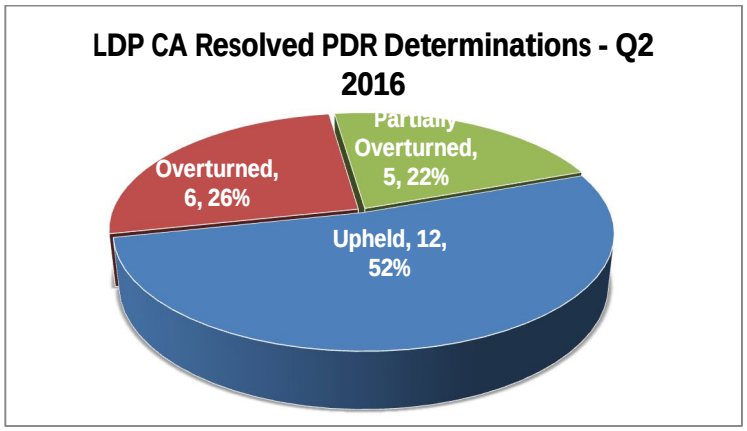


FIGURE 3.12.8-2. RESOLVED PROVIDER DISPUTE RESOLUTION (PDR) DETERMINATIONS IN Q2 2016



3.12.9 Expedited State Fair Hearing

3.12.9.1 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:

A. Meets the criteria for an expedited appeal process but was not resolved within the vendor's expedited appeal timeframes, or

B. Was resolved wholly or partially adversely using the vendor's expedited appeal timeframes.

3.12.9.2 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.

3.12.9.3 The vendor is bound by the decision of the Fair Hearing Officer and must comply with any decision resulting from the Fair Hearing process.

We have established policies and procedures that comply with State Fair Hearing requirements in many states, and can easily adopt the process, timeframes and requirements established by the DHCFP for State Fair Hearings and Expedited State Fair Hearings in Nevada.

3.13 MANAGEMENT INFORMATION SYSTEM (MIS)

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3.13 MANAGEMENT INFORMATION SYSTEM (MIS)

3.13.1 The vendor shall operate an MIS capable of maintaining, providing, documenting, and retaining information sufficient to substantiate and report vendor's compliance with the contract requirements.

LIBERTY Offers DHCFP a Strategic and Forward-Thinking Partner with Exceptional Systems Capabilities

Management Information Systems (MIS) and information technology (IT) infrastructure are at the core of LIBERTY's business operations and systems structure. Through our platforms and integrated solutions, LIBERTY offers the State of Nevada, Division of Health Care Financing and Policy (DHCFP) a seamless system that integrates payer-provider collaboration, claims and encounters processing and payment, fraud prevention, care management, eligibility and enrollment management, utilization and quality management, professional services, and member services.

In 2006, LIBERTY foresaw the need to build to capacity and to offer seamless integration to ultimately provide better care to our recipients and support our providers in transforming the way they deliver care. At this pivotal point, LIBERTY developed a strategic information technology plan for how it would support its business moving forward. Consequently, we migrated to a new MIS platform, which offers an integrated application to support business functions across our systems. Today, while all recommendations in the plan have been met, LIBERTY is constantly re-evaluating this system, determining if actions have resulted in their intended results, and measuring outcomes.

The transformed vision for IT at LIBERTY has allowed our business to grow from approximately 100,000 members 2006 to over 3 million members in 2016. During that time, we have built over 300 active benefit plans, and we now manage membership for approximately 10,000 groups. Approximately 75% of our membership is recipients in government programs (e.g., Medicaid, Medicare, CHIP, Dual Eligibles). We process approximately 190,000 claims each month for these recipients, and our data are available to our recipients, providers, and groups in real time through our various online portals.

General System Description

Our IT platform offers cutting edge solutions with innovative and configurable health benefit administration. MIS delivers a comprehensive system with a unified infrastructure that controls the whole process from start to finish. In the 10 years that LIBERTY has been on the MIS application suite, the system has gone through annual upgrades and releases to meet both our clients'—and LIBERTY's own—functionality needs. We constantly re-evaluate our core needs and current functionality, introducing additional

systems and applications to support our business and vision. Some recent results of these efforts include:

- ***Developing Claims Transforms – customizable XML that can be added to the core adjudication logic either for short term projects or for outlier detection for possible fraud, waste, and abuse.***
- ***Enhancing the workflow processes, including adding access to events or workflows within all core screens to allow for quicker call tracking and the routing of information between departments for follow-up.***
- ***Redesigning the database structure to optimize performance and scalability for both current and long term needs.***
- ***Streamlining claims, estimate, and referral processes, which has allowed us to increase our claims intake handling and processing without increasing the need for additional staff.***
- ***Creating an individual billing platform that has allowed us to enter the various state and federal exchanges.***
- ***Modifying Office, Provider, and Vendor Online Portals to provide more tools and access to electronic interfaces—in 2010 only 7% of claims submission came through the web, where today we are averaging 26%.***

In 2010, LIBERTY adopted the core MIS data warehouse, Medimart, which has allowed for expanded reporting capabilities and additional process automation. The application is now on SQL.NET platform that stores the data for all aspects of claims processing. Many applications that make up the MIS application suite share the same databases and image server that store the data, documents, and images. These include:

- ***Meditrac for claims, provider, group, and enrollment management. This also houses the tools to both build and manage the benefit plans, as well as the tools to help manage the claims processes.***
- ***HIPAA Gateway for transaction management of EDI file processing.***
- ***Uniflow for member services and workflow management.***
- ***MIS Administrator for application security management. It also houses the tools for transaction management for the non EDI files to import data through batch and automated processes.***
- ***Online Website and Portals for recipient and provider engagement.***
- ***Scanning Assistant for document and attachment scanning.***
- ***Medimart for data warehousing.***
- ***Perfect Claim for paper claim data capture.***

3.13.2 The vendor shall have an MIS capable of documenting administrative and clinical procedures while maintaining the privacy and confidentiality requirements pursuant to HIPAA. The vendor shall provide 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.

Documenting Administrative and Clinical Procedures

One of the components of our primary application allows LIBERTY to manage claims data. This includes claims processing, enrollment, benefit administration, Provider/Office information management (e.g., credentialing, contracting, assigned recipients, specialty, etc.), financial processing (including checking payments to providers and billing to groups/individuals), UM, reporting, and document storage. The mission of our claims processing department is not to beat industry standards on processing metrics, but rather to be a true partner to our clients and identify fraud, ensure proper and timely payment, and provide transparency. As such, LIBERTY's claims processing capabilities are very robust. Currently our auto adjudication rate is 67%, but this number is intentionally lower than it could be due to our efforts to conduct UM activities and Fraud, Waste, and Abuse (FWA) auditing review.

To ensure the highest level of accuracy possible with our claims, LIBERTY conducts random samplings from audit packages by both processors and by claims associated with Groups. If we were to loosen the adjudication rules, the system would auto adjudicate over 90% of claims. In 2016 to date, 99.9% of all claims received have a turnaround time of less than 20 days and 71% of claims are turned around in 5 days or less. Our MIS system allows for custom reports to be mapped to each group so that data can be pulled based on the relationship between the recipient and a specific group. These can be created using Crystal Reports and in our next release of the application SSRS reporting as well. We currently manage a library of almost 1,000 reports that have custom logic based on our client needs and branding requirements, and we can create additional reports for DHCFP if these do not meet DHCFP's needs. These are automatically created in batch processes, either when check runs are processed or by other means (for reports that are not tied to payments). We also have the ability to launch and create automated reports as part of the workflow process. Ninety-five percent of our reports have an OMR or barcode that allow delivery to our fulfillment department and auto-processing into a mail process. Users can also choose to have these documents delivered electronically through our online portal. Batch loads can be manually launched using the application or can be scheduled to run by the TASK Agent. Some examples of reports that are automated today are:

- ***Explanation of Benefits (EOB)***
- ***Referrals***
- ***Pre-Estimate***
- ***Recipient PCP Transfer letters***
- ***Term letters***
- ***Provider letters***
- ***Checks and supporting documents***

Claims adjudication rules can be updated by plan or by group specific rules through various modules and tools within MIS. We have the ability to add custom logic to our normal claims processing or for special projects in the form of transforms (XML code added to the adjudication process). During adjudication, LIBERTY's systems offer the flexibility to add rules driven by office or office and procedure code combinations and identify claims that contain certain combinations of procedures and route them for review if we determine these combinations to be used for FWA. These rules allow us to drill down to any level (recipient, office/provider, group, plan, line-of-business, or other data element stored in the system) and can be updated as DHCFP requires. It can also be used to direct claims during adjudication to be reviewed by specific users or business units.

This flexibility and the ease of making this level of changes has been very helpful in managing our contracts with State and Federal programs, including the State of Florida Department of Health, State of California Department of Health Care Services, State of New Jersey Department of Human Services, and State of Illinois Department of Human Services. These rules and detection methods have led to providers being put on corrective action plans. In the last three years, the State of California has awarded LIBERTY two other carriers' membership for plans that were not meeting requirements because the state knew that LIBERTY could manage the membership and their claims correctly. We were given two weeks to migrate the membership for both groups, which consisted of 10,000 to 30,000 recipients, into our system, and we did so smoothly with no interruption of service to the membership or claims processing. Our MIS applications and processes allowed us to easily configure the new groups and benefits and onboard the membership.

We also have additional tools available in the form of Service Restrictions that allow us to customize claims rules to stop claims for review due to business requirements. All these rules supplement what is already built into the various benefit plans. The benefit modules in MIS allow us to control how a claim will behave during the auto adjudication

process. This would include benefit frequencies, limitations, utilization rules, copays (recipient responsibilities), and other benefit information.

Maintaining Privacy and Confidentiality Requirements

LIBERTY utilizes industry best practices to ensure all PHI data are protected and secure across all platforms and communications, as well as to ensure our MIS maintains compliance with current and future versions of HIPAA Transaction and Code Set Requirements. Toward this end, we implement a number of third party audits and certifications, including:

- ***Penetration Testing—We use a third party company to conduct an annual mandatory penetration test. This test is an audit of external and internal networks to identify any system vulnerabilities and correct them. The results of this audit are available to DHCFP upon request.***
- ***Boeing Audit—We hired Boeing consultants to conduct an audit to further test protection and security of external and internal network against flaws, gaps, malicious software, etc. We were prepared to implement corrective actions where necessary. The Boeing test/audit results are also available to DHCFP upon request.***
- ***SSAE16 Audit—We conduct an annual review of our access controls, security, and HIPAA regulations to ensure compliance with industry standards.***
- ***HI-TRUST Certification—We are in the process of conducting the Self-Assessment. Upon completion, we will work on obtaining the yearly Hi-Trust Certification.***

We will use SFTP site to exchange information with DHCFP using 834 files. Additionally, all data will be encrypted at rest and in motion as per LIBERTY policy. We also have the ability to set up a TLS encrypted tunnel for site-to-site data transfers. As an added element of protection, we use PGP Encryption software, which prevents anyone from opening the data, even in the unlikely event of a leak or breach. All data will be transmitted and received in the appropriate standard formats (as described below), and the above-described safeguards adhere to regulations as directed by HIPAA, the ASC X12 TR3 Reports and MMIS guide specifications. We will also independently obtain and update all reference data.

Nevada's data will remain intact as they pass through security PGP decryption. LIBERTY utilizes HIPAA Gateway for integrity validation and reformatting from 834 into flat file extract and client data are transformed into an extract of the original file using a standard output. Client data remain sequestered thus far, but have been altered into a pre-defined format.

All MIS information will be made available to representatives authorized by Nevada or other federal and state agencies. We currently undergo at least one risk assessment a year that addresses all system, hardware, and physical security of the LIBERTY facilities. This is a full scan of all systems, and includes penetration testing. The risk assessment also reviews internal physical security and consists of a comprehensive review of our policies and procedures. Our client portal, iTransact, allows providers to look up Members, Claims Data, Utilization Data, and access reports. Nevada will be given "Read Only" access for their client-specific information. These controls are in place to maintain information integrity and include the periodic audits as described above.

Access Restrictions

MIS Administrator is the primary administration tool to control security within the MIS applications. It allows LIBERTY to setup security, access controls, and auditing or tracking. Since security is one of our top concerns, we are always reviewing our policies, procedures, and build to ensure we have the appropriate levels set and in place. The Security section in MIS houses the access restrictions by hierarchical level. The following levels can be maintained within MIS Administrator: users, roles, role permissions; security by individual; departments; and entity access.

Security

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- ***Users – This is where users are created and defined. This level includes Roles, Department, and other security options. Each user utilizes a unique username and password with options to control both the timeframe in which a password is valid and its complexity.***
- ***Roles – LIBERTY can define groups of users that share the same job functions.***
- ***Role Permissions – This is where individual permissions are attached to the various roles we have created. Currently there are over 3,000 permissions that can be set to ensure users only have access to the functionality and data that they should have.***
- ***Security By Individual – When permissions need to be unique down to the user level and roles do not meet the requirement, we can add permission to the individual.***
- ***Departments – Allows users to be managed by their department within their profile.***

- ***Entity Access – This allows for a specialized access to various group screens over and above what is controlled by the Role Permissions.***
- ***Audit Trail – Allows for tracking all users' footprints within the application. It tracks who users that were in the MIS application and all updates that were made.***

Aggregated Performance and Outcome Data

LIBERTY has various reporting tools within the MIS system to report or mine data that can be provided to the DHCFP. This includes all claim data provided from network providers. This data is used to measure performance of our providers. This data is managed by our Network Services and Utilization Management teams to ensure it is accurate, and to identify outliers or trends. This data is then used to evaluate our network, and possible CAP (Corrective Action Plans) on an office\provider. This data can be made available to our clients, and sent via a secure method. This is usually SFTP, but other methodology's can be discussed. We will work with DHCFP to define the requirements.

Audit Trails

Our core application that stores Recipient, Claims, Group, Provider, Vendor, and other related data keeps an audit trail for all transactions. It contains an auditing tool, "Audit Trail Viewer," that allows the IT Administration team to pull transactional updates for all users and track all changes at all times. The system also has various history screens throughout to view past information and to note which users performed the update(s).

Some of the historical information that users can view and track includes:

- ***Last updated and by whom***
- ***Provider assignment history***
- ***Recipient benefit history***
- ***ID Card requests***
- ***Recipient loads***
- ***Export tracking***
- ***Job History logs***

The history screens also allow the IT Administration Team to perform an audit trail by screen to identify who updated various field elements, or by "pull data by user" to identify updates performed by a specified user throughout the system. All IT systems have inherent functionality that prevents the alteration of finalized records through the above processes.

Validity and Consistency

We have proven processes in place to validate the integrity and compliance of eligibility, claim, encounters, providers, members and utilization data, which will allow

us to provide the DHCFP with accurate and timely submissions. A variety of validation methods are used to ensure we are in compliance with HIPAA transaction regulations. We require our providers to submit claims and encounters with appropriate CDT codes. Our system validates recipient data, provider data, authorization requirements, benefit applications and claims history.

3.13.3 Eligibility Data

3.13.3.1 The vendor enrollment system shall be capable of linking records for the same enrolled recipient that are associated with different Medicaid and/or Nevada Check Up identification numbers; e.g., recipients who are re-enrolled and assigned new numbers.

Our MIS system is capable of linking records for an enrolled member (recipient) who has different Medicaid identification numbers. Our system assigns its own unique identification number to each individual enrolled into our system. This allows us to recognize recipients who are simultaneously enrolled in more than one plan, members who are reinstated with a new identification number, or that have multiple simultaneous coverages based on various eligibility factors such as "duals" members who have both Medicaid and Medicare. Our system is flexible enough to allow the same person to be enrolled with more than one member number, yet sophisticated enough to recognize and track such members as the same individual. Our system can store and cross-reference multiple member-identifiers to ensure smooth interfaces between inbound and outbound file processes.

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

We strive to maintain current demographic information for all members including name, phone numbers, address, telephone number and email. We update information in our MIS system when we learn about changes to member demographic information. We have mechanisms in place to distinguish the source of updates and to report changes submitted by members back to DHCFP as part of a data reconciliation process. Such a process would be carefully coordinated with the client in order to maintain data integrity.

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

We will notify the DHCFP of member addresses that we believe are inaccurate in the manner and frequency requested by the DHCFP. Our data reconciliation process would is designed to identify discrepancies between the client-submitted data and our membership database, without regard to any member-reported changes. Moreover, if any addresses are deemed undeliverable by the USPS, our discrepancy report would include that as a non-deliverable address discrepancy.

3.13.4 Encounter and Claims Records

3.13.4.1 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.

3.13.4.2 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.

LIBERTY has over a decade of experience, managing approximately 2 million Medicaid recipients—both children and adults—and has the capability to meet various DHCFP program standards. We provide encounter data on either a weekly or a monthly basis for 80% of our clients' membership, and we commend DHCFP for examining encounter information and considering quality of care, not just quantity. LIBERTY fully complies with industry-accepted clean claim standards for all encounter data, including submission of complete and accurate data for all Medically Necessary Covered Services, including Value-Added Services, for all fields required on standard billing forms or electronic claim formats to support proper adjudication of a claim. We will work with DHCFP to ensure compliance with the established data reporting standards, particularly as it relates to complete and accurate encounter data submission.

Ensuring Accurate and Timely Encounter Data

LIBERTY has a robust Claims and Encounter System with strong analytical tools built into the Core Application System. Checks and balances are in place to ensure that the data entered are accurate, complete, and compliant with government, internal, and DHCFP standards. In 2016 to date, we have reported encounter data on approximately two

million recipients with 98% accuracy and timeliness, and will work with DHCFP to maintain this accuracy rate. Encounter data accuracy is one of our top priorities. We receive and review all 999, 277's, and other error reports and verify that all applicable errors are resolved and resubmitted within required timeframes.

Claims/Encounter Automated and Manual Review

Claims data are mined for encounter information, and in the event that there are data that are incorrect, no longer valid, or an element of a claim not identified as part of the original claim needs to be changed, LIBERTY can easily adjust the encounter claim immediately. Similarly, if DHCFP's requirements change, we are accustomed to working quickly to correct or update the file layout, systems, or processes to meet those needs. Most corrections are data related, not format related, and therefore do not require a layout update.

We maintain an internal audit team that reviews claims processing and adjudication rules to ensure claims are processed correctly. Prior to any new group going live, sample or test claims are processed to meet all the scenarios based on the plan. This is run through the adjudication and claims processing within our core application to ensure that once we promote the plan and group to production, all issues have been addressed. Once promoted to production, we continue to audit the claims. This includes, but is not limited to, group review, claims processor (to ensure adjustment accuracy), Lines of Business (LOB), and other packages that perform either random sampling or complete reviews. Reports are given to claims management for them to perform corrective action plans in the event unfavorable findings are found.

Provider Education

The encounter data that we collect from our providers and reports on are grouped into member characteristics, provider characteristics, and services furnished to members. We work with our providers to educate and train them on claims submission, which includes encounter data elements. We also work with our providers to accept claims via electronic submission and paper submission. LIBERTY has the ability to receive encounter data in all standardized formats (e.g., paper, EDI, Clearing House, FAX, Portals).

We monitor encounter data for completeness via our Management Information System. Our Utilization and Provider Relations teams work to identify offices that are either not submitting, or are under-submitting, their encounter data. We then implement outreach campaigns to have encounter data submitted in the required manner.

Every time a claim goes through the check process and the group is slated for 837D, an encounter submission record is created. In the HIPAA Gateway output screen, any

unsent records are shown. Once the 837D file is created, the file name and date are attached to the EDI tab of each individual claim so that you can see when they have been submitted. There are reports that show claims that do not have submissions. These are especially helpful when verifying that all claims have been sent out to DHCFP or troubleshooting issues.

For offices that have low utilization, Network Managers outreach to the practices and offer educational support and training. Our counseling sessions have anecdotally proven to be effective in engaging with providers and improving submission of accurate and complete claims and encounters. In the event that utilization rates do not improve after counseling sessions, we will stop new enrollment to the practice and may eventually terminate the office's contract.

3.13.5 Data Requirements and Certification

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

3.13.5.2 All encounter data must reflect all adjustments and voids.

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

3.13.5.4 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.

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

A. The vendor's Chief Executive Officer;

B. The vendor's Chief Financial Officer; or

C. 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.

3.13.5.6 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.

Our systems are highly flexible, allowing us to accommodate most data requests, including identifying different and specific data elements in the 837D or other encounter file formats that we send. We will work with DHCFP to develop a mutually agreeable method of delivering encounter data. All encounter data is stored in our MIS system, and tracks all adjustments of an encounter. Each file sent to DHCFP will be accurate and contain adjustments. Our system does not "Void" a claim, it would be adjusted based on the current information at processing. In the event an encounter was processed incorrectly, it would be adjusted and reprocessed. That data would then be submitted to DHCFP in the encounter file.

Timeliness is our other top priority when it comes to encounter data. All encounter data reporting needs will be recorded in our compliance database to ensure timely submission. Our compliance database alerts us to all report due dates and sends reminders until the report is submitted and a copy is uploaded to the system. Report submission timeliness is reviewed on a monthly basis and corrective actions are taken, if necessary. Our system flags all encounter data submitted through the 837 process as sent once it is output to file. Subsequent files only pull claims data that is not marked as sent. For custom or flat files submissions, data are generated by paid date, and prior to sending files to clients, they are audited to ensure the proper date ranges. We have internal controls to ensure that all data are loaded and processed in our MIS database, to include claims inventory reports, aging reports, checks or financial reports, and other controls within the system to cross balance the encounter data.

We are able to handle the fully compliant HIPAA 5010 837D transaction set, and that can be customized to meet the requirements provided. Our software (HIPAA Gateway) is extremely customizable and can format the standard 837D to meet a variety of compliance requirements. These data include, but are not limited to, applicable member, provider, claim, and payment details. We can also provide other file submission layouts (CSV, ASCII, TXT, Fix Width, or other) in the event they are required by to DHCFP

their encounter or other reporting requirements. We currently send these formats to other clients upon their request. LIBERTY prides itself on its flexibility and responsiveness in meeting our clients' needs, and we can provide custom layouts upon request.

Validation

All of our files are run through EDIFECS for validation and can also test with other validation tools (e.g., state compliance tool). There are data integrity checks in place to prevent non-compliant data from entering into the system. These integrity checks include CPT procedure codes and HIPAA Claim Adjustment Reason Codes (CARCs). CPT and CARC codes are reviewed and updated at least annually. We can also accept

DHCFP's layout and work to meet your requirements. We understand that statutes and regulations are ever changing, and will work with DHCFP to meet your current and future needs.

We will provide all processed versions of a claim to DHCFP, including first time and adjustments (for any reason) within the encounter file. This includes financial information that meets your reporting requirements. HIPAA 837D has a flag to show if a claim is an original claim or if it is a replacement. Every time a claim goes through the payment process and that group is slated for 837D, a record is created in HIPAA Gateway that will be picked up on the next 837D run, which can occur weekly or monthly, depending on volume. LIBERTY's standard CSV claim export also sends adjustments, as it is based on check data as well. Other formats could include this information if requested.

We maintain an internal audit team that reviews claims processing and adjudication rules to ensure claims are processed correctly. Prior to any new group going live, sample or test claims are processed to meet all the scenarios based on the plan. This is run through the adjudication and claims processing within or core application. This ensures once we promote the plan and group to Production, that all issues have been addressed. Once promoted to Production we continue to audit the claims. This includes but not limited to, group review, claims processor (to ensure adjustment accuracy), Lines of Business (LOB), and other packages the either random sampling or complete reviews are done. Reports are given to claims management for them to do correct action plans in the event unfavorable finding are found.

We understand that HIPAA compliant files need to contain an NPI to be compliant. As part of our network recruitment process, this is one of the required elements to becoming an active provider in our system. In the event of an "Out of Network" provider being utilize for treatment, the claim would be denied and sent to DHCFP in the encounter file (Unless OON benefits apply) and we would reach out to provider to get an NPI.

We are capable and willing to submit the encounter file on a weekly or monthly basis. We can meet the two (2) day submission schedule without issue. We maintain the life cycle of all its applications to ensure we are compliant with current and future regulatory requirements. We also work with our business partners to enhance our systems we necessary to meet client specific needs as well.

3.13.6 EPSDT Tracking System

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

Our system currently tracks EPSDT activities overall, by region, by county, by city, by zip code and for each Medicaid eligible child by name and Medicaid identification number for our other Medicaid programs. The system runs CMS-416 (measures 12a – 12f) and HEDIS® Annual Dental Visit (ADV) reports for custom specified timeframes to track utilization of EPSDT services for all of our state Medicaid programs, and will do the same for the State of Nevada. We currently provide this information to our other Medicaid clients on a monthly or quarterly basis, and examples of the output reports and our experience tracking EPSDT services are below. LIBERTY compares these reports to local and nationwide statistics as well as previous years' statistics to measure effectiveness of current programs, to ensure services are delivered within established timeframes, to identify opportunities to improve current programs, and to identify opportunities for future programs. Members who are identified as not having received services within established timeframes are contacted via our outbound call campaigns, text messaging, and the additional EPSDT outreach programs listed throughout this proposal, specifically in section 3.3.4.

3.14 OPERATIONAL REQUIREMENTS

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3.14 OPERATIONAL REQUIREMENTS

3.14.1 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.

We will employ a Dental Director licensed to practice dentistry in the State of Nevada. Our Dental Director will be located at our office in Las Vegas, and will provide regional expertise to support the oversight of our robust Internal Quality Assurance Program (IQAP). The Dental Director will also be responsible for all aspects of that program including IQAP Committee and IQAP Sub-Committees, grievances and appeals, access and availability, Potential Quality Issues (PQI), Utilization Management, and Utilization Review. All Dental Services staff located in the Las Vegas office will have access to the Dental Director for clinical decision making. Ultimately, our Dental Director, Utilization Management program, and IQAP Committee are accountable to LIBERTY's Board of Directors.

LIBERTY currently administers dental in Nevada with over 64,000 members and 1,339 providers, and we are familiar with Nevada's diverse population and unique needs. LIBERTY has a Medicaid presence in 6 states, and as a result, employs many licensed Dental Directors and Dental Consultants who, combined, have well over 150 years of Medicaid experience either in dental practice or dental plan administration. Our Dental Directors and Dental Consultants work collaboratively to identify trends and address needs in each state. In addition to routine daily contact, LIBERTY conducts monthly Quality Management/Utilization Management meetings for each state where we have a Medicaid presence, in which all Dental Directors participate and gain exposure and knowledge about state-specific and/or nationwide trends in Medicaid markets.

3.14.2 The responsibilities of the Dental Director include the following:

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

3.14.2.2 Directs the development and implementation of the vendor's Internal Quality Assurance Plan (IQAP) and utilization management activities and monitoring the quality of care that vendor' recipients receive;

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

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

The Dental Director will serve as the Chair to the Utilization Management and Quality Assurance Plan Committees. In that role, our Dental Director will lead and direct the QM and IQAP activities not only at the Committee level, but also in terms of day to day operations. As with our Medicaid operations across the country, our Nevada Dental Director will be available to our staff for clinical decision making and advice concerning several aspects of the plan operation, including Utilization and Quality Management. LIBERTY's Dental Director is tasked with the ongoing development of our clinical care guidelines and practice standards and will oversee all potential quality of care problems.

3.14.2.5 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;

We understand the value of clear and comprehensive clinical care guidelines and practice standards. LIBERTY's guidelines and practice standards are the culmination of several years of industry experience combined with local market knowledge. Because LIBERTY is currently operating in the Nevada commercial market, our clinical care guidelines and practice standards are developed not only to be consistent with nationally recognized standards of dental care but also sensitive to any specific requirements in Nevada. LIBERTY's Dental Director is tasked with the ongoing development of our clinical care guidelines and practice standards. On an annual basis, our Peer Review Committee conducts a thorough review of our clinical care guidelines and practice standards to ensure they remain current.

3.14.2 6 Oversees the vendor's provider recruitment and credentialing activities;

LIBERTY's Dental Director is responsible for the oversight of the provider recruitment and credentialing processes. He/she is engaged in the recruitment goal setting, ensuring we are meeting provider access and availability standards in Nevada, as well as

geographic needs. LIBERTY's experienced credentialing department is located in Irvine, California and performs NCQA level credentialing. The Credentialing team relies on the leadership of our Dental Directors throughout the country. Our Nevada Dental Director will provide similar oversight of the initial credentialing and recredentialing activities for Nevada providers.

3.14.2.7 Serves as a liaison between the vendor and its providers, communicating regularly with the vendor's providers, including oversight of provider education, in-service training and orientation;

Through initial orientation, routine periodic newsletters, our online provider portal, our ongoing educational opportunities, and frequent Fax Blasts, LIBERTY maintains an ongoing two-way line of communication with our providers. Our online provider portal contains continuing education courses on various topics for our providers to access. Our Dental Directors participate in the creation and ongoing development of the material and language used in provider orientation and any in-service training needed.

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

LIBERTY's Nevada Dental Director will be available for consultation through phone or email for LIBERTY's dentist and non-dentist staff as well as our network providers for assistance with or questions about referrals, denials, grievances and any other problems that require clinical expertise.

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

Coordination of Out-of-Network Services

The Nevada Dental Director will oversee all coordination of out-of-network services processed by our Internal Response Unit (IRU).

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

LIBERTY's Dental Director will be the designated liaison to work with DHCFP regarding utilization review and quality assurance issues.

3.14.3 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:

3.14.3.1 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.

We understand and will comply with the requirements of section 3.14.3.1.

Proposed Staffing Plan

In order to provide comprehensive dental services to the State of Nevada Medicaid recipients, LIBERTY has created a customized staffing plan to ensure that we have staffing levels ready to provide these services. We operate from a community-based approach that leverages existing relationships and programs and builds on local expertise. LIBERTY believes in "thinking globally and acting locally" when designing our staffing plan for the State of Nevada.

LIBERTY is proud of the local Nevada workforce we have built, which is comprised of talented, highly qualified individuals who carry out our mission of making a lasting difference in our members' lives by improving their health and well-being. Since LIBERTY's member populations represent a wide variety of demographic backgrounds, health and socioeconomic needs, and psychosocial challenges, staffing profiles and plans have been developed to support a diverse population.

To maintain staffing levels, we draw upon our expertise in technology and utilize the latest social media platforms to simultaneously reach out to large numbers of potentially qualified candidates who fit our position demographics. This approach is particularly important for the customer support positions that do not frequent job fairs or post resumes. Instead, LIBERTY is able to contact this targeted audience through Facebook, blogs, Twitter, LinkedIn, and at local schools and businesses. Our approach of "One Click Applying" increases the response rate and the pool of qualified candidates for each position.

We also understand the importance of hiring locally from a base of seasoned local management who is familiar with the state's regional differences. By hiring local and using existing Nevada employees who are already familiar with Medicaid business and the nuances of the State of Nevada,, our staff becomes a powerful resource that maximizes operational efficiency and minimizes start-up time.

Assuming the growth in membership predicted in the RFP, we project that we will hire additional employees for the program, the majority of whom will be located in our Nevada office.

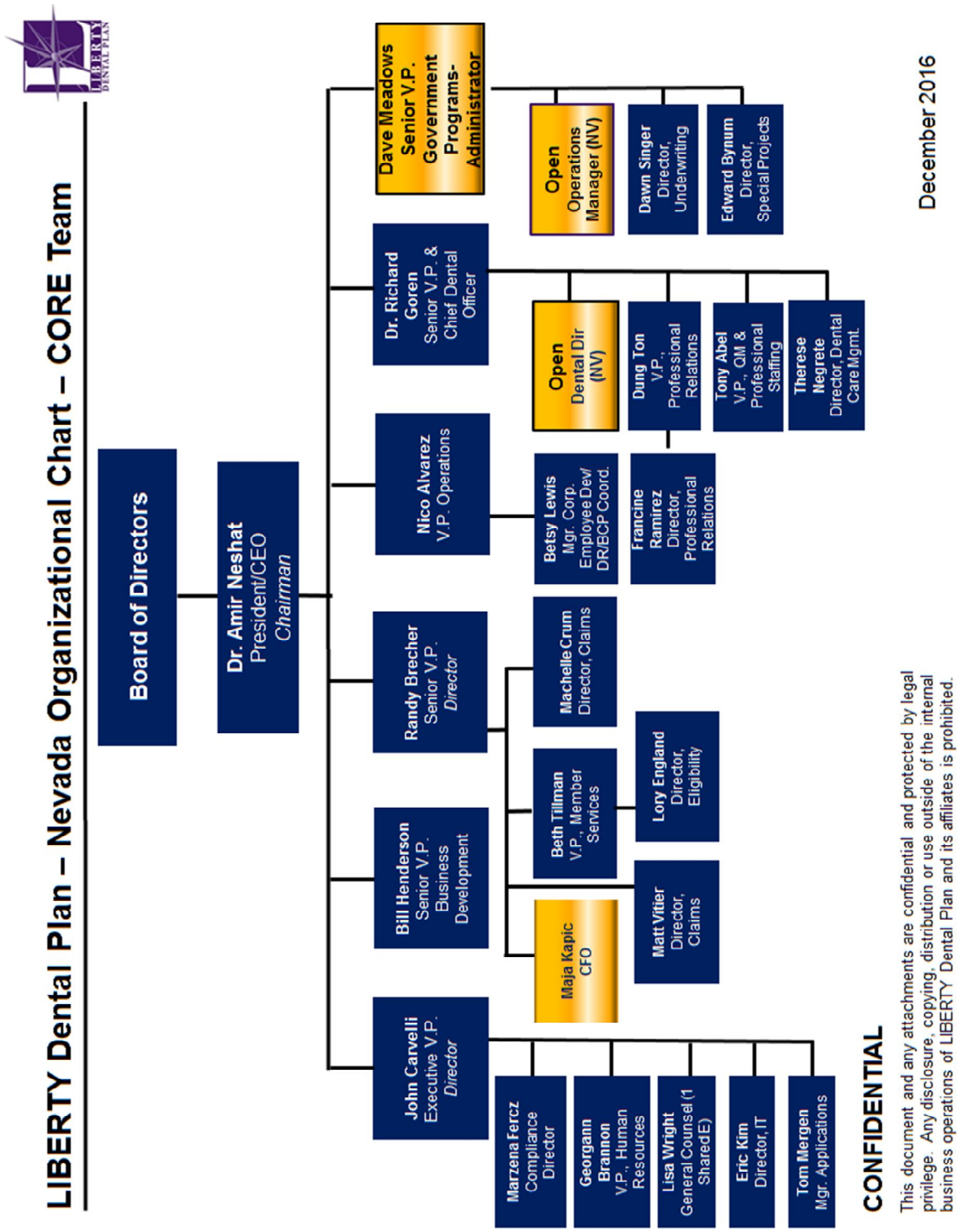
LIBERTY thrives in a dynamic environment and expansion and growth has been the cornerstone of expanding our mission to serve more recipients. We are experienced in hiring and onboarding large numbers of new staff to maintain the needed staffing levels of our operations. Developing a qualified workforce to serve the Nevada population will be a top priority of implementation which we will achieve through our expertise and proven processes.

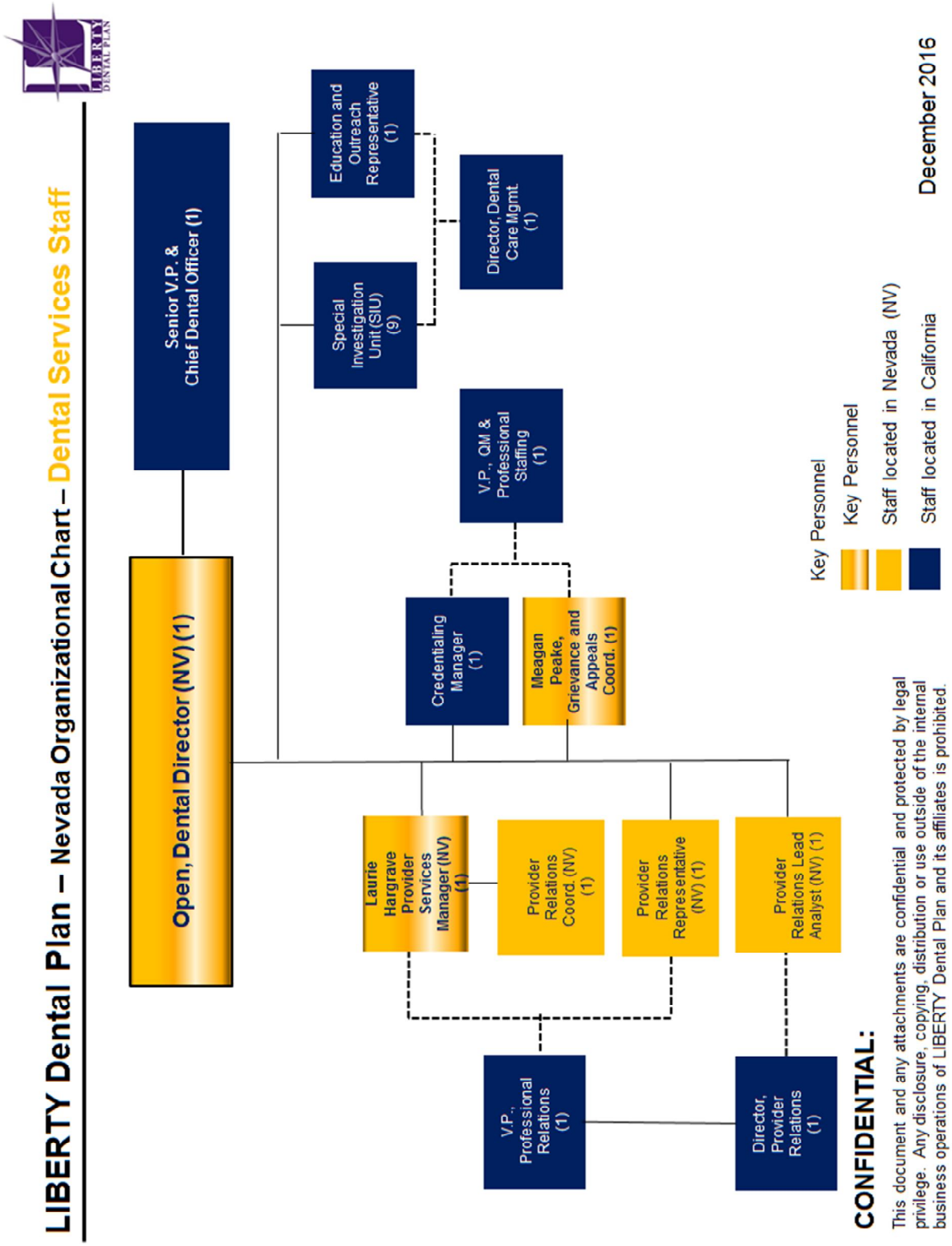
An important component of our staffing and screening process includes an exhaustive pre-employment background check that includes E-Verify to ensure that all staff is authorized to render services under the law in Nevada. Additionally, our background check reviews criminal, civil, OIG, and SAM's requirements and ensures that each candidate is legally authorized to render services in Nevada and is not debarred or suspended before he or she can move forward in the hiring process. We run a monthly OIG/SAM's report on existing personnel to confirm that the standards are maintained throughout the tenure of all employees and contingent staff.

We will provide to DHCP an updated organizational chart every six months or whenever a significant change in the organization occurs. The organizational chart depicts each functional unit of the organization, number of types of staff and each function with lines of authority governing the interaction of staff. The organizational chart identifies key personnel and senior-level management staff and clearly delineates lines of authority over all functions involved in this contract. The names of key personnel are in the organizational chart. We understand that DHCFP reserves the right to require the removal of any recipient of our key staff from the project.

Following in Figure 3.14.2-1 is our organization chart:

FIGURE 3.14.2-1. ORGANIZATIONAL CHARTS




LIBERTY Dental Plan – Nevada Organizational Chart – Dental Services Staff
Senior V.P. & Chief Dental Officer (1)
Open, Dental Director (NV) (1)
Education and Outreach Representative (1)
Special Investigation Unit (SIU) (9)
Director, Dental Care Mgmt. (1)
V.P., QM & Professional Staffing (1)
Credentialing Manager (1)
Meagan Peake, Grievance and Appeals Coord. (1)
Laurie Hargrave Provider Services Manager (NV) (1)
Provider Relations Coord. (NV) (1)
Provider Relations Representative (NV) (1)
Provider Relations Lead Analyst (NV) (1)
V.P., Professional Relations (1)
Director, Provider Relations (1)
Key Personnel
Key Personnel
Staff located in Nevada (NV)
Staff located in California
December 2016
CONFIDENTIAL:
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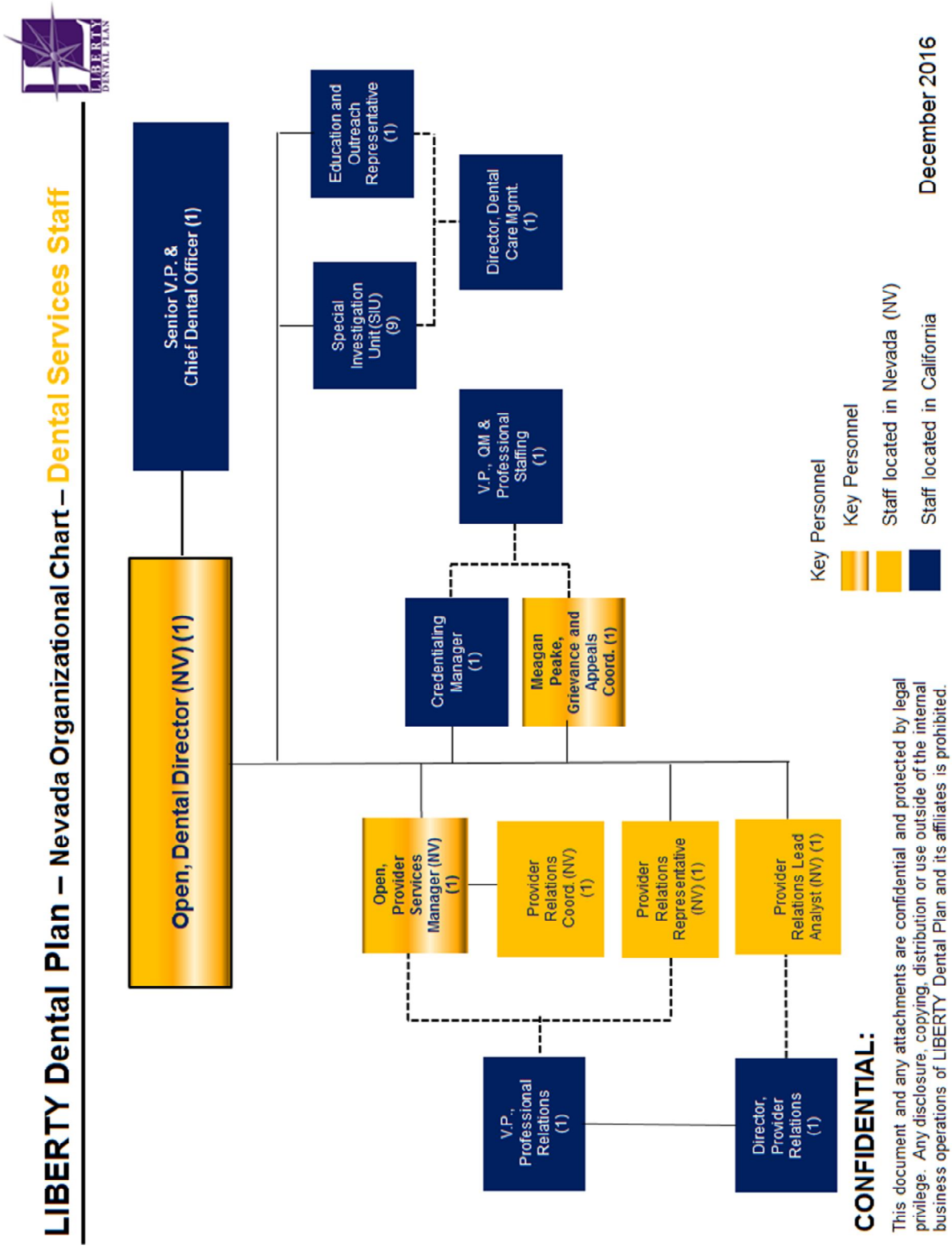
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Key Personnel
Key Personnel
Staff located in Nevada (NV)
Staff located in California
December 2016
CONFIDENTIAL:
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3.14.3.2 The vendor must have in place the organizational, management and administrative systems capable of fulfilling all contract requirements. At a minimum, the vendor must have qualified staff in the following areas:

A. Executive management;

B. Operations Manager;

C. Accounting and budgeting;

D. Dental Director's office;

E. Dental Management, including quality assurance/utilization review;

F. Recipient services;

G. Provider services;

H. Grievances, appeals, and fair hearings;

I. Claims processing;

J. Management information systems (MIS); and

K. Program Integrity.

We understand and will comply with the requirements of Section 3.14.3.2 A-K.

With operational experience in the State of Nevada since 2008, starting with operational management to recipient services, claims processing and provider services, to name a few, we are prepared to fulfill DHCFP's dental contract. Our staffing approach is based on a robust model, factoring in multiple variables to create optimal staffing to maintain appropriate levels at all times and to ensure the achievement of the recipients' clinical outcomes and high recipient satisfaction.

Our administrative systems have the flexibility to adjust the scale of our operation effectively and efficiently.

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

A. Administrator;

B. Chief Financial Officer;
C. Dental Director;
D. Recipient Services Manager;
E. Provider Services Manager;
F. Grievance and Appeals Coordinator;
G. Claims Administrator; and
H. Nevada Operations Manager.

We understand and will comply with the requirements of Section 3.14.3.3 A-H.

Training Offered to Employees

To acclimate new employees to LIBERTY, all new staff members attend an onboarding New Employee Manual (NEM) training provided by Corporate Employment Development Department (CEDD) which allows our employees to learn about LIBERTY's culture, and the industry in which we work. NEM training provides an overview of various departments at LIBERTY and what the responsibilities of each. We discuss Enrollment, Member Services, Claims, Account Management, Provider Relations, Provider Services, and Quality Management responsibilities at a high level and how all the departments interact. Additionally, every employee who works on unique software applications receives three to four weeks of specific computer education. For example, the Member Services Representative training involves an additional three weeks and up to four weeks for new employees in the Claims Department. After successful completion and certification of new hire training, employees transition to their departments for production training.

As CEDD focuses on providing training to help develop employees for a successful tenure at LIBERTY, it offers the following courses on an ongoing basis. These courses are developed with adult learning methods in mind.

Cultural Awareness ***- This course provides general knowledge of cultural awareness/sensitivity in the workplace relating to language, ethnicity, religion, gender orientation, and the teams with whom we work. The definition of Cultural Differences is addressed in addition to providing a related activity.***

LIBERTY Dental Plans 101 ***- Overview of LIBERTY Dental Insurance products, services, and network types.***

LIBERTY Dental Plans 102 ***- Medicaid and Medicare Overview as it relates to LIBERTY. This course is intended to provide an overview of Medicaid and Medicare programs and***

lines of business. Also, to develop an understanding of the different sub-programs that fall under the Medicaid and Medicare groups at LIBERTY (TANF, CHIP, SNF etc.).

Soft Skills - This training will allow participants to gain the proper skills to communicate with beneficiaries, providers, vendors, business partners, and colleagues. This training is available to all LIBERTY employees desiring to improve their customer service soft skills.

Supervisor I - Phase I - Establishing relationships by building trust and respect, Effective vs Non-effective Supervisor traits, Active Listening Protocol, Administrative responsibilities (Ways to get organized).

Mentoring - we provide mentoring to staff identified on our succession plan

Supervisor II - Phase II - FOCUS ON BUILDING YOUR TEAM: Time management, Difficult Conversations, Delegating, Teambuilding Exercises

Supervisor III - Phase III - THE MINDSET OF A LEADER. Growing into an effective leader: How to evaluate your team, Boost Morale - Create a positive culture

Leadership Development - centered on four main programs, "Exploring Leadership" for individual contributors, "ICL" for individual contributors on the succession plan, "Operations Management Leadership" for all team leader and manger level employees, and "Leadership for the Next Generation" for Sr. Managers on the succession plan.

Annual Corporate Training

All staff receives annual training on a variety of key subjects to ensure they are equipped with the knowledge to perform their job duties to meet the highest performance and compliance standards. Courses include:

- ***Employee Code of Conduct***
- ***CMS – Fraud, Waste, and Abuse Training***
- ***Culturally and Linguistically Appropriateness***
- ***HIPAA Privacy***
- ***Critical Incident Training***
- ***Language Assistance Training***
- ***CMS – General Compliance Training***
- ***Fidelis 2016 Compliance Training***
- ***Physical Security***
- ***Internet Security***

CEDD Dashboard

Our CEDD Dashboard (Figure 3.14.3.3-1) was created to keep employees current in required training. Each employee's dashboard provides employees with a list of all the classes they have completed and which courses remain pending. Through dashboards, managers and business owners are able to view in real time those Staff with outstanding coursework.

FIGURE 3.14.3.3 -1. CEDD DASHBOARD

Our commitment is to provide an unmatched quality of service to our recipients, clients and providers and believe that to accomplish this goal we must have a team that is qualified, trained and experienced to perform at a high standard. Should we find it necessary to make a change in staff in any of the key positions noted by DHCFP, we will inform DHCFP in writing within seven calendar days.

3.14.4 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:

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

3.14.4.2 The vendor is responsible for oversight of all network subcontracts and is accountable for any responsibilities it delegates to any subcontracted provider (AKA, subcontractor). The vendor must evaluate the prospective subcontractor's ability to perform the activities to be delegated;

3.14.4.3 All subcontracts for administrative services provided pursuant to this RFP, including, but not limited to, utilization review, quality assurance, recipient services, and claims processing, shall be prior- approved by DHCFP. Prior to the award of any subcontract or execution of an agreement with a delegated entity, the vendor must provide written information to the DHCFP disclosing the vendor's ownership interest of five percent (5%) or more in the subcontractor or delegated entity, if applicable. All

subcontracts shall be submitted to DHCFP for approval prior to their effective date. Failure to obtain advance written approval of a subcontract from DHCFP will result in the application of a penalty of $25,000 for each incident;

3.14.4.4 By the service start date and whenever a change occurs, submit to DHCFP for review and approval the names of any material subcontractors the vendor has hired to perform any of the requirements of the Contract and the names of their principals;

3.14.4.5 Maintain all agreements and subcontracts relating to the contract in writing. Provide copies of all agreements and subcontracts to DHCFP within five (5) days of receiving such request. All such agreements and subcontracts shall contain relevant provisions of the contract appropriate to the subcontracted service or activity, specifically including but not limited to the provisions related to confidentiality, HIPAA requirements, insurance requirements and record retention. The vendor has the responsibility to assure that subcontractors are adequately insured to current insurance industry standards;

3.14.4.6 Remain fully responsible for meeting all of the requirements of the Contract regardless of any subcontracts for the performance of any Contract responsibility. No subcontract will operate to relieve the vendor of its legal responsibility under the Contract;

3.14.4.7 Must have a written agreement with the subcontractor that specifies the activities and report responsibilities delegated to the subcontractor and provides for revoking delegation or imposing sanctions if the subcontractor's performance is inadequate or substandard;

3.14.4.8 Must monitor the subcontractor's performance on an on-going basis and subject the subcontractor to formal review according to periodic schedules established by the State, consistent with industry standards and/or State laws and regulations. If the vendor identifies deficiencies or areas for improvement, the vendor and the subcontractor must take corrective action;

3.14.4.9 Notify DHCFP, in writing, immediately upon notifying any material subcontractor of the vendor's intention to terminate any such subcontract;

3.14.4.10 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;

3.14.4.11 DHCFP retains the right to review contracts between the vendor and providers. DHCFP agrees to protect the terms of Vendor-Provider contracts, if the vendor clearly label individual documents as a "trade secret" or "confidential"" as per Section 25 of Attachment D, Contract Form; and

3.14.4.12 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.

We have the unique ability to directly and effectively perform nearly all the activities required under the DHCFP contract. We intend to engage only three subcontractors under the Nevada contract. We have extensive experience working with these subcontractors in other states and have developed thorough oversight mechanisms to ensure they deliver high quality services. Below are the subcontractors and services they intend to offer:

1. ***Interpretation/Translation services provided by MAGNUS***
2. ***Primary source verification services provided by VerifPoint and***
3. ***Fulfillment services provided by OCDM***

Due to our long relationship with these subcontractors providing services for our other Medicaid contracts throughout the country, they are fully aware of, and compliant with, our strict policy requiring contracts with subcontractors and downstream vendors to adhere to all the same conditions and obligations as those LIBERTY is bound to in our contracts with state and federal entities, including compliance with:

1. ***All relevant sections of 42 CFR 438, as applicable;***
2. ***Relevant confidentiality and HIPAA provisions, including a BAA, if applicable;***
3. ***Insurance requirements (adequate insurance, current industry standards)***
4. ***Record retention obligations***
5. ***Clear and specific scope of work, including sanctions for failure to perform, or substandard performance;***

Our agreements with these subcontractors are maintained in writing and we are fully capable of providing DHCFP copies within five (5) days of request. In addition, we regularly maintain through affidavits, and are prepared to provide full and complete information about the ownership of any subcontractor with whom we have 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.

While we do not intend to engage any subcontractor other than those listed above to perform activities under the Nevada contract, if circumstances arise that require us to do, we fully understand and will comply with Nevada's requirement to obtain prior approval from DHFCP. In addition, we are prepared to formally submit to DHCFP for review and approval the names of the subcontractors noted above, and the names of their principles and will do so by the service start date, and whenever a change occurs. Similarly, we will notify DHCFP, in writing, immediately upon notifying any material subcontractor of our intention to terminate their subcontract.

Due Diligence

Based on their proven track records, and our working relationships with OCDM, MAGNUS, and VerifPoint, all three vendors consistently meet or exceed our contractual performance expectations. Nonetheless, LIBERTY continues to monitor and evaluate their performance to ensure the activities they are delegated provide the best possible service to our members. LIBERTY accomplishes this through specific Policies and Procedures dedicated to the oversight of delegated activities which apply to any entity to which we have delegated administrative or health care functions. At the outset of any engagement, and on an ongoing basis thereafter, our Delegation Oversight Committee formally evaluates each subcontractor's ability to perform delegated activities. Specifically, upon initial contracting any subcontractor, we perform a pre-delegation assessment covering several components, including:

- ***Compliance – to determine whether the vendor has adequate systems in place to comply with all applicable regulatory and contractual requirements to which LIBERTY is subject (FWA, False Claims Act, HIPAA Privacy & Security, etc.).***

- ***Organizational and Financial Stability – to evaluate the vendor's business practices and financial and operational stability, including their ability to perform all activities LIBERTY requires of a transportation vendor.***

- ***Onsite Visit – to review, first hand, the vendor's facilities and to meet and interview, in person, key personnel, including outlining expectations to ensure a high level of service quality.***

- ***Privacy & Security – we enter into a Business Associate Agreement with any vendor that handles or has access to our members' PHI.***

- ***Grievances – at the outset of any new vendor engagement, we establish a documented protocol for identifying and referring grievances to LIBERTY for resolution. LIBERTY requires all vendors to fully cooperate with us in researching and resolving complaints, in order to ensure our ability to comply with applicable grievance, appeal, and fair hearing procedures and timelines.***

Vendor Oversight

Moreover, if LIBERTY is awarded the Nevada contract, our Vendor Oversight Program, carried out by LIBERTY's Delegation Oversight Committee will be responsible for the following, consistent with DHCFP's prescribed schedules, and applicable law:

- ***Ensuring delivery of administrative and health care services at an acceptable or higher level of care to meet all standards required by this RFP. In LIBERTY's pre-delegation assessment, and ongoing oversight program, we evaluate whether subcontractors are accountable, responsive, reliable, patient, have well-developed communication skills, and adhere to customer service industry's best practices. In addition, LIBERTY ensures that the subcontractor maintains a reasonable accounting system that enables LIBERTY, our clients, and relevant oversight entities to readily audit, examine, and make copies of or extracts from all financial and other records related to services it performs on behalf of LIBERTY, including onsite inspections, on demand.***

- ***Ensure adherence to required grievance policies and procedures. With each vendor that performs administrative or healthcare services for us, we establish a documented protocol for identifying and referring grievances to LIBERTY for resolution. LIBERTY requires our vendors to fully cooperate with us in researching and resolving complaints, in order to ensure our ability to comply with applicable grievance, appeal, and fair hearing procedures and timelines. We regularly monitor our vendors' adherence to complaint protocols, during monthly joint operating committee meetings and work collaboratively with them to resolve the root causes of any instances of member or provider dissatisfaction.***

3.14.5 Implementation

3.14.5.1 Vendor Plan

The vendor shall:

A. Develop and submit to DHCFP for approval, no later than one (1) month after notification that DHCFP has selected it for Contract negotiations, a detailed work plan and timeline for performing the obligations set forth in the Contract for the first contract year.

B. Provide DHCFP with updates to the initial work plan and timeline, identifying adjustments that have been made to either, and describing the vendor's current state of readiness to perform all Contract obligations. Until the service start date,

the vendor shall provide biweekly written updates to the work plan and timeline, and thereafter as often as DHCFP determines necessary.

C. Unless otherwise agreed to by 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.

D. 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.

E. 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.

F. Ensure that there is no interruption of covered services to enrolled recipients and work cooperatively with the DHCFP to meet these requirements.

G. Ensure that a toll-free telephone number is in operation at the vendor's office as of 8:00 a.m. (Pacific Time) on the first day of the open enrollment period 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.

H. Establish and implement enrollment procedures and maintain applicable enrolled recipient data.

I. Establish its Provider Network and maintain existing Provider Agreements with such Providers.

Implementation Work Plan and Timeline

For implementation, we will assemble a team of representatives from each of our internal departments to ensure a successful implementation in partnership with DHCFP. This includes a streamlined and efficient process whereby we dedicate our Nevada-based team of experienced local community professionals who will work closely with our corporate management team to synchronize the entire implementation process.

Our teams will collaborate to design a custom implementation work plan and timeline to be successfully executed under the guidance of our dedicated Nevada-based team. All aspects of the implementation work plan and timeline are subject to approval by DHCFP. The plan will have measurable objectives, timetables for completion, and incremental goals that are logically organized to result in a streamlined implementation process where all stakeholders are informed throughout.

We will hold bi-weekly meetings with DHCFP to provide updates to the initial work plan and timeline. These scheduled meetings will be used to address issues, resolve problems swiftly, provide the utmost in continuity and efficiency, and detail the current state of readiness to perform the details outlined in the contract. We will hold meetings with stakeholders to provide status, present issues for discussion, gather recommendations, and respond to DHCFP requests. A tracking document will be provided to allow DHCFP to remain informed on all levels of detail until implementation has been successfully completed. We commit to submitting all deliverables no less than ten business days prior to the service start date for DHCFP's review and revision. After the start date, meetings will continue as often as determined necessary by DHCFP.

Implementation tasks include:

- ***Project Planning. Overall planning process to ensure that the project phases, activities, and tasks are undertaken in a coordinated fashion.***
- ***Project Execution. Identify the specific activities in the project, the resources applied to the project, and the organization of the project.***
- ***Project Closure. Release the deliverables to the business (once complete), close the project tasks, and perform a Post Implementation Review of the project.***
- ***Project Management. Discuss the project to ensure all parties are on schedule, and track the progress of the plans, such as:***
    - ***Time Management.***
    - ***Cost Management.***
    - ***Quality Management.***
    - ***Change Management.***
    - ***Risk Management.***
    - ***Issue Management.***
    - ***Communications Management.***

We have successfully implemented multiple Medicaid programs in several states within relatively short timeframes, including those of Nevada's size and scope. For example, we successfully implemented both Florida Medicaid Managed Medical Assistance (MMA) and Illinois' Family Health Plan and Affordable Care Act (FHP/ACA), for effective dates of May 2014 and July 2014, respectively, at the exact same time for over 1 million members between the two states. As with all of our new partnerships, our goal is to ensure a seamless transition without any interruption of services to members. Our claims system has the flexibility to allow for the setup and tracking of continuation of care by member. The claims system will be tested prior to the effective date and will include testing of: claims payment, preauthorization processing, provider payments

and retroactive membership claims. We would dedicate that same level of commitment, expertise and personalization to the Nevada program.

Figure 3.14.5.1-1 below contains an excerpt of our sample implementation work plan and timeline; from here, we will work with DHCFP representatives to fully develop a custom plan for the contract.

Key Responsibilities

Below we describe a number of our key responsibilities and how we plan to address them.

Recruiting, Enrolling, and Maintaining an Appropriate Dental Provider Network

We have 10 years of experience in developing and maintaining networks that serves a

culturally and geographically diverse patient base. We understand the importance of ensuring that Nevada membership has access not only to dentists and staff that speak threshold languages, but that are also located within the defined regions. In developing provider networks, our primary concern is to recruit general dentists and specialists that are currently treating members in the program, familiar with special health care needs, and can offer wide range of services. By no later than 60 calendar days prior to service start date, we commit to having a sufficient number of providers to serve initial member enrollment and will continue to develop, monitor and recruit our provider network. We also commit to implementing procedures necessary to obtain executed Medicaid provider agreements and contracts.

We will employ local Network Managers to support the growth of the Nevada membership and development of a strong and accessible provider network. Our team monitors our network adequacy, anticipates future needs, and promptly identifies and addresses gaps to ensure that members have access to care and that we continue to meet Nevada standards. We will provide an access report at any time should DHCFP require one.

Workplace-Office Space, Equipment and Staff

We commit to having Nevada office space, post office boxes, telephone systems, computer equipment, staffing, etc. in place prior to the service start date. We are experienced in hiring, training and maintaining staff specifically for Medicaid programs in numerous states. Staffing models based on utilization data are used in each department to ensure we are hiring and maintaining sufficient staff levels throughout the life of the contract. We understand the importance of providing seasoned local management familiar with Nevada's regional differences, and towards that end, we will commit our current Nevada office of seasoned professionals to support the implementation of the Nevada program.

Toll-free Telephone Number Operation

As of 8AM PT on the first day of open enrollment and on-going for the remainder of the contract, we will dedicate a toll-free telephone number with options to channel members and providers to different caller categories.

Eligibility data and verification

We will establish and implement enrollment procedures and maintain data with DHCFP. We will verify eligibility for members and providers using numerous tools to ensure our members and providers have user-friendly, convenient ways to access information at any time. Our Member Service team handles routine eligibility verifications daily, while our web portal allows both members and providers to easily verify eligibility in real time without having to directly contact us. Also, members have the ability to verify their eligibility through our smart phone application, and even present a digital ID card to their provider as proof that they are a current member.

3.14.5.2 Pre-Implementation Readiness Review

DHCFP may conduct Operational and Financial Readiness Reviews on all awarded vendors and will, subject to the availability of 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.

Our experience and expertise in delivering network, dental, and administrative services to Medicaid managed care plans and states allow us to be proficient at completing pre-implementation reviews in a responsive manner in order to demonstrate to clients, governmental entities, and other oversight bodies our compliance with a variety of regulatory, quality, and service requirements. Such reviews span all company operations and a wide array of state, federal, and industry requirements, and frequently include onsite audits, direct file and system reviews, and in-person interviews. Areas frequently reviewed include:

- ***adherence to financial operations;***
- ***administration and organization;***
- ***recipient services;***
- ***provider network;***
- ***quality improvement; and***
- ***management information systems, including claims processing and reporting systems.***

In Nevada, we will complete the required readiness review by engaging our expert Quality and Compliance teams, and applying our established workflows.

1. ***Readiness Tool:*** ***Within approximately three days or fewer of receiving readiness review materials, our survey teams will develop a customized internal crosswalk mapping each discrete review element to the functional area within LIBERTY responsible for response and ongoing oversight.***

2. ***Document Production:*** ***LIBERTY maintains a comprehensive repository of current policies, procedures, and substantiating documents used to respond to readiness review requests. We are skilled at producing clean, responsive materials which fulfill review requirements upon initial submission. Based on past experience with similar reviews, we estimate we can produce the required materials within 30 days of request.***

3. ***Offsite Review Question/Answer:*** ***LIBERTY designates highly trained, dedicated staff to liaise with each reviewer concerning any questions or requests for additional information. We strive for first contact resolution and, when this is not possible, we aim to produce additional materials within 24 to 72 hours of request.***

4. ***Onsite Review:*** ***LIBERTY is accustomed to having auditors on site and has established effective protocols for providing appropriate access to personnel, records, systems, and materials. Reviewers routinely compliment us on our open and engaging approach, our impressive facilities, and our knowledgeable staff.***

LIBERTY's strong readiness review record comes from both our extensive experience in managing new implementations, and our formal approach to monitoring and adapting to relevant requirements at both the state and federal levels. We are confident that applying this same approach in Nevada will yield similar and strong results.

3.14.6 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.

As a direct contractor with the state of California for its Medicaid dental program, LIBERTY currently operates under the rule that we must obtain approval prior to publishing or making public presentations of statistical or analytical material regarding the program, and will operate under the same rule if awarded the contract in Nevada. We also will not provide statistical or analytical reports to outside entities, including

other state programs or departments, without express consent from DHCFP to ensure the material protects the privacy and confidentiality of specific recipients to the extent required by both federal and state law and regulation.

3.14.7 Vendor Marketing Materials

3.14.7.1 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.

3.14.7.2 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.

3.14.7.3 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:

A. The recipient must enroll with the vendor in order to obtain benefits or in order not to lose benefits; or
B. The vendor is endorsed by CMS, the federal or state government, or similar entity.

While many plans have adopted an aggressive marketing and advertising approach, LIBERTY has always relied on word of mouth and member referrals as our main marketing engine. We have not developed marketing or advertising materials for any of our Medicaid programs and currently do not have any plans to do so. LIBERTY's primary marketing strategy has been to distinguish itself as the leading plan with regard to the level of service it provides to our beneficiaries and contracted providers in our Medicaid dental programs. We know that satisfaction with our Nevada program will be significantly influenced by community organizations and advocates. For example, our specific indirect marketing strategies allow for the development of long lasting and interactive relationships with our recipients, providers, and community organizations and have recently brought new enrollment to the State of California. The Department of Health Care Services approved the assignment of two failed dental plans' membership to LIBERTY, which is further testament to the appropriate marketing strategy concerning our Medicaid beneficiaries. Also, we recognize the vulnerability of the Nevada recipient population and we will thoroughly monitor aggressive and/or inappropriate marketing activities in any of our contracted provider offices.

If we decide to utilize marketing and/or advertising materials, our local Nevada-based team will be involved in the creation of these materials to ensure that we reflect the regional culture in our communications. We fully understand that any and all marketing or advertising materials must be submitted to DHCFP for review and approval a minimum of sixty (60) days prior to the scheduled Medical Care Advisory Committee (MCAC) meeting. We understand that we are not permitted to market directly to potential recipients and that we are prohibited from providing materials that contain false or misleading information, and from initiating cold calls to potential recipients. We also understand that we may not seek use of approved marketing materials to influence enrollment in conjunction with the sale or offering of any private insurance, and that we may not, directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities. We further agree that any and all costs associated with developing, printing and distributing materials are our responsibility.

Our Director of Fulfilment will ensure that any and all marketing and/or advertising materials receive DHCFP approval prior to printing and/or releasing materials for mass distribution, whether printed or electronic. If materials have not received DHCFP approval, the Director of Fulfilment will send the materials back to the appropriate Account Executive and/or Director of Compliance to ensure approval is received prior to distribution. By ensuring any and all marketing and/or advertising materials are approved by DHCFP prior to distribution, we can assure the DHCFP that any marketing and advertising plans and materials we do create are accurate and do not mislead, confuse, or defraud recipients or potential recipients, or the DHCFP.

3.15 PROGRAM INTEGRITY

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3.15 PROGRAM INTEGRITY

3.15.1 General Requirements and Authorities

3.15.1.1 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.

3.15.1.2 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.

A. Sections 1128, 1156, and 1902(a)(68) of the Social Security Act;

B. 42 C.F.R.§ 438, Subpart H;

C. 42 C.F.R. § 455 Subpart A, B and E;

D. 42 C.F.R. § 1000 through 1008;

E. 42 C.F.R. § 456.3, 456.4. 456.23;

F. 42 C.F.R. § 457.950(a)(2);

G. Section 6032 of the Federal Deficit Reduction Act of 2005;

H. Nevada Revised Statutes, Chapter 422;

I. Nevada DHCFP Medicaid Services Manual; and

J. Nevada DHCFP Medicaid Billing Guides.

We understand and will comply with section 3.15.1.

We are committed to complying with the requirements of Section 6032 of the Federal Deficit Reduction Act of 2005, and to preventing and detecting any fraud, waste and abuse. Our successful track record in identifying and addressing fraud, waste and abuse (FWA) – as well as usage patterns that do not rise to the level of FWA but nonetheless impose unnecessary excess costs. Examples of our work in this area are conveyed in the Figure 3.15.1-1 below.

FIGURE 3.15.1-1. EXAMPLES OF LIBERTY'S SUCCESSES IN IDENTIFYING AND INVESTIGATING FRAUDULENT ACTIVITIES IN OTHER STATES

- ***In 2014, LIBERTY identified an outlier provider from the State of Illinois Medicaid program within 2 months of the health plan's transition to LIBERTY. Upon investigation, it was found the provider been billing for years for services that were not rendered. We counseled the provider regarding the aberrant patterns, and authorities were notified. The provider abandoned the office and LIBERTY terminated this provider's contract. In June 2016, the Office of Inspector General sent out a provider alert to a wide array of different carriers suspending all payments to this entity.***
- ***In February 2015, an outlier provider in Florida was identified as warranting investigation. Our on-site audit revealed the office environment was not conducive to child well-being, and we subsequently terminated the provider contract. The provider was later arrested for Medicaid fraud and allegations of child abuse.***
- ***In April 2015, LIBERTY identified a provider that demonstrated a pattern below the standard of care. The provider was deemed to be systematically undermining and defrauding the system. Children who obtained care had undetected caries, sealants place over fillings, fillings placed over sealants, and overall treatment was below the standard of care. We terminated the provider contract and reported to authorities. As of November 2016 this case is still under investigation by the Illinois State Police.***

In furtherance of this policy and to promote compliance with the Deficit Reduction Act, LIBERTY disseminates the below policy to all personnel (including management, contractors and other agents) to ensure that such persons are aware of relevant federal and state laws regarding the submission of false claims.

Policy

LIBERTY prohibits the submission of a false claim for payment from a federal or state funded health care program. The submission of a false claim (i) violates federal and state law; (ii) may result in significant administrative and civil penalties under the federal False Claims Act and/or Nevada State False Claims Act, respectively; and (iii) may also violate federal and state criminal laws.

To assist LIBERTY in meeting its legal and ethical obligations, any individual who reasonably suspects or is aware of the preparation or submission of a false claim or report, or any other potential fraud, waste or abuse related to a federal or state funded health care program, is required to report such information to his or her supervisor and the LIBERTY Compliance Officer. Any individual who reports such information will have the right and opportunity to do so anonymously, and will be protected against retaliation and intimidation for reporting such information under our internal compliance policies and procedures, as well as federal and state law. However, LIBERTY retains the right to take appropriate action against an individual who has participated in a violation of federal or state law or LIBERTY policy.

LIBERTY is committed to the prompt and thorough investigation of actual or potential fraud, waste and/or abuse, and requires all personnel to assist in such investigations. If an individual believes that LIBERTY is not responding to his or her report within a

reasonable period of time, he or she is required to bring the matter to the attention of the Compliance Officer. Failure to report and disclose, or assist, in an investigation of fraud, waste and/or abuse is a breach of the duty that all personnel have to LIBERTY and may result in disciplinary action, up to and including termination.

Federal & Nevada Statutes Relating To False Claims and Whistleblower Activity

LIBERTY's operations fully comply with all federal laws. We have closely reviewed Nevada's False Claims and Whistleblower statutes. LIBERTY agrees to comply with these provisions. We are committed to conducting all business activities in a highly ethical manner, and to ensuring that the provider community delivering services to our enrollees does the same.

3.15.2 Provider Credentialing

3.15.2.1 The vendor must:

A. 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.

B. 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.

C. Provide Credentials for network providers, subcontractors, or subcontractor's providers to the DHCFP and/or MFCU upon request, at no cost.

LIBERTY has established credentialing and re-credentialing policies and procedures to ensure providers meet all our criteria to participate, which will be amended to meet all Nevada Medicaid requirements upon award. Providers must be licensed by the State of Nevada to be approved during the credentialing process. LIBERTY conducts ongoing monthly reviews of providers to identify any providers who are nearing license expiration and notifies providers of the need to renew their licensure. Additionally, during the initial credentialing period and during these ongoing reviews, LIBERTY identifies any providers who are excluded, debarred, or suspended from participating the Medicaid program. LIBERTY will submit all credentialing criteria to the DHCFP ninety

days before the start of the contract period for approval. LIBERTY agrees to submit any changes to the criteria to DHCFP for approval thirty days prior to the set implementation of the changes. If any unanticipated changes the criteria occur, LIBERTY will submit the changes within five calendar days of the change. Upon request, LIBERTY will provide all credentials for network providers, subcontractors, and subcontractors to the DHCFP and/or MFCU at no cost.

3.15.3 Provider Enrollment

3.15.3.1 The vendor must comply with federal requirements including the Patient Protection and Affordable Care Act (PPACA) of 2010 for Medicaid enrollments.

With more than 2 million Medicaid members throughout the county, we fully understand and comply with federal Medicaid enrollment guidelines for providers, including those established under the ACA. We only permit providers who are eligible to participate in government programs to participate in our networks.

Upon initial contract, and at least annually thereafter, LIBERTY requires each participating provider to disclose any person or entity with an ownership interest of five percent (5%) or more in the Provider's Office, including disclosure of all owner affiliates and subsidiaries. LIBERTY screens any entities/individuals the provider discloses against all required databases.

In addition to these screenings, our Quality Management Department oversees an extensive credentialing process for reviewing and accepting or rejecting the professional credentials of each of our applicant and contracted dental providers. Our reviews fully comply with all federal Medicaid enrollment guidelines for providers, including those established under the ACA In addition, we perform required individual background history checks on our providers, and review information from the applicable State Board of Dental Examiners and other pertinent federal and/or state provider sanction and licensure reports during Credentialing Committee meetings.

3.15.3.2 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.

LIBERTY continuously recruits providers to ensure that the Medicaid population has appropriate access to care. We have been successful in other states in bringing new dental providers (not previously accepting Medicaid patients) into our Medicaid program, which allows us to improve recipient access to care and maintain our access standards, appointment standards, ratio of member to provider and changes in cultural and linguistic needs of the population.

Our Network Managers are responsible for obtaining all necessary applications and required contracting information and credentialing documents from the dental providers during the contracting process. Network Managers will work with the dental offices if they have not yet enrolled in the Nevada Medicaid program to provide enrollment instructions, contact information, and education to help them register with Medicaid. LIBERTY's contracting process requires that each dentist is registered with Medicaid and has a valid Medicaid identification number before treating recipients.

During the provider enrollment process, we also work to ensure that all our providers are enrolled with Nevada Medicaid as an approved service provider. On a regular basis, we request a State Medicaid provider file. Upon receipt of a provider application, we validate the Medicaid number provided against the State Medicaid file. Once we verify that a provider is listed in the Medicaid file, we initiate the credentialing process. If the provider is not listed in the file, we still initiate the credentialing process; however, we assist the provider in becoming a Nevada Medicaid provider. Additionally, we compare our data that we have received from our provider application process to the data in the State Medicaid file to identify any discrepancies in the data. We follow up with the provider and state to facilitate the effort to maintain only accurate information in all systems.

3.15.3.3 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.

LIBERTY requires that all network providers maintain an active license at all times. To be considered for participation in the network, a provider must complete a credentialing application and submit the following:

- ***Practice name, address, phone and fax numbers.***
- ***TIN and SSN for processing and collecting the required individual background history checks.***
- ***NPI for providers (Type I) and billing entities (Type II), as applicable.***
- ***Education and training information as appropriate to practice specialty(ies).***

- ***Specify if Board Certified and Hospital Privileges, as applicable.***
- ***The most recent five (5) years of work history.***
- ***Signed and dated Credentialing Attestation, Authorization and Release Forms.***
- ***A current professional Dental License(s).***
- ***A current DEA Certificate or State Controlled Substance certificate, if applicable.***
- ***A current Malpractice Insurance Certificate showing 'Professional Liability' coverage with coverage of at least $1,000,000 per occurrence and $3,000,000 aggregate.***
- ***A Specialty Certification from the educational facility attended (if applicable).***

Only providers who successfully completed our NCQA credentialing process can provide treatment to our recipients. For providers willing to treat Nevada Medicaid recipients but are outside of Nevada, they must be licensed in their home state of practice in order for us to enter into a single case agreement.

3.15.3.4 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.

When network providers are not available to provide services to recipients, we will contact non-Medicaid providers who are willing to enter into single case agreements when necessary. During our discussion, we will ensure that providers understand the benefits and needs of the population before we enter into the single case agreement. Our goal is to ensure that recipients receive prompt access to needed dental services and receive high quality care. We will report to DHCFP any single case agreements that we enter into, within DHCFP's required timeframe and in a format approved by DHCFP.

3.15.3.5 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.

When a provider is dis-enrolled, de-credentialed, terminated or removed from our active Provider list, we will notify the DHCFP and will provide all required documentation and reasons or causes. Our goal is to keep quality providers in-network and minimize disruption to recipients.

If we initiate a termination due to credentialing or other reasons, we will comply with section 3.6.5.11 and will notify DHCFP Provider Enrollment Unit within five (5) business days.

3.15.3.6 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.

LIBERTY will submit to DHCFP, on a monthly basis and no later than the tenth (10) calendar day of the month, a list of network providers who are servicing Nevada Medicaid recipients. We will note any new providers who enrolled to the network and report the required documentation for any providers who have been terminated, de-credentialed or dis-enrolled from the network. We commit to provide DHCFP with our new network providers – and our terminated providers by reason -- within the timeframe requested and in a format that is approved by DHCFP.

During our Aug.2016 Credentialing Committee meeting there were three providers who were not in compliance with Re-Credentialing requirements. As a result, the Committee unanimously DENIED each of the three providers, which resulted in network termination.

A provider's network status may be reduced, suspended or terminated for any lawful reason, including, but not limited to: a lapse in basic qualifications, such as licensure, insurance, board certification or required dental staff membership or privileges at a specified hospital/healthcare facility; a determination that the provider cannot be relied upon to deliver the quality or efficiency of member care desired by Nevada; or a determination that the provider cannot be relied upon to follow our clinical or business guidelines or directives.

3.15.4 Provider Contracts

3.15.4.1 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.

As part of the provider contracting process, LIBERTY requires that our providers submit a signed master provider agreement along with credentialing application for each practicing dentist at the location. Upon successful credentialing of providers, we

counter sign the provider agreement and forward an executed copy to the providers for their file. After we enter provider information and activate the contract in our system, we store all contract and credentialing documents in our provider file. These written provider agreements can be easily accessible as they are stored in our MIS system.

We routinely monitor our existing network to ensure we have a sufficient number of qualified providers, to ensure access to care for all members (recipients).

3.15.4.2 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.

LIBERTY will provide our base provider contract for DHCFP's review before we begin our recruitment effort. Our Compliance Department will research various regulations and include Nevada and federal requirements to ensure that LIBERTY and our network providers comply with DHCFP requirements. After receiving DHCFP's approval, if there are substantive changes or amendments to the base provider contract, we will further submit to DHCFP for review and approval before implementation. We will make available our provider contracts to DHCFP upon request.

3.15.4.3 The timing and other events associated with provider recruitment must occur in a manner that will ensure meeting the objectives noted within this RFP. The effort must include outreach to providers who are not currently participating in the DHCFP's dental program or have a signed agreement but do not actively accept eligible recipients.

As an organization founded and led by a dentist, we are committed to establishing and maintaining strong provider relationships. LIBERTY has successfully recruited, contracted, developed, and maintained Medicaid dental provider networks in multiple states. It is LIBERTY's goal to provide the support and resources our network providers need to optimally care for our members.

If LIBERTY is awarded the Nevada Medicaid contract, we will partner with DHCFP and take the following steps to make sure that there is no disruption to recipients' care.

1. Identify Key Providers to Contract. In order to support the growth of the network with minimal disruption to recipients' care, we will work with DHCFP to request a list of providers that shows each dentist's volume of Medicaid recipients, along with claim

dollars. This will allow us to prioritize our recruiting efforts to maximize continuity of care, reaching out to those dentists that account for the largest portion of the Medicaid population.

2. Provide an Endorsement Letter. We will work with DHCFP to provide an endorsement letter for LIBERTY shortly after the award announcement. In our previous recruitment experiences, an endorsement letter affords a huge advantage in enticing providers to sign contracts much more quickly once an award is announced. At minimum, this letter will validate that LIBERTY is the State's selected dental partner for Nevada's Medicaid program.

3. Develop Fee Schedule. We will work closely with DHCFP to ensure that our fee schedule meets the requirements of the Nevada Medicaid program. We will partner with DHCFP to ensure that our efforts to administer dental benefits include cost effective unit pricing.

4. Identify Additional Providers. In addition to prioritizing key providers to recruit by Medicaid recipient volume (see step #1 above), we use our database to identify all Medicaid dentists by county, and all non-Medicaid dentists with appropriate background and utilization profiles, to include in our recruitment plan.

5. Distribute Recruitment Letters. We will coordinate a mailing to include highly utilized dentists (see step #1), along with additional providers we identified (see step #4). Mailings will include DHCFP's endorsement letter, our provider agreement, a Medicaid addendum, fee schedule, credentialing application and our recruitment flyers.

6. Assemble a Recruitment Team. We will assemble a team of experienced Network Managers that have successfully recruited a Medicaid network in other markets, as well as our current Network Manager who is already familiar with the Nevada market and has developed great relationships with the dentists. Together, they will contact providers to discuss the award announcement, share our Medicaid experiences in other states, review our mission, assist with contracting questions, and ultimately build and strengthen relationships with the providers.

7. Monitor Recruitment Results. We monitor access, disruption and in-network claims volume results by using our recruitment dashboard. This dashboard summarizes the total number of targeted dentists, along with a status of which providers have submitted contracts or are in credentialing, those who have verbally agreed to contract, or are still making a decision. This dashboard allows us to effectively follow up with Network Managers on a specific provider or status at any time. During an active recruitment project, our Project Management team monitors the dashboard daily to review progress

and results; if necessary, we will shift or add resources where needed to ensure we meet our objectives.

8. Generate GeoAccess Reports. During our monitoring of the recruitment effort (step #7), we will generate GeoAccess reports weekly to review adequacy of the Nevada network and identify areas that need further expansion. This will allow us to meet Nevada's recipients' needs by having providers that meet DHCFP's access requirements.

9. Follow Up with Providers. Our Network Managers will follow up with providers after the initial phone call or visit if no decision has been made within 3-5 days. This keeps the momentum going so providers remember our recent contracting discussion. Depending on how close we are to obtaining contract documents, our Network Managers will visit the providers to pick up contracts or even assist them in filling out the necessary documentation.

Network Managers are responsible for obtaining all necessary applications and required contracting information and credentialing documents from the dental providers during the contracting process. Network Managers will work with the dental offices if they have not yet enrolled in the Nevada Medicaid program to provide enrollment instructions, contact information, and education to help them register with Medicaid. LIBERTY's contracting process requires that each dentist is registered with Medicaid and has a valid Medicaid identification number.

We are aware from this RFP that we can enter into single case agreements with non-Medicaid providers as needed. For providers willing to treat Nevada Medicaid recipients but are outside of Nevada, they must be licensed in their home state of practice in order for us to enter into a single case agreement.

LIBERTY has extensive experience in developing a network within the timeframe requested by clients. Below in Table 3.15.4.3-1 is an example of States where we were successful in building a network organically to meet specific implementation requirements.

TABLE 3.15.4.3-1. NETWORK DEVELOPMENT TIMEFRAMES

State	*Total Providers by Contract Effective Date*	*Implementation Timeframe*	*Total Providers in Network after Implementation*
Arizona	311	5 months	664
Arkansas	58	6 months	128
Tennessee	164	6 months	457
South Carolina	226	6 months	701
Mississippi	52	6 months	124
Florida	12,867	6 months	14,737
New Jersey	712	6 months	11,664

3.15.4.4 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.

Our provider agreement requires that providers comply with our policies and procedures. Upon request of the DHCFP, we will submit our policies and procedures within 5 business days upon any change of policies and procedures. Below in Figure 3.15.4.4-1 is an excerpt of a Compliance section of our provider contract.

FIGURE 3.15.4.4-1. EXCERPT FROM PROVIDER MANUAL

ii. Compliance with Policies and Procedures. Dental Office shall, and shall ensure all Dentists and other Dental Office Agents, comply fully with, and abide by, the rules, policies, and procedures that LIBERTY has established or will establish, including, but not limited to, those related to timeliness of access to care, coverage rules and payment, quality improvement/management, utilization management (including, but not limited to, precertification procedures, referral processes or protocols, and reporting of clinical encounter data), member grievances, provider credentialing, and LIBERTY's compliance program. Dental Office shall, and shall ensure Dentists and other Dental Office Agents, also comply with all policies, procedures and guidelines identified in the Provider Manual, which may be amended from time to time by LIBERTY.

iii. Compliance with Applicable Laws. Dental Office shall, and shall ensure all Dentists and other Dental Office Agents, comply with all applicable state and federal laws, regulations, rules and guidelines.

We have a systematic process for the ongoing review and evaluation of our network providers to ensure that they comply with our policies and procedures. This can be assessed through the review of member satisfaction survey results, complaints and grievance tracking reports, utilization patterns, and desktop audits to identify potential quality issues.

If we identified that a provider is not complying with our policies and procedures, below are actions that we take to address:

- ***Schedule a counseling session to discuss with the provider and/or office staff on the specific issue. Our goal during the counseling session is to identify the cause of the issue, partner with the provider to resolve the issue; we may include our Dental Director in the meeting when appropriate.***
- ***Re-educate provider on the section(s) or area(s) that they did not comply***
- ***Follow up within x days to ensure compliance (timeframe depends on the severity of the issue)***
- ***Continue to monitor if improvement is shown and follow through until provider is in compliance***
- ***Close the office to accept new recipients if no improvement is shown within 60-90 days (timeframe may be shorter depends on the severity of the issue)***
  Term the office from the contract if there is no effort or refusal to comply with our policies and procedures.

3.15.4.5 Provider contracts must not be structured to provide financial or other incentives to providers and subcontractors for denying, reducing or limiting medically necessary services.

Our provider contract does not allow financial or other incentives to providers and subcontractors for denying, reducing, or limiting medically necessary services to a recipient. Below in Figure 3.15.4.5-1 is an excerpt from our provider contract.

FIGURE 3.15.4.5-1. EXCERPT FROM PROVIDER MANUAL

Fees. In exchange for the provision of Covered Services to Members, Dental Office shall be compensated in accordance with the applicable compensation set forth in an Exhibit and/or in the applicable compensation addendum or fee schedule based upon the applicable coverage of the Dental Plan(s) in which Dental Office participates. LIBERTY shall pay or deny Dental Office claims in accordance with any applicable prompt payment statutes. Dental Office acknowledges and agrees that all such compensation will be based on the current, applicable Dental Plan(s). Dental Office agrees to accept such compensation and any applicable Cost Sharing as payment in full for the rendered Covered Services. Dental Office acknowledges that LIBERTY shall not be liable in any way for payment for Covered Services rendered by Dental Office to Members to the extent such payment is the responsibility of the Payor under the applicable Dental Plan. In addition, LIBERTY shall not directly or indirectly make payment to a Dental Office as an inducement to reduce or limit medically necessary services furnished to a Member.

3.15.4.6 The use of "gag" clauses in Provider contracts is prohibited.

LIBERTY does not include "gag" clauses in our provider contracts.

3.15.4.7 All provider contracts must be made available to the DHCFP and / or MFCU within five (5) business days upon request.

Scanned executed provider contracts are stored in our MIS system and can be accessible at any time. We will make available to the DHCFP of all provider contracts within five (5) business days of the request.

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

A. Initial and ongoing credentialing;

B. Adding, deleting, and periodic contract renewal;

C. Provider education; and

D. Discipline/termination, etc.

To maintain and support a provider network that creates the highest standard of care for our recipients, we assign a Network Manager to each dental provider. Our Network

Managers are the liaisons to our providers, and are their main point of contact whenever a need or question arises. The Network Manager performs an initial service visit to the provider's office upon contract execution, and then follows up annually. Service visits further strengthen the working relationship and provide assistance with issues or questions.

Additionally, the Network Manager provides education and training to our providers and their staff during the onboarding process, after staff changes, and upon request. Our Network Managers encourage and support providers to participate in various community-sponsored events, such as health fairs, as a way to provide free screenings and conduct recipient outreach.

Our Network Managers maintain and ensure the highest quality in our provider networks through various approaches: 1) Conducting service calls 2) Reviewing utilization patterns 3) Addressing recipient complaints, and 4) Monitoring provider networks.

These are each described in more detail below.

Conducting Service Calls

Adding/deleting and periodic contract renewals

At each provider service call, the Network Manager confirms that the provider profile is current. This includes, but is not limited to, confirming wait times for periodic evaluations, wait times for non-urgent and urgent appointments, languages spoken, after hours, dentists participating at the practice, and whether they are accepting new recipients.

Provider education

Next, the Network Manager discusses any new policies or procedures that have been implemented that could impact Nevada recipients. We remind providers and their staff where to locate and request a copy of the Provider Manual. In addition, we review any concerns or issues that need to be discussed with providers or their staff. This strengthens our partnership as we work together to resolve issues.

Each service call is documented using our Provider Service Report (PSR) summarizing the discussion and findings. If there are changes with the provider profile, we update the information in our system accordingly.

1. Reviewing Utilization Patterns – discipline/termination

Our core MIS system allows us to identify unique elements on claims through custom logic, providing us with an opportunity to evaluate for Fraud Waste and Abuse (FWA) or other outliers. Key elements of data are then analyzed by our Utilization Management team to help minimize or eliminate potential FWA, while maximizing effectiveness of care. If a provider is identified as having any aberrant utilization pattern, the Network Manager is notified. The Network Manager will schedule a counseling session with the

provider, the provider staff, and our Dental Director to review claims in question, discuss patterns identified, evaluate standards of care, and determine next steps. A summary of the meeting is documented using our Provider Service Report (PSR). We also take this opportunity to educate providers and review our general standards of care, reminding them of our policies and procedures. A follow up meeting is scheduled within 60 or 90 days (depends on the severity of the concern) to evaluate if there was improvement. If no improvement is made, we may restrict the provider to new recipients and ultimately proceed in terminating the provider from the network. An example has been provided in the sidebar.

If we do proceed with restricting or terminating a provider, we will evaluate the overall network to ensure that recipients continue to have ample choices, and communicate this change to the membership. Our ultimate concern, whenever there is a change to the provider network, will be that all changes to access and availability are clearly and timely communicated to Nevada recipients.

2. Addressing Recipient Complaints

We are able to track and trend recipient complaints, including those that are provider-specific. If a trend is identified where a provider has a high number of complaints, the Network Manager is notified. The Network Manager schedules a counseling session with the provider and their staff to discuss the specific complaints. The Network Manager reviews our policies and procedures as they apply to the complaint. If necessary, the Network Manager may conduct an unannounced service call. A summary of all meetings are documented using our Provider Service Report. Depending on the nature of a complaint, the Network Manager follows up to ensure any corrective action is completed until the issue is resolved.

3. Monitoring Provider Networks

Network Managers are very familiar with their assigned territories, and use various tools and reports (such as GEO Access) to confirm when it is necessary to add dentists to the network. GEO Access reports are reviewed at least quarterly and as often as needed when changes impact the network. When there is a change to the provider network, such as termination or a provider not accepting new recipients, Network Managers research our system to identify existing providers that are currently participating within 5 or 10 miles radius. This determines the urgency of adding new dentists to the network.

4. Re-Credentialing

Our provider re-credentialing cycle repeats every three years (or more frequently should an issue be identified). Sixty days before the re-credentialing date, the dentist will receive a written request to submit required documents to our designated CVO. If a provider fails to forward any required information to the CVO, our Credentialing

Coordinator will assist in obtaining the missing or expired information. We utilize a Peer Review Committee to review any contracted provider who has generated an adverse report. Explanations are then assessed and determined to be either inadequate or satisfactory. Failure to comply with requests for information can result in provider termination from the network.

3.15.4.9 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.

LIBERTY's provider agreement requires that providers comply with our policies and procedures. Figure 3.15.4.9-1 is an excerpt of a Compliance section of our provider contract.

FIGURE 3.15.4.9-1. EXCERPT FROM PROVIDER MANUAL

ii. Compliance with Policies and Procedures. Dental Office shall, and shall ensure all Dentists and other Dental Office Agents, comply fully with, and abide by, the rules, policies, and procedures that LIBERTY has established or will establish, including, but not limited to, those related to timeliness of access to care, coverage rules and payment, quality improvement/management, utilization management (including, but not limited to, precertification procedures, referral processes or protocols, and reporting of clinical encounter data), member grievances, provider credentialing, and LIBERTY's compliance program. Dental Office shall, and shall ensure Dentists and other Dental Office Agents, also comply with all policies, procedures and guidelines identified in the Provider Manual, which may be amended from time to time by LIBERTY.

iii. Compliance with Applicable Laws. Dental Office shall, and shall ensure all Dentists and other Dental Office Agents, comply with all applicable state and federal laws, regulations, rules and guidelines.

We have a systematic process for the ongoing review and evaluation of our network providers to ensure that they comply with our policies and procedures. This can be assessed through the review of member satisfaction survey results, complaints and grievance tracking reports, utilization patterns, and desktop audits to identify potential quality issues.

If we identified that a provider is not complying with our policies and procedures, below are actions that we take to address:

- ***Schedule a counseling session to discuss with the provider and/or office staff on the specific issue. Our goal during the counseling session is to identify the cause of the issue, partner with the provider to resolve the issue; we may include our Dental Director in the meeting when appropriate.***
- ***Re-educate provider on the section(s) or area(s) that they did not comply***
- ***Follow up within x days to ensure compliance (timeframe depends on the severity of the issue)***
- ***Continue to monitor if improvement is shown and follow through until provider is in compliance***
- ***Close the office to accept new recipients if no improvement is shown within 60-90 days (timeframe may be shorter depends on the severity of the issue)***

Terminate the office from the network if there is inadequate resolution or a refusal to comply with our policies and procedures.

3.15.4.10 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:

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

B. 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

C. If the vendor is notified or discovers that the OIG, DHCFP or another state Medicaid agency or certification/licensing entity has taken an action or imposed a sanction against a network provider, the vendor shall review the provider's performance related to this RFP and take any action or impose any sanction, including disenrollment from the vendor's provider network.

LIBERTY's Special Investigative Unit (SIU) maintains a training and educational library specific to Fraud, Waste and Abuse (FWA) in conjunction with LIBERTY's Compliance Program, and assists in providing training to employees, contractors and other business entities. The Program Integrity Plan fully supports and requires compliance with the federal and state laws that prohibit the submission of false claims in conjunction with federal health care programs, including Medicaid and Medicare.

LIBERTY maintains a FWA Prevention and Detection Plan that demonstrates its commitment to prevent, detect, and correct incidents that could lead to FWA, including provider disciplinary actions and/or sanctions.

Provider Verification

Our FWA plan works closely with the Quality Management Department, which oversees an extensive credentialing process for reviewing, accepting or rejecting the professional credentials of each applicant dentist or contracted dental provider. The Provider Relations Department conducts verification that a provider is eligible to participate in the Medicare, Medicaid or Children's Health Insurance Programs (CHIP), along with the required individual background history checks. Our Provider Relations team also verifies NPI provider (Type I) and billing entities (Type II) for accuracy and maintenance purposes. Monthly, information on sanctions, limitations on licensure, and complaints are reviewed between credentialing and subsequent re-credentialing cycles. These sanctions and disciplinary reports are addressed within 30 days of their publication. Information from the State Board of Dental Examiners and other pertinent provider sanction and licensure reports are reviewed at Credentialing Committee meetings. Complaints and adverse events (e.g., injury to a member that happened while receiving health care services from a provider) are tracked and reported to the QMI Committee at least quarterly, or as areas for improvement are identified.

LIBERTY's FWA plan also includes initial background checks as a proactive method to prevent affiliations with or relationships with:

- ***An individual or entity who/that is debarred, suspended, or otherwise excluded from participating in procurement activities under federal Acquisition Regulation or from participating in non- procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;***
- ***An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation; or***
- ***Any individual or entity excluded for cause from participation in ant state Medicare or Medicaid program.***

LIBERTY performs and examines additional screenings for criminal convictions, Office of the Inspector General (OIG) and General Services Administration (GSA) exclusion lists, and other background records prior to employing an associate or appointing a non-employee Director. Upon hire, individuals must agree to comply with LIBERTY's Code of Business Ethics and Conduct and complete all mandatory FWA training courses.

DHCFP's Provider Enrollment Unit will be notified if LIBERTY denies a provider credentialing application, disenrolls a provider for program integrity-related reasons, or otherwise limits the ability of a provider to participate in the program, for program integrity reasons.

A provider's network status may be reduced, suspended or terminated for any lawful reason, including, but not limited to: a lapse in basic qualifications, such as licensure, insurance, board certification or required dental staff membership or privileges at a specified hospital/healthcare facility; a determination that the provider cannot be relied upon to deliver the quality or efficiency of member care desired by Nevada; or a determination that the provider cannot be relied upon to follow our clinical or business guidelines or directives.

3.15.5 Affiliations with Debarred or Suspended Persons

3.15.5.1 Monitoring for Prohibited Affiliations

A. The vendor may not employ or contract with providers excluded from participation in federal healthcare programs.

B. The vendor may not be controlled by a sanctioned individual.

C. 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.

D. 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:

1. Any individual or entity excluded from participation in federal healthcare programs; or

2. Any entity that would provide those services through an excluded individual or entity.

E. 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.

F. 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.

G. 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.

H. 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.

LIBERTY is committed to preventing individuals and entities that are excluded, debarred, suspended, or are otherwise ineligible to participate in federal or state Health Care Programs or Procurement or Non-Procurement Programs, from direct or indirect affiliation with our company. Since government programs make up the vast majority of our business, we have rigorous internal protocols in place to ensure we conduct all required exclusion screenings upon initial engagement and at least monthly thereafter and, for non-contracted payees, prior to payment; that screenings are properly tracked and monitored; that we immediately and appropriately verify and report exclusions to required oversight agencies, and properly pursue any required recoupment; and that we maintain all relevant screening documentation for a minimum of 10 years.

LIBERTY's exclusion screening protocols protect the integrity of the programs in which we participate, and are designed to ensure compliance with contractual requirements, best practices, and all applicable state and federal law including 42 CFR 1002; 42 CFR 438.610; Section 1128(b)(8)(B) of the Social Security Act, etc. Our standard protocols, which have proven effective in LIBERTY's other Medicaid markets, involve:

Screening all owners, employees, providers and subcontractors against federal and state exclusion databases upon initial engagement, and on at least a monthly basis thereafter, and requiring our providers and subcontractors to do the same.

Requiring our officers, providers and subcontractors to disclose any individual or entity with a direct or indirect ownership of five percent (5%) or more in LIBERTY, the Provider Office, or the subcontractor, respectively, together with the individual's date of birth and SSN and/or entity's EIN.

Preventing any individual or entity listed in the excluded or disbarred databases (including owners, employees, providers and subcontractors) from any direct or indirect affiliation with LIBERTY, and requiring our providers and subcontractors to do the same.

Requiring any services directly or indirectly provided by excluded individuals or entities to be refunded to the appropriate entity, and/or obtained elsewhere.

Screening for Suspended, Excluded or Disbarred Entities

Our exclusion screenings apply to our owners, to all employees (including directors, officers, partners, temporary employees and interns), members of our Board of Directors for all LIBERTY subsidiaries and affiliates, all providers to whom we issue payment or who participate in our networks, and all contractors which do business with LIBERTY. We perform required exclusion screenings, at a minimum, upon initial hire/contract and monthly thereafter, and in the case of non-contracted payees, prior to payment. The exclusion screenings we perform include an automated, electronic review of the following databases:

- ***The United States Department of Health and Human Services, Office of Inspector General's ("OIG") List of Excluded Individuals/Entities ("LEIE").***
- ***The General Service Administration's ("GSA") Excluded Parties List System ("EPLS")***
- ***State Medicaid Inspector General's Lists of Restricted, Terminated or Excluded Individuals or Entities***
- ***The Office of Foreign Assets Control – Specially Designated Nationals (OFAC)***

We also check other sources and lists if appropriate. For example, if a potential employee's application indicates that s/he worked in another state—or if a contractor works, or has worked, in any another state—we will check the relevant state-specific databases, if available.

Owner and Employee – Screening and Oversight

LIBERTY's ownership is verified at least annually, through attestations which require disclosure of any person or entity with an ownership interest of five percent (5%) or more in our company, including disclosure of all owner subsidiaries and affiliates. In addition, we require that these attestations be updated any time ownership changes. We screen all owners, including their subsidiaries and affiliates, if any, and all employees, including partners, officers, directors, temporary employees and interns upon initial engagement and at least monthly thereafter, against all required exclusion lists, including those listed above. Our protocols also require comprehensive criminal background checks on all owners and employees.

If LIBERTY learns any owner or employee is excluded, debarred, suspended, or is otherwise ineligible to participate in any of our programs, our protocol requires us to:

- ***Prevent payments to the individual or entity;***
- ***Discontinue any affiliation with the individual or entity;***
- ***Report the individual or entity to all required oversight agencies; and***
- ***Pursue recoupment of funds issued to the individual or entity.***
- ***Subcontractor Screening and Oversight***

LIBERTY contractually binds any vendor that provides us health related or administrative services to adhere to the same exclusion screening protocols as we do. During the due diligence process, LIBERTY also requires each vendor to disclose any person or entity with a direct or indirect ownership interest of five percent (5%) or more in the vendor, including disclosure of all owner affiliates and subsidiaries. In addition to our vendors, LIBERTY screens any entities/individuals the vendor discloses against the required databases. If a LIBERTY vendor or any of its owners, employees or subcontractors becomes suspended, excluded or disbarred at any time, we require the contractor to immediately disclose such information to LIBERTY so that we may ensure that the relationship with the party is properly terminated, all funds are appropriately refunded, and all required regulatory reporting is completed.

In addition to the controls described above, LIBERTY's Delegation Oversight Committee is responsible for formal, ongoing oversight of delegated functions, including verifying, at least annually, that vendors have performed the required exclusion screenings, and that ownership disclosures are current.

Provider Screening and Oversight

Upon initial contract, and at least annually thereafter, LIBERTY requires each participating provider to disclose any person or entity with an ownership interest of five percent (5%) or more in the Provider's Office, including disclosure of all owner affiliates and subsidiaries. LIBERTY screens any entities/individuals the provider discloses against the required databases.

In addition to the routine screenings described above, our Quality Management Department oversees an extensive credentialing process for reviewing and accepting or rejecting the professional credentials of each of our applicant and contracted dental providers. Among other reviews, we perform required individual background history checks on our providers, and review information from the applicable Board of Dental Examiners and other pertinent provider sanction and licensure reports during Credentialing Committee meetings.

Screening Consequences

LIBERTY's policy requires us to place any individual or entity that appears on any exclusion list on a "HOLD payment" status, which prohibits payment from being made to that person or entity, until we verify that the person or entity is indeed excluded from affiliation with our company. If, following an appropriate and prompt investigation, LIBERTY determines that the individual/entity is ineligible to participate with us, we will terminate them or, if they are seeking participation with us, we will withdraw any offer made to them. In addition, we will notify all appropriate government entities, including DHCP, consistent with applicable law or contract. Finally, we will make all reasonable efforts to recover any payments made to excluded entities or individuals and refund them to the appropriate party(ies).

In short, LIBERTY is committed to protecting our recipients' and providers' rights, as well as preventing potential fraud against DHCP and the state of Nevada. We are confident that the strong exclusion screening protocols that have proven to be effective in our other Medicaid markets will be equally successful in Nevada, and will comply with all related requirements under this contract.

3.15.6 Compliance Plan

3.15.6.1 Vendors must have a program that includes administrative and management arrangements or procedures, including a mandatory compliance plan to guard against fraud and abuse.

3.15.6.2 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.

3.15.7 General Requirements

A. 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.

B. The compliance plan must be reviewed and approved annually by the DHCFP.

C. The compliance plan must include the following elements, and any others as directed by the DHCFP:

1. Written policies and procedures for the functions in this section;
2. Standards for effective communication between the Compliance Officer, Program Integrity staff, management, vendor staff, and the DHCFP;

3. 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;
4. Delineation of the staff and division of responsibilities within the vendor's Program Integrity Unit;
5. Specific objectives and goals for Program Integrity operations in the coming year;
6. The process that the vendor will use to enforce program integrity standards through well publicized disciplinary guidelines;
7. The process that the vendor will use to complete internal program integrity monitoring and auditing;
8. How the vendor will promptly respond to detected program integrity offenses and develop corrective action initiatives; and
9. A report on the success of the objectives and goals from the previous year.

We understand and agree to comply with Section 3.15.6 and 3.15.7.

LIBERTY's Compliance Plan clearly defines standards, describes the methods for monitoring standards, and identifies corrective action processes and, among other objectives, is designed to guard against fraud and abuse. Since it is regularly vetted by our various Medicaid and Medicare plan partners to ensure adherence with applicable law, contractual requirements and best practices, we are confident that it will satisfy all requirements under the Nevada contract. Consistent with industry standards, our Compliance Plan includes the following components:

Administratively

- ***Communicates LIBERTY's commitment to compliance.***
- ***Communicates specific organizational objectives to our staff and supports organizational standards of integrity in reporting inappropriate conduct, fraudulent activities, and abusive patterns.***
- ***Establishes a consistent process for distributing and communicating new regulations, regulatory changes, and modifications within the organization.***
- ***Creates accountability for receiving regulatory information, operationalizing regulatory requirements, and monitoring performance against standards.***

Programmatically

- ***Identifies specific regulatory statutes that govern our various Medicaid managed care program operations.***
- ***Establishes program standards in accordance with the specific regulations.***

- ***Establishes a consistent process for analyzing and interpreting the organizational impact of regulations.***

Monitoring

- ***Provides a process to assess our performance against regulatory requirements and established internal performance standards.***
- ***Provides guidance and standards for monitoring activities such as claims processing, customer service, and enrollment functions.***

Disciplinary and Corrective Actions

- ***Provides a process for disciplinary actions for wrongdoing and unlawful behavior.***
- ***Provides a structure for the formation and implementation of corrective measures.***

In addition, our Compliance Plan reflects all elements of a successful compliance program, including:

1. ***Standards & Procedures – LIBERTY has written policies, procedures, and standards of conduct that articulate our commitment to comply with all applicable Federal and State standards.***

2. ***High Level Oversight and Delegation of Authority – LIBERTY has a designated compliance officer and a compliance committee that are accountable to our Board of Directors.***

3. ***Employee Training – We provide effective, comprehensive compliance training and education to all employees and providers upon new hire/contract, and annually thereafter.***

4. ***Communication – We have well publicized, effective lines of communication between our compliance officer and employees, including various mechanisms for anonymous reporting (online, email, phone, and fax).***

5. ***Monitoring and Auditing – LIBERTY is subject to up 15 independent audits per month to ensure compliance with all applicable standards.***

6. ***Enforcement and Disciplinary Mechanisms – We enforce compliance standards through well-publicized disciplinary guidelines.***

7. ***Corrective Actions and Prevention – After an offense has been detected, LIBERTY takes reasonable steps to respond appropriately t and to develop corrective action initiatives, including adhering to any applicable reporting requirements.***

8. ***Program Integrity – We delineate the staff and division of responsibilities within our Program Integrity Unit, and outline specific objectives and goals for Program Integrity operations annually***

9. ***Reporting – We report to the Board of Directors quarterly on our compliance program, and issue a year end summary on the success of the year's goals.***

3.15.8 Deficit Reduction Act

3.15.8.1 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:

A. 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);

B. 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

C. 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.

LIBERTY is fully aware of and compliant with the requirements of Deficit Reduction Act of 2005. As a result, through our Fraud Waste and Abuse program (attached) we establish comprehensive written polices for our employees and staff that provide detailed information about the False Claim Act and any related state laws pertaining to civil or criminal penalties for false claims and statements, and whistle blower 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.

In addition, our employee handbook and annual compliance training includes specific discussion of these laws, the rights of employees to be protected as whistleblowers, as well as our policies and procedures for detecting and preventing fraud, waste, and abuse. Please see Attachment 15 for our FWA Program.

3.15.9 Under-utilization of Services

3.15.9.1 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:

A. An annual review of their prior authorization procedures to determine that they do not unreasonably limit a recipient's access to Medicaid-covered services;

B. An annual review of the procedures providers are to follow in appealing the vendor's denial of a prior authorization request to determine that the process does not unreasonably limit a recipient's access to Medicaid-covered services; and

C. Ongoing monitoring of vendor service denials and utilization in order to identify services which may be underutilized.

We rely on utilization and authorization data to monitor trends in recipient utilization, as well as provider treatment patterns, to ensure beneficiaries are accessing appropriate covered services and providers are emphasizing preventive and restorative services when appropriate. We have developed a proprietary UM analysis tool that allows us to establish network normative patterns for every dental service category. We use various methods to identify and track Utilization Data from our core application. Our system houses Claims, Estimate, Check, Provider\Office, Group, Billing, Member communications, and all other supporting data. Our reporting tools enable us to pull data from the core system on a regular basis, using the existing datasets, which can then be exported and referenced for a variety of reporting needs. These include test and reporting environments, data warehouse, and custom applications that share data from the core system.

To supplement the review of submitted utilization data, we leverage data produced by our Analytics and Dental Care Management teams to identify trends in care gaps suggesting under-utilization of services. Utilization management and care gap data are reviewed and analyzed regularly and discussed at quarterly QM and Peer Review meetings for utilization management. Information is also presented to our Utilization Management Commitment to solicit feedback and drive actions to improve utilization and, ultimately, health outcomes.

In addition, our UM analysis tool automatically analyzes every network dental office against the established patterns of utilization and identifies both over and under-utilizing

providers in each dental service category. The UM Tool allows us to develop customized corrective actions and counseling for every provider identified.

We conduct an annual review of all Utilization Management policies and procedures which includes the processes for prior authorizations (and LIBERTY's follow-up and outreach to monitor any under-utilization of services approved through the prior-authorization process) to ensure they do not unreasonably limit Medicaid covered services. Figure 3.15.9-1 provides a sample UM reporting authorization form.

FIGURE 3.15.9-1. SAMPLE UM REPORTING AUTHORIZATION

Qtr	Category	Total Pre-Service Requests	Fully Favorable	% Fully Favorable	Partially Favorable	% Partially Favorable	Adverse	% Adverse	Pre-service Determinations made Within Required Timeframes (Std)	% Pre-service Determinations made Within Required Timeframes (Std)	Pre-service Determinations Made Within Required Timeframes (Expedited)	% Pre-service Determinations Made Within Required Timeframes (Expedited)	Pre-service Monthly Submissions
	Jan 2016												
	Feb 2016												
	Mar 2016												
1st Qtr. Total													
	Apr 2016												
	May 2016												
	Jun 2016												
2nd Qtr. Total													
	Jul 2016												
	Aug 2016												
	Sep 2016												
3rd Qtr. Total													
	Oct 2016												
	Nov 2016												
	Dec 2016												
4th Qtr. Total													
	2016 Total												

We will set guidelines and maintain a complaint and appeals process to streamline the claims/preauthorization settlement practices and provider appeal resolutions in accordance with current regulations. An annual review of the procedure providers are instructed to follow in appealing a denial of an authorization request is conducted to ensure the process does not unreasonably limit a recipient's access to Medicaid-covered services.

We review denial data quarterly, or upon demand when a provider or pattern is identified as part of our UM program in identifying over/under utilization.

An example of our success in monitoring and acting on under-utilization is detailed below. Other examples are available in section 3.3.4.1 of this proposal.

Fluoride Initiative for Children

Through utilization trend analysis and discussions with numerous professionals, advocates and stakeholders, we identified that an unusually high number of our child members were not receiving fluoride treatments

during their office visits. Research shows that a simple fluoride swab may be critical to eliminating or diminishing dental disease. Visiting a dental provider at an early age for oral health examinations and preventive services significantly decreases or eliminates a child's anxiety about dental treatment. Therefore, we developed the Fluoride Initiative in California to increase early fluoride application on children three years and younger. We will work with DHCFP to implement this initiative immediately as part of our initial outreach and education efforts, as it improved utilization rates of fluoride treatments in the California Medicaid Managed Care Program by 31 percent for our members. Below, we describe the premise of the outreach program, as well as its successful results.

We worked with several providers chosen specifically for their ability to work with and effectively treat young children. These providers were paid an additional supplemental payment to perform child visits and apply fluoride varnish to children between the ages of zero and three years old. For this particular outreach program, we contacted the parents and guardians of the zero to three populations via an outbound phone call campaign, and helped those members set dental appointments at the identified providers.

To measure our progress and success, we used claims data to determine the number of eligible children between the ages of zero and three years old, who received fluoride treatments prior to the initiative and again following the initiative. Table 3.15.9.2-2 demonstrates the significant utilization improvement of 31 percentage points for fluoride treatments for the California Medicaid Managed Care Program due to our fluoride initiative.

TABLE 3.15.9-2 FLOURIDE TREATMENTS IN CHILDREN 0-3

	Prior	After
Eligible Members Age 0-3	4,298	5,040
Members Who Received Fluoride Treatments	828	2,515
Percentage of Member Who Received Fluoride Treatment	19%	50%

3.15.10 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.

LIBERTY closely monitors employee, provider and subcontractor activities in order to prevent and detect embezzlement and theft. Our existing protocols require us to immediately report any suspected criminal activity to the appropriate authorities, such as the DHCFP SUR unit, should we be awarded the Nevada contract.

Employees

LIBERTY uses a comprehensive set of internal controls to identify potential employee theft and embezzlement. Here is an overview of some of the practices we use to prevent and discover theft of cash, cash equivalents, and property:

- ***We secure all checks and deposit slips. By storing account checks and deposit slips separately from our operating accounts, we make it more difficult for employees to steal, and lessen the chance of someone mistakenly writing a check on or making a deposit to the wrong account.***
- ***We require supporting documentation when signing checks or authorizing transactions. Our accounts payable staff is well trained to question check requests for any non-approved vendor, or any vendor whose name is not recognized.***
- ***We employ formal check-writing procedures. For example, requests for "rush" or blank checks are not permitted under standard operating procedures. The greater the check amount, the more levels of approval required before payment is issued.***
- ***We limit the amount of petty cash we keep on hand.***
- ***We routinely review all bank statements and transactions for any irregularities. Our finance team verifies that deposits were made in a timely manner and that no deposits were reduced by cash returned to the person making the deposit. We also look for any missing checks or breaks in check sequence.***
- ***We review financial statements at least quarterly for any radical changes in expenditures. Among other transactions, payroll and office expenses are highly scrutinized.***
- ***We conduct periodic audits. If we discover missing or altered documents or past-due notices for bills that should have been paid, we investigate. We also review to be sure amounts credited to clients on billing statements match the funds collected.***
- ***We know our people. We perform comprehensive background checks, and verify employee references.***
- ***We separate and rotate accounting duties. Since centralized accounting responsibilities make it more difficult to detect theft or other problems, we ensure payroll is scrutinized by someone other than the person responsible for cutting the payroll checks.***
- ***We carefully inventory and monitor our IT, and other high value assets.***

In addition, LIBERTY's Employee Handbook sets forth our expectations of employees, and describes what employees can expect from us. Our handbook makes employees aware that we may investigate them if they are suspected of dishonesty or theft, and sets parameters and consequences for conduct that falls into those categories. When we discover evidence that leads us to believe employee theft has occurred, we take immediate action including suspending or placing the employee on administrative leave pending a full investigation. In the event our investigation confirms a finding of employee theft, we immediately involve and cooperate with any relevant enforcement agencies, make all reasonable efforts to recover the stolen assets, and inform our clients and oversight agencies, as required by law or contract.

Providers & Subcontractors

Our services must be delivered by appropriately licensed and accredited providers. Members and Providers are expected to truthful represent all clinical circumstances and only to use/provide clinical services that are medically necessary. As part of this commitment, LIBERTY has established and will maintain a Corporate Compliance Program that includes a Fraud, Waste, and Abuse Prevention Program (FWAP Program). The LIBERTY Compliance Officer is responsible for oversight of the FWAP Program. All Covered Individuals are expected to immediately report any potential false, inaccurate, or questionable claims or Suspicious Activity, to their supervisors, the LIBERTY Compliance Officer, or the Compliance Hotline. The LIBERTY Compliance Officer will promptly investigate and report Suspicious Activity. LIBERTY does not discriminate or retaliate in any way against any Employee or other party who reports a perceived problem, concern or Fraud, Waste, and Abuse issue in good faith.

A provider's submission of a claim for payment constitutes a representation by the provider that the services or supplies reflected on the claim, including all quantities set forth on that claim:

- ***Were medically necessary in the provider's reasonable judgment;***
- ***Were filed accurately, using complete and appropriate coding;***
- ***Have been properly documented in the member's medical record(s);***

A provider's submission of a claim for payment also constitutes the provider's representation that the claim is not submitted as a form of, or part of, fraud, waste and abuse)as defined above) and is submitted in compliance with all applicable state and federal laws and regulations.

Any amount billed by a provider in violation of this policy, if paid by LIBERTY, constitutes an overpayment by LIBERTY that is subject to recovery.

Any amounts billed to and paid by members in violation of this Policy, must be immediately refunded to such members. A Provider may not bill members for any amounts due resulting from violation of this Policy.

Providers are responsible for submission of accurate claims. All EDI claims must be submitted in accordance with HIPAA 5010 Standards and Paper claims must be submitted on either CMS1500 or CMS1450 (UB04) claim forms. LIBERTY's reimbursement policy includes the use of Current Procedural Terminology (CPT®1), guidelines from the Centers for Medicare and Medicaid Services (CMS), and other coding guidelines. Providers will be reimbursed based on the codes(s) that correctly describe the health care services provided.

LIBERTY reserves the right to audit any provider and/or facility to ensure compliance with the guidelines stated in this payment policy in accordance with our provider review policy.

Examples of Suspicious Activities

Providers:

- ***Billing for services or supplies that were not provided. This includes billing for "no shows" (for example, billing members for services that were not actually furnished because the patients failed to keep their appointments)***
- ***Misrepresenting the diagnosis for the patient to justify the services or equipment furnished***
- ***Altering claim forms or medical records to obtain a higher payment amount***
- ***Deliberately applying for duplicate payment (for example, billing LIBERTY and the member for the same service or billing both LIBERTY and another insurer in an attempt to get paid twice)***
- ***Soliciting, offering, or receiving a kickback, bribe, or rebate (for example, paying for a referral of patients in exchange for the ordering of diagnostic tests and other services or medical equipment)***
- ***Unbundling or billing for separate portions, rather than for the whole procedure (for example, the billing of a multi-channel set of lab tests to appear as if the individual tests had been performed)***
- ***Characterizing the service differently than the service actually rendered or misrepresenting the services rendered, amounts charged for services rendered, identity of the person receiving the services, dates of services (for example, falsely indicating that a particular healthcare professional attended a procedure)***
- ***Upcoding to maximize payments (for example, billing for 45-50 minutes of psychotherapy when the documentation states 20-30 minutes of face to face psychotherapy occurred)***
- ***Using unlicensed staff and billing for their services as if provided by a licensed health care professional or physician***
- ***Performing unnecessary procedures, tests, or even surgeries or prescribing additional and unnecessary treatments (over-utilization) or more expensive than indicated medications (drug diversion)***
- ***Requiring a member to return for unneeded follow-up services***
- ***Balance billing members for services***
- ***Billing for non-covered services as covered services (for example, routine foot care billed as a more involved form of foot care to obtain payment)***
- ***Participating in schemes that involve collusion between a provider and a member, or between a supplier and a provider that result in higher costs or charges***
- ***Utilizing split billing schemes (for example, billing procedures over a period of days when all treatment occurred during one visit)***
- ***Billing for "phantom" providers who are not really doctors, dentists, or health care professionals, who attempt to get money from a health plan by submitting claims on real members that they have not seen. These providers may or may not supply a W-9 and do not have licenses to perform the services.***
- ***Billing for "phantom" patients who do not exist and did not receive services***
- ***Billing for more hours than there are in a day***

FIGURE 3.15.10-1L'BERTY's SUCCESSES IN IDENTIFYING AND INVESTIGATING FRAUDULENT ACTIVITIES IN OTHER STATES

Examples of LIBERTY's Successes in Identifying and Investigating Fraudulent Activities in other States

- ***In 2014, LIBERTY identified an outlier provider from the State of Illinois Medicaid program within 2 months of the health plan's transition to LIBERTY. Upon investigation, it was found the provider been billing for years for services that were not rendered. We counseled the provider regarding the aberrant patterns, and authorities were notified. The provider abandoned the office and LIBERTY terminated this provider's contract. In June 2016, the Office of Inspector General sent out a provider alert to a wide array of different carriers suspending all payments to this entity.***
- ***In February 2015, an outlier provider in Florida was identified as warranting investigation. Our on-site audit revealed the office environment was not conducive to child well-being, and we subsequently terminated the provider contract. The provider was later arrested for Medicaid fraud and allegations of child abuse.***
- ***In April 2015, LIBERTY identified a provider that demonstrated a pattern below the standard of care. The provider was deemed to be systematically undermining and defrauding the system. Children who obtained care had undetected caries, sealants place over fillings, fillings placed over sealants, and overall treatment was below the standard of care. We terminated the provider contract and reported to authorities. As of November 2016 this case is still under investigation by the Illinois State Police.***

Members:

- ***"Loaning" or using another person's insurance card to obtain medical care and benefits***
- ***Providing false information when applying for programs or services***
- ***Filing requests for reimbursement for services or medications not received***
  - ***Adding an ineligible dependent to the plan or not taking a dependent off a policy when the dependent is no longer eligible for coverage***
  - ***Failing to disclose multiple coverage policies, or leveraging various coverage policies to "game" the system, resulting in improper coordination of benefits.***
- ***Using a false home address to obtain coverage when your primary address is out of the service area***
- ***Forging or altering bills or receipts to obtain inappropriate reimbursement from the health plan.***
- ***Forging or altering a prescription or improperly obtaining prescriptions for controlled substances.***

- ***Obtaining prescription drugs from a provider, possibly for a condition from which the member does not suffer, and giving or selling this medication to someone else.***
- ***Doctor shopping: Member consults a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might also be indicative of an underlying scheme, such as stockpiling or resale on the black market.***

Non-Members:

- ***Using a stolen member card for obtaining medical services, including medical supplies and prescriptions***

Brokers and Agents:

- ***Altering documents***
- ***Accepting or offering kickbacks or bribery***
- ***"Clean sheeting" or falsifying or misrepresenting member or group information to obtain better rates. This act makes the applicant for coverage appear to be a better risk for policy acceptance.***
- ***Failure to disclose information that may affect conditions of coverage***
- ***Sale of non-existent policies***

Health Plan Employees:

- ***Fabricating claims***
- ***Risk Adjustment***
  - ***Participating in schemes that involve collusion between a provider and an employee where the claim is assigned (for example, the provider deliberately over-bills for services, and the employee then generates adjustments with little or no awareness on the part of the member)***
  - ***Manipulating claims data on unassigned claims for one's own benefit (for example, through manipulation of member address or the claims history record, an employee could generate adjustment payments against many member records and cause payments to be mailed to an address known only to him/her)***
  - ***Failing to provide medically necessary items or services that the organization is required to provide (under law or under the contract) to a member, and that failure adversely affects (or is substantially likely to affect) the member.***
  - ***Marketing Schemes: When a health plan violates the Medicare or Medicaid marketing guidelines, or other federal or state laws, rules, and regulations to improperly enroll members. Examples of such violations include, but are not limited to:***
    - ***Offering members a cash payment as an inducement to enroll in a Medicare or Medicaid plan;***
    - ***Unsolicited door-to-door marketing;***
    - ***Use of unlicensed agents;***
    - ***Enrollment of members without their knowledge or consent;***

- ***Stating that a marketing agent/broker works for or is contracted with the Social***
- ***Security Administration or CMS;***
- ***Misrepresenting the product being marketed as an approved Medicare Plan when it actually is a Medigap policy or non-Medicare plan;***
- ***Requesting member financial information or check numbers (potential identity theft by marketing agents).***

3.15.11 Verification of Services

3.15.11.1 The vendor must verify that services billed by providers were actually provided to recipients.

3.15.11.2 The vendor may use Explanations of Benefits (EOBs) or Verification of Services (VOS) letters for such verification.

3.15.11.3 VOS letters, if used instead of EOBs, must be sent to at least 500 recipients each month.

We understand and agree to comply with Section 3.15.11.

We will verify that services were actually performed using multiple approaches. First, our Member Services Team performs monthly service verification surveys using outbound call surveys and call campaigns. These monthly surveys help verify and validate services rendered to recipients, as well as notify recipients of their benefits in an effort to increase utilization of preventive services.

Leveraging our call center personnel, outbound calls to survey recipients regarding a description of the service furnished, the name of the provider who furnished the service, the date on which the service was furnished, and the amount of payment made for the service. Though September 2016, our outbound call unit has completed approximately 20,000 calls to recipients in calendar year 2016. This year's outbound call campaigns included Notification of Utilization calls, Transition of Care calls for new business, and various surveys including Verification of Services rendered.

All feedback will be used to modify and enhance the verification of receipt of paid services sampling methodology. In addition, all survey results that indicate that paid services may not have been received by the recipient will be referred to DHCFP and our own internal Fraud, Waste, and Abuse department within three business days for review.

The second way that we will verify that services were actually performed is via claim documentation analysis. Our Claims Management team verifies services based on documentation submitted with claims, including attachments such as radiographs,

study models, photographs, chart notes, and narrative reports. Our Claims Processing staff, along with our licensed Dental Consultants on staff, manually review approximately 30% of the claims that are received that are not auto-adjudicated. In situations where something does look questionable or raises a flag, the Claim Processors will escalate the information to our Utilization Review team to investigate. We have determined that less than 1% of submitted claims appear to be related to service(s) that were not actually performed.
Our Internal Audit team investigates a random sampling of all claims completed within a given month, also verifying documentation submitted to justify services or provide a rationale for necessity. This review looks at another approximately 5% - 10% of claims.

Finally, we have a vigorous Utilization Review process which reviews dental billing patterns for outliers. Providers' billing patterns are compared against their peers' for the same or a similar population, analyzing variables such as average procedures per recipient, per appointment, or per quadrant. For example, we take a proactive approach for some Health Plans when it comes to providing preventive services by analyzing providers within a given geographical area who do sealants on children. After establishing a threshold for the number of sealants that need to be performed on children and an acceptable standard deviation from that threshold, we can identify those providers who fall below the standard deviation, reach out to them, and consult with them on performing more sealants.

If an outlier is identified via these internal service verification methods, our local Dental Directors reach out to the offices to either discuss the results of our internal research or, in some cases, perform a desktop audit of dental charts from that office. We have regular reporting options that can be generated to report these audits and audit results.
Additionally, we have the capability to create ad hoc reports based on almost any criteria or data that we capture internally. Once requirements are provided, we can write specifications needed and generate requested state reports within a week, depending on the complexity and volume of data required. Our thorough internal service verification processes will ensure the provision of accurate claims for services confirmed to have been performed.

3.15.12 Hotline for Reporting Suspected Fraud, Waste, Abuse or Improper Payments

3.15.12.1 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.

3.15.12.2 The hotline number must be prominently displayed in a stand-alone frame placed on the vendor's front page of their Nevada Medicaid website.

3.15.12.3 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.

3.15.12.4 If the vendor also uses a web page for receiving program integrity complaints, it must:

A. Be accessible and simple to use by the public, recipients and providers;

B. Have a stand-alone highlighted button or link on the vendor's front page of their Nevada Medicaid website; and

C. Be identified with language which states clearly the button or link is for use in reporting Medicaid fraud, waste or abuse.

We understand and agree to comply with Section 3.15.12.

We understand that under the federal False Claims Act, as well as The Nevada False Claims Act, any person or entity that knowingly submits a false or fraudulent claim for payment of United States Government funds is liable for significant penalties and fines. LIBERTY maintains a FWA Hotline for anonymous reporting for the public, recipients and providers to report allegations of fraud, waste, abuse and improper payments. We encourage anonymous, confidential and private, good faith reporting of FWA issues and make available a stand-alone frame that easily identifies the hotline number which will be displayed on our Nevada Medicaid website.

We utilize the most up-to-date technology to provide service and support to our Recipients and providers. LIBERTY's website provides us with an avenue to assist and educate our Recipients and Providers 24/7. While all information on our website is available through other means if requested by the Recipient or Provider, our website allows full and convenient access to the information they need.. LIBERTY offers technology platforms for our Recipients and Providers to use. The Nevada Medicaid website will include separate sections for Recipients, Providers and the general public. A stand-alone highlighted button or link will bring the user to a venue where they can easily log their concern.

We have developed our technology platforms with our Recipients and Providers in mind. All navigation and links are designed to provide simple navigation to Recipients of all education levels and technology experience. Upon contract award, LIBERTY will be committed to ensuring our member-facing technology platforms have the functionality to meet all of Nevada's requirements.

3.15.13 Vendor's Program Integrity Unit

3.15.13.1 Unit Composition

A. 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.

B. 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.

C. 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.

D. 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.

E. Qualified staff shall have experience in health care claims review, data analysis, professional medical coding or law enforcement.

F. The number of full-time equivalents (FTEs) dedicated to the PIU must be at least one per 50,000 Medicaid recipients.

G. 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.

We understand and agree to comply with section 3.15.13.

LIBERTY maintains a distinct Program Integrity Unit (PIU) whose responsibilities include the identification, review, recovery, and reporting of improper Medicaid payments, including fraud, waste, and abuse (FWA) activities.

Our PIU plays a critical role in ensuring the integrity of the programs in which we participate, and:

Is led by our compliance officer and committee, both of whom are accountable to senior management and our Board of Directors. Our compliance officer is accustomed to regularly communicating with state oversight agencies, such as the DHCFP Program Integrity and SUR staff, by telephone, email, text message, etc., on demand, during and after standard business hours, based on the circumstances of any given PIU matter.

Is properly resourced with highly qualified staff, experienced in health care claims review, data analysis, professional medical coding and law enforcement, who are available to conduct reviews, recovery and reporting of improper payments, including

FWA activities. Our PIU staff receive on-going, specialized training in conducting compliance reviews.

If awarded the Nevada contract, we will dedicate at least one PIU FTE to every 50,000 Nevada Medicaid recipients. In addition, our PIU is fully prepared to meet with DHCFP personnel either in person or via telephone on a monthly basis to provide information and updates on cases.

3.15.14 Fraud Identification and Referral

3.15.14.1 Vendor shall establish policies and procedures to identify and refer credible allegations of fraud to the SUR Unit of the DHCFP.

If the PIU determines possible fraud, waste or abuse has occurred, we will report these findings and supporting documentation to the SUR Unit of the DHCFP.

We will comply with DHCFP /SUR Unit and will report any credible allegations of fraud including, but not limited to, the false or fraudulent filing of claims and the acceptance of or failure to return reimbursement for claims known to be fraudulent for investigation by SUR Unit, of the Nevada DHCFP office.

Our FWA and PIU staff will work in collaboration with SUR in all program integrity related matters. It is our goal to assist the SUR Unit Team in seeing all potentially fraudulent activity come to a resolution. Fraudulent activity may involve, but is not limited to: an associate, Director, employee, contactor or member who is involved in inappropriate schemes or behavior, or a health care provider who is involved in false documentation; inappropriate referrals; falsification of conditions in order to help an individual receive an otherwise uncovered service under Medicare or Federal programs; or a combination of scenarios.

3.15.14.2 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.

LIBERTY maintains a FWA Hotline for anonymous reporting and a Program Integrity Unit (PIU) that investigates all reports of potential FWA. We currently work with designated state and Federal agencies, and law enforcement to pursue individuals or organizations who may be involved in activities that fall under the FWA umbrella and will pursue prosecution of health care fraud and abuse.

When a report or identification of suspected provider fraud, waste or abuse is communicated to the PIU through the various reporting mechanisms, a preliminary investigation is initiated to collect relevant data and evaluate and analyze the circumstances of the allegation. We will determine if a credible allegation of fraud exists prior to reporting issues to the SUR Unit of the DHCFP.

3.15.14.3 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.

Upon confirmation that a credible allegation of fraud exists, the PIU will submit a fraud referral form to the SUR Unit of the DHCFP within two (2) days of such confirmation. Our PIU will submit this form via the DHCFP website.

3.15.14.4 The vendor's fraud referral must provide, at a minimum, the following information and any other information specified by the DHCFP:

A. Provider's name, Medicaid provider number or provider's National Provider Identifier (NPI);

B. Nevada Medicaid provider type;

C. Recipient's name and Medicaid number;

D. Date and source of the original complaint or tip;

E. Description of alleged fraudulent activity, including:

1. Specific laws or Medicaid policies violated;

2. Dates of fraudulent conduct; and

3. Approximate value of fraudulently obtained payments.

Our PIU staff will follow the guidelines set forth by DHCFP/SUR Unit as it relates to fraud referral submission. At a minimum the referral will include but not be limited to:

- ***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;***

- ***Approximate value of fraudulently obtained payments by the provider.***

F. Any other agencies or entities (e.g., medical board, law enforcement) notified by vendor, and any actions they have taken;

An important aspect of our Fraud, Waste and Abuse (FWA) plan addresses referrals to relevant government agencies for investigations and/or prosecution when appropriate. Any knowledge obtained from outside agencies or through the efforts of LIBERTY's SIU will be fully disclosed as appropriate. Our goal is to serve as a conduit of information to the DHCFP/SUR Unit to help ensure a thorough and concise investigation on their part therefore all documents and preliminary investigative analysis will accompany the fraud referral to the SUR Unit. We will include available information regarding any actions taken by other agencies or entities, including the dental board and law enforcement.

G. The findings from the vendor's preliminary investigation and proposed actions;

H. After submitting the fraud referral, the vendor will take no further action on the specific allegation until the SUR Unit responds;

I. 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

J. 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.

An important aspect of our Fraud, Waste and Abuse (FWA) plan addresses referrals to relevant government agencies for investigations and/or prosecution when appropriate. Any knowledge obtained from outside agencies or through the efforts of LIBERTY's PIU will be fully disclosed as appropriate. Our goal is to serve as a conduit of information to the DHCFP/SUR Unit to help ensure a thorough and concise investigation on their part therefore all documents and preliminary investigative analysis will accompany the fraud referral to the SUR Unit.

Once we have referred any suspected case of FWA to the SUR Unit, LIBERTY will cease all investigative efforts until further notification from the SUR Unit.

Upon notification that the referral has been declined by the SUR Unit, LIBERTY will continue our initial investigation in accordance with the reporting requirements contained in this contract.

Upon notification that the fraud referral has been accepted by the SUR Unit, we will work closely with the Nevada SUR Unit as instructed in identifying and investigating allegations of FWA and erroneous payments. We will cooperate fully in any investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. We will provide, upon request, any information, access to records, and access to interview LIBERTY employees, subcontractors and providers that will assist in bringing investigations to resolution at our own expense.

3.15.15 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.

If the potential Fraud, Waste and Abuse (FWA) involve a provider, the inquiry may initially focus on pulling claims data and reviewing it to identify potential FWA. The provider's records will be requested and obtained for analysis. Nevada's DHCFP provider agreements will contain language requiring providers to comply with record requests. The review may include engaging dental experts and clinicians to assess medical necessity and review of claims to identify up-coding and other fraudulent behaviors. These investigative efforts are supplemented by interviews, public records reviews and similar investigative efforts to get as complete and accurate understanding of the issue as possible. Once a determination has been made that a provider has engaged in Credible Allegations of Fraud (CAF), remedial actions will be identified, which may include payment suspension, recovery of an overpayment, termination of the provider and referral to the SUR unit of the DCCFP.

LIBERTY will work collaboratively with the DHCFP and upon instruction; impose suspension of payment to an entity or individual to avoid possible imposed penalties.

3.15.16 Compliance Reviews

The vendor's PIU must specifically address the identification, review, recovery, prevention, and reporting of improper payments, including fraud, waste, and abuse.

LIBERTY's strength in FWA and improper payment detection and resolution is our proactive identification of inappropriate care patterns that burden Medicaid programs with unnecessary costs. We have protocol and workflows in place to identify and counsel providers regarding potential utilization outliers—behaviors such as billing for services not rendered; unusual billing patterns; deviations from the Standards of Care; and practices below the Standards of Care. Our core MIS system allows us to identify unique elements on claims through custom logic, providing us with an opportunity to evaluate FWA, improper payments or other outliers.

Each quarter, LIBERTY will conduct desk audits and/or on-site focused patient chart audits on the contracted provider network. The audits may also be initiated upon direction from the Dental Director based on benchmark outlier patterns. The objective is to have all contracted network providers receive either a desk audit or a focused on-site audit once every three years. Each quarter, LIBERTY's SIU Committee produces an internal summary report to the Quality Management and Improvement Committee summarizing the FWA activities and results from that quarter. The summary report looks at FWA indicators including, but not limited to:

- ***Double billing***
- ***Eligibility***
- ***Patterns of care below expected or established standards***
- ***False dates of service***
- ***Inappropriate misleading coding (leading to an incorrect benefit)***
- ***Excessive treatment patterns***
- ***Improper payments***

The report presents new and resolved audits, as well as the status of all other current audits. In the case of ongoing audits, the report documents the recoveries, recoupments, and initiatives from specific providers to summarize LIBERTY's FWA activities and progress in meeting program integrity-related goals. Finally, the Audit Report documents the instances of referrals of fraud and prosecutions and instances of FWA training in the respective quarter. In the third quarter of 2016, for example, ten SIU cases were identified by various means and 11 cases were resolved. Nine of the 11 resolved cases required additional action, such as counseling, creation of a Corrective Action Plan, and/or recovery measures.

This FWA Audit Report will be adjusted to a format and method approved by DHCFP or

OIG and delivered on a quarterly basis, or as otherwise directed. With this information, LIBERTY can create a report for DHCFP with recoupment totals for the reporting period, as well as projected upcoming activity and the top providers on LIBERTY's list for audit.

LIBERTY has a detailed Fraud, Waste and Abuse (FWA) and improper payments training education program for our members and participating providers. Helping our members and providers to be aware of what to look for, and to be encouraged to "say something when they see something" is our first line of defense in preventing FWA and improper payments.

LIBERTY's FWA and improper payment prevention training program includes:

- ***Examples of FWA behaviors.***
- ***CMS Fraud, Waste, Abuse and Improper Payment on-line training.***
- ***Instructions for reporting potential FWA.***
- ***Education on LIBERTY's FWA reporting hotline.***
- ***Training on LIBERTY's Grievance Process.***

Member FWA/Improper Payment Training

We believe that the prevention of Fraud, Waste and Abuse and the awareness of improper payments begins with raising member awareness upon enrollment. Members are educated through various methods including, but not limited to the member handbook, the member portal and the member welcome letter. Members also receive ongoing education through our Member Services outreach programs. We encourage members to report FWA and improper payments. LIBERTY investigates all reported FWA's and take appropriate actions.

Provider FWA and Improper Payments Training

LIBERTY has developed a robust Fraud, Waste and Abuse prevention education and training program for our providers. We educate our providers via webinars education sessions, in person education during orientations and service visits conducted by our Network Managers. We require our providers to complete either the CMS-developed or the LIBERTY version of General Compliance and Fraud Waste and Abuse training courses. We also evaluate provider utilization patterns through our Dental Care Management program to identify potential fraud, waste and/or abusing providers and/or members.

3.15.17 Identification

3.15.17.1 The PIU will review all tips, complaints and referrals in a timely manner. Sources may include, but are not limited to:

A. Fraud hotline or website;

B. Referrals from the DHCFP;

C. Referrals from the vendor's own organization including utilizations of data systems to identify issues such as provider profiling or data analysis; or

D. Verification of Service letters/EOB's complaints.

3.15.17.2 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.

3.15.17.3 All tips, complaints and referrals must be tracked and reported to the DHCFP monthly regardless of the outcome.

The PIU employs a team of knowledgeable professionals dedicated to detecting, investigating, preventing and remedying of FWA. The PIU team includes investigators who collaborate with dental coding auditors and a clinical nurse in order to resolve allegations of FWA on the part of providers or members. The PIU's senior data analyst proactively identifies possible cases of FWA utilizing statistical analysis and data mining software. The PIU also employs business analysts and dental care management coordinators, all of whom assist with case referrals, the case management system, the PIU anti-fraud hotline, respond to requests from government partners, internal departments and support the PIU's regulatory reporting responsibilities.

The PIU team will respond and review all tips, complaints and referrals in a timely manner that meets or exceeds expectations set by the DHCFP.

Throughout the process, DHCFP will be engaged as appropriate and required in LIBERTY's agreements with DHCFP. This includes formal reporting of all tips monthly, immediate reporting of allegations being investigated and formal monthly reporting in the format prescribed by DHCFP.

3.15.18 Review

3.15.18.1 The PIU will conduct a review of any identified issues by collecting and analyzing available relevant information, including, but not limited to:

A. Encounter data;

B. Provider credentialing and enrollment records;

C. Provider self-audits;

D. Provider treatment records;

E. Prior authorization records;

F. Recipient verification of service letters/EOB's;

G. Nevada Medicaid Services Manual (MSM); and

H. Nevada Medicaid Billing Guidelines.

3.15.18.2 The PIU will determine which, if any, encounters were improper payments.

LIBERTY's PIU identifies FWA through a variety of sources, including, but not limited to:

- ***Incorporating clinical and non-clinical sources of information to analyze patterns of care based on patient age and demographics, and by provider type and geography.***
- ***Comparing statistics with regional, product-based and national profiles.***
- ***Analyzing and establishing benchmarks and standards.***
- ***Providing clinical feedback and guidance from our Chief Dental Officer and State Dental Directors.***
- ***Focusing on managing the appropriateness of care (as defined by clinical criteria, professional standards of care, and based on each member's available dental benefits), for both services that are auto-adjudicated and services that are reviewed for medical necessity by licensed dental consultants.***
- ***Benchmarking provider's performance against other comparable providers, based on specialty and geography.***
- ***Managing, tracking and trending of practice patterns based on Utilization data.***
- ***Analyzing clinical patterns and developing action plans as appropriate.***
- ***Encounter data.***
- ***Provider credentialing and enrollment records.***
- ***Provider treatment records.***
- ***Prior authorization records.***
- ***Provider self-audits.***
- ***Nevada Medicaid Services Manual (MSM).***
- ***Nevada Medicaid Billing Guidelines.***

Our core MIS system allows us to identify unique elements on claims through a custom logic, allowing us to evaluate for FWA or other outliers. Our Utilization Management team then analyzes key elements of data to help minimize or eliminate potential FWA and improper payments, while maximizing effectiveness of care. We also conduct monthly retrospective chart reviews of randomly selected providers in addition to utilization data that is reviewed.

The PIU unit will determine which, if any, encounters were related to improper payments based on initial analysis of the data and the array of follow-up investigative work conducted by our PIU staff.

3.15.19 Recovery and Education

3.15.19.1 The PIU will notify the provider of the identified overpayment. The notification will include:

A. The amount of the overpayment;

B. A detailed listing of the encounters affected;

C. Education and citations supporting the findings;

D. Options for repayment;

E. Any internal appeal rights afforded by the Vendor; and

F. The provider's right to an Administrative Fair Hearing through the DHCFP after internal appeals with the vendor are exhausted.

3.15.19.2 The PIU must collect and retain the overpayments resulting from a vendor fraud and abuse investigation or audit.

3.15.19.3 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.

We will notify a provider if the Plan has determined it has overpaid a claim in writing clearly identifying the claim, name of the patient, the date service and including a full explanation of the basis upon which the claim was in excess of the amount due. For each claim that is denied, adjusted or contested, the Plan shall provide an accurate and clear written explanation of the specific reasons for the action taken within the timeframes specified. We can offset overpayments of claims within 30 days, if the provider has not contested the overpayment. LIBERTY will adjust or void affected encounters within sixty (60) calendar days following the identification of the overpayments, regardless of whether LIBERTY is able to recover the overpayment from the provider.

LIBERTY has template letters to include the following types of encounters:

- ***Improper payment for services.***
- ***Payment for services that fail to meet professionally recognized standards/level of care.***
- ***Charges in excess or selection of the wrong code(s) for services.***

- ***Billing for items or services that should not have been or were not provided based on documentation supplied.***
- ***Duplicate charges and redundant charges.***
- ***All required documentation is not present in the dental record.***
- ***Other coverage that is discovered after a claim has been made.***

LIBERTY includes education about Fraud, Waste and Abuse (FWA) into our initial and ongoing communications with both providers and members because we know that the best line of defense to prevent improper payments is to ensure members and providers know how to identify and avoid irregular behaviors, as well as to empower them to detect and report suspicious activity.

This process begins with our employees, who serve on the front lines working with providers and members every day. Every employee of LIBERTY undergoes extensive compliance training (including specific FWA training) within 30 days of being hired and annually thereafter so they can respond to potential cases of FWA and improper payments and can pass important information on to providers and members through both formal and informal means.

Upon provider request, LIBERTY will make a collaborative effort to make reasonable repayment options available.

Dispute Resolution System

LIBERTY provides an effective provider and non-participating provider dispute resolution mechanism process whereby providers can dispute decisions made by the Plan regarding billing and claims. We require that any dispute determination is fair, fast and cost effective for contracting and non-participating providers and require attachments and supplemental information or documentation.

- ***Notice to provider of Dispute Resolution Mechanism***
  - ***LIBERTY makes available upon request to providers the dispute resolution mechanism form whenever the plan contest, adjusts, or denies a claim.***
- ***Submission of provider disputes***
  - ***LIBERTY's Policies and Procedures explain the procedures for submission, processing and resolution of provider.***
  - ***The contracted provider can notify LIBERTY challenging, appealing or requesting reconsideration of a claim that has been denied, adjusted or disputing a request for reimbursement of an overpayment of a claim. The request must include complete identification of the disputed item, date of service and explanation why provider believes the action is incorrect.***

- ***Time period of submission of disputes***
  - ***LIBERTY will accept provider disputes from contracted providers within 30 days from the date of the plan's last action on the claim, whether the claim is denied or adjusted. Along with any returned provider dispute, the plan will clearly identify in writing the missing information necessary to resolve the dispute. The provider may submit an amended provider dispute within 15 days working days of the date of receipt of a returned provider dispute setting forth the missing information. The provider will not be required to submit any previous documentation that was submitted.***
  - ***LIBERTY will accept provider disputes from non-contracted providers if:***
    - ***it is received in writing, and***
    - ***the dispute is being submitted due to LIBERTY's error to pay the claim correctly.***
- ***Time period for acknowledgement and resolution***
  - ***LIBERTY acknowledges the receipt of each provider's dispute. In the case of an electronic provider dispute, the acknowledgment occurs within two (2) days of the date of receipt. In the case of paper provider dispute, the acknowledgement occurs within fifteen (15) working days of the date of receipt.***
  - ***LIBERTY attempts to resolve the dispute and issue a written determination within thirty (30) days of the receiving the dispute. The plan's written determination will state the pertinent facts and explaining the reasons for its determination within thirty (30) working days after the date of the provider dispute or amended dispute.***
  - ***If a dispute is found in favor of the provider which involves past due payments, LIBERTY pays any outstanding monies determined to be due, and all interest and penalties required.***
- ***Non-contracted Provider appeals***
  - ***Non-contracted providers may appeal on their own behalf only if they complete a waiver of liability statement indicating that they will not bill the recipient, regardless of the outcome of the appeal.***

The Fair Hearing process for providers is cited at NRS Chapter 422.306 – Hearing to review action taken against provider of services under state plan for Medicaid regulations; appeal of final decision. LIBERTY will abide by all rules set forth and make information about the process available to the provider.

The PIU will aggressively pursue recoveries of any amounts paid that relate to identified fraud, waste, abuse and improper payment activities. These recoveries and/or adjustments will be made in regards to all federal and DHCFP laws and requirements.

In the event that we are unable to gain resolution, 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.

3.15.20 Monetary Recoveries by State or Federal Entities

3.15.20.1 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.

3.15.20.2 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.

3.15.20.3 Any funds recovered and retained by a government entity will be reported to the actuary to consider in the rate-setting process.

3.15.20.4 If any specific payments are identified as improper, those encounters must be adjusted or voided, as appropriate.

3.15.20.5 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.

LIBERTY understands and will fully comply with the requirements delineated in sections 3.15.20.1 through 3.15.20.5. LIBERTY is committed to detecting and preventing fraud, and to working as a partner with Nevada's DHCFP and criminal justice agencies in this regard.

There are also numerous situations that are not criminally fraudulent, but where we have identified that Medicaid providers are delivering services and billing in an excessively

costly manner, and where we implemented corrective actions with that provider that resulted in appropriate behavior modification. A recent example of this dynamic is conveyed in Figure 3.15.20-1 below.

FIGURE 3.15.20-1. FWA CASE EXAMPLE

Case Example

A provider was identified as being an outlier due to higher than normal cost per member and aberrant patterns with fillings (mainly one surface "B" fillings) for adults which triggered a "red flag." The provider did not bill for any crowns which is suspicious as crowns are a covered benefit – but unlike fillings, require prior authorization. The provider would need to send an x-ray so the Dental Consultant could review for medical necessity. A counseling call was made on 6/1/2016 with the provider and the Dental Director to discuss patterns which resulted in a change of behavior in overall treatment patterns and an 18% reduction in costs. This office will be monitored to confirm provider's behavior has remained changed.

3.15.21 Reporting Requirements

3.15.21.1 All information provided to the DHCFP must be submitted according to the format in the forms and reporting guide.

3.15.21.2 The vendor must report certain information to the DHCFP on a per occurrence basis. This includes, but is not limited to:

A. Every allegation, complaint, or referral pertaining to overpayments whether caused by fraud, waste, abuse or billing errors;

B. Every CAF;

C. Every employee of the vendor who is employed by, has ownership interest in, or contracts with, any provider enrolled with Nevada Medicaid; and

D. Every provider that is de-credentialed or denied credentialing for whatever reason.

3.15.21.3 The vendor must report certain information to the DHCFP on a monthly basis. This includes, but is not limited to:

A. All active reviews and their status; and

B. 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.

3.15.21.4 Upon request, vendor must provide encounter data to the MFCU at no cost.

Our current program integrity protocols already require us to report certain information to our clients on a per occurrence basis, including:

1. ***Every allegation, complaint, or referral pertaining to overpayments whether caused by fraud, waste, abuse, or billing errors;***
2. ***Every CAF;***

3. ***Every LIBERTY employee who is employed by, has ownership interest in, or contracts with any provider enrolled with the State Medicaid program; and***
4. ***Every provider that is de-credentialed or denied credentialing for whatever reason.***

Similarly, as we do in many of the other Medicaid markets where we operate, we are fully prepared to report the following information to the DHCFP on a monthly basis:

1. ***All active reviews and their status; and***
2. ***All completed reviews with a detailed reason and the amount of each overpayment recovered from our fraud and abuse investigations or audits, including determinations of no overpayment.***

Finally, our rigorous reporting framework, which we discuss in detail in the following section, allows us to be agile in responding to any DHCFP ad hoc reporting requests.

3.15.22 Provider Compliance Reviews by the DHCFP

3.15.22.1 The DHCFP may conduct reviews of encounter data and vendor providers to ensure compliance with Nevada Medicaid policies.

3.15.22.2 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.

3.15.22.3 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.

3.15.22.4 All improper payments identified by the DHCFP, must be adjusted or voided from the encounter data within sixty (60) days after notification from DHCFP.

LIBERTY serves over 3 million individuals across the country, more than 2 million of whom are Medicaid beneficiaries. Since the vast majority of our members are enrolled in government sponsored programs, we are highly adept at undergoing comprehensive third party compliance reviews, including reviews focused on encounter data and provider payments. LIBERTY routinely receives scores of 100% (i.e., no adverse findings) in these reviews, which validates our ongoing compliance with program requirements.

Additionally, each month we produce a wide array of customized data reports to assist clients and oversight agencies in monitoring us for continued compliance. Constant third party oversight not only validates our ongoing compliance, it also speaks to our ability to efficiently manage compliance reviews and related reporting obligations, and provides us frequent opportunities to proactively identify and remediate potential compliance issues before they escalate.

Given our experience participating in compliance reviews focused on encounter data and provider payments, we have well established protocols to respond to a finding of improper payment:

1. ***We reimburse the applicable state agency, like DHCFP, or health plan client for any improper payments discovered, which have not previously reported as being under review***
2. ***At the reviewer's instruction, we withhold payment from a provider in our network as a result of an overpayment discovered by the reviewer***
3. ***We adjust or void such payments from encounter data within sixty (60) days of learning of them.***

3.15.23 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.

Given LIBERTY's extensive experience in government programs, we are fully aware of and compliant with the 2011 CMS final rule implementing the requirements of Section 2702 of the ACA, specifically requiring states to implement non-payment policies for provider preventable conditions (PPCs) in the Medicaid population. The goal of this regulation is consistent with LIBERTY's own values of ensuring high quality services to Medicaid recipients. Thus, our current policies and procedures are consistent with, and therefore readily equip us to 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 NV DHCFP criteria.

In addition, our PPC protocols require us to adhere to all applicable state and federal reporting requirements, and require our participating providers and subcontractors to do the same, including the requirement to identify and report to all applicable government agencies, like the SUR Unit in DHCP, PPC that are associated with claims for Medicaid payment of courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available.

Although in the dental context, PPC are less prevalent, LIBERTY is fully aware of their significance, and we are prepared to properly respond to and promptly report such events.

3.15.24 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.

LIBERTY Dental Plan of Nevada, Inc. ("LIBERTY") will disclose information to the DHCFP on ownership and control, information related to business transactions, and information on persons convicted of a crime, in accordance with Section 3.15.24. LIBERTY understands that if it 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 LIBERTY.

3.15.24.1 Disclosures are due at any of the following times:

A. Upon the vendor submitting the proposal in accordance with the State's procurement process.

LIBERTY agrees to provide all of the required disclosures upon submitting its proposal in accordance with the State's procurement process. Accordingly, LIBERTY has provided the required disclosures in Section 3.15.24.2.

B. Upon the vendor executing the contract with the State.

LIBERTY agrees to provide all of the required disclosures upon executing the contract with the State.

C. Upon renewal or extension of the vendor's contract.

LIBERTY agrees to provide all of the required disclosures upon renewal or extension of the contract with the State.

D. Within five (5) calendar days after any change in ownership of the vendor.

LIBERTY agrees to provide all of the required disclosures within five (5) calendar days after any change in its ownership.

3.15.24.2 Disclosures on Ownership and Control by Vendor.

A. The following disclosures must be provided by the vendor (42 CFR 455.104(b), 1903(m)(2)(A)(viii), 1124(a)(2)(A)):

1. Any person or business entity with an ownership or control interest in the vendor that:

a. Has direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the vendor's equity.

The following, Table 3.15.4.2-1, is a list of persons and business entities with an ownership or control interest in LIBERTY Dental Plan of Nevada, Inc. that has a direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the vendor's equity:

b. 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.

Not Applicable.

c. Is an officer or director of a vendor organized as a corporation.

The following is a list of officers and directors of LIBERTY Dental Plan of Nevada, Inc.:

Directors:
Amir Neshat
John Carvelli
Randy Brecher

Officers:
CEO – Amir Neshat
President – Randy Brecher
Treasurer/CFO – Maja Kapic
Secretary – John Carvelli
Assistant Secretary – Donald Regan

d. Is a partner in a vendor organized as a partnership.

There are no partners in LIBERTY Dental Plan of Nevada, Inc., as it is organized as a corporation.

2. 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.

The following is a list of persons (whether individual or business entity) with an ownership or control interest in LIBERTY Dental Plan of Nevada, Inc.:

3. Date of birth and Social Security Number (in the case of an individual).

4. 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.

There are no other tax identification numbers with an ownership or control interest in LIBERTY Dental Plan of Nevada, Inc. or in any subcontractor in which LIBERTY Dental Plan of Nevada, Inc. has a five percent (5%) or more interest.

5. If your firm is not a Qualified Health Maintenance Organization, provide the disclosures described at 42 U.S.C. 1396b(m)(4)(A)."

3.15.24.3 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.

No entity or individual with an ownership or control interest in the vendor is related to another.

3.15.24.4 The name of any other Medicaid provider or fiscal agent in which the person or corporation has an ownership or control interest.

There is no other Medicaid provider or fiscal agent with an ownership or control interest.

3.15.24.5 The name, address, date of birth, and Social Security Number of any managing employee of the vendor.

The following is a list of managing employees of LIBERTY Dental Plan of Nevada, Inc., along with the name, address, date of birth, and Social Security Number of each such individual:

3.15.24.6 Vendor requirements for collecting and validating information related to ownership and business transactions from providers or subcontractors.

A. 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.
   1. The vendor must require the provider or subcontractors to submit full and complete information about:
      a. 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
      b. 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.

3.15.24.7 Vendor's requirements for collecting and validating information related to providers/subcontractors convicted of crimes. (42 CFR 455.106)

3.15.24.8 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:

A. Has ownership or control interest in the provider, or is an agent or managing employee of the provider/subcontractors; and
B. 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.

We understand and agree to comply with sections 3.15.24.6 – 3.15.24.8.

LIBERTY currently serves over 3 million members nationwide, over 2 million of whom participate in various Medicaid programs. Through this experience, we have become extremely proficient at seamlessly amending our provider and vendor contracts, and related processes, to comply with a wide array of state and program specific provisions. If selected in Nevada, we will use this proven approach to amend our contracts and to require our providers and subcontractors to furnish upon request, information related to ownership and business transactions, including full and complete information about:

1. ***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***

2. ***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.***

We will also ensure our Delegation Oversight and Credentialing Committees incorporate these items in their formal, ongoing review of subcontractors and providers, respectively.

In addition, given our extensive experience in government programs, LIBERTY's contracts and processes already comply with Nevada DHCFP's requirements to:

1. ***Collect and validate information related to providers and subcontractors convicted of crimes, consistent with 42 CFR 455.106; and***

2. ***Require providers and subcontractors to disclose to LIBERTY the identity of any person who***

    a. ***Has ownership or control interest in the provider/subcontractor, or is an agent or managing employee of the provider/subcontractor; or***

    b. ***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 their inception.***

Specifically, LIBERTY already contractually binds all subcontractors to adhere to the same exclusion screening protocols as we do, which includes review of the following databases for all owners, employees, directors, providers and downstream entities upon initial engagement and, a minimum, monthly thereafter and, in the case of non-contracted payees, prior to payment:

- ***The United States Department of Health and Human Services, Office of Inspector General's ("OIG") List of Excluded Individuals/Entities ("LEIE").***

- ***The General Service Administration's ("GSA") Excluded Parties List System ("EPLS")***

- ***State Medicaid Inspector General's Lists of Restricted, Terminated or Excluded Individuals or Entities***

- ***The Office of Foreign Assets Control – Specially Designated Nationals (OFAC)***

Upon initial contracting, LIBERTY also requires each provider and subcontractor to disclose any person or entity with a direct or indirect ownership interest of five percent (5%) or more in the subcontractor or provider, respectively, including disclosure of all owner affiliates and subsidiaries. LIBERTY screens all our subcontractors and providers and any entities or individuals they disclose against the required databases. If at any time a LIBERTY subcontractor or provider, or any of its owners, employees or subcontractors becomes suspended, excluded or disbarred, we contractually require the subcontractor or provider to immediately disclose such information to LIBERTY so that we may ensure that the relationship with the party is properly terminated, all funds are appropriately refunded, and all required regulatory reporting is completed.

In addition to the controls described above, LIBERTY's Delegation Oversight and Credentialing Committees are responsible for formal, ongoing oversight of delegated functions and providers, respectively, including verifying, at least annually, that ownership disclosures are current, and required exclusion screenings are properly performed.

3.15.25 Denial or Termination of Provider Participation.

3.15.25.1 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.

In addition to LIBERTY's robust NCQA level credentialing program, which mainly focuses on the dentist or associate dentists who will directly treat our members, we are aware that a non-practicing practice co-owner or practice employee may also impact our decision. LIBERTY's decision to enter into an agreement with or renew and agreement with a particular provider may be impacted if we learn that any person who has ownership or who controls interest in or is a managing employee of that practice has been convicted of a criminal offense related to involvement in any Medicaid or Medicare program or Title XX Services Program.

3.15.25.2 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.

LIBERTY also reserves the right to deny participation in our network or terminate an existing agreement with a provider in the event we determine that a provider did not fully and accurately disclose all issues and actions as requested in our provider agreement and application. In the event we identify an issue related to inaccurate or

incomplete disclosure, LIBERTY's credentialing team will conduct an review of the particular provider's file and when necessary contact or request additional information from the provider. Ultimately, the decision to deny participation or terminate an agreement is made by our Dental Director and/or the Credentialing Committee.

3.15.25.3 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.

We are committed to prompt notification to the DHCFP Provider Enrollment Unit in the event we take any action on a provider's application for participation in the program.

3.16 REPORTING

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3.16 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.

We understand and will comply with the provisions of section 3.16.

In this RFP we will be identifying some information as "Trade Secret" or "Confidential".

3.16.1 Encounter Reporting

3.16.1.1 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.

3.16.1.2 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.

3.16.1.3 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.

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

We understand and agree to comply with sections 3.16.1 through 3.16.1.4.

LIBERTY has over a decade of highly relevant experience, managing approximately 2 million Medicaid recipients—both children and adults—and has the capability to meet various DHCFP program standards including all reporting requirements. We will work with DHCFP to ensure compliance with the established data reporting standards, particularly as it relates to complete and accurate encounter data submission. We will work to establish timelines to meet your deliverables, in the media and format required.

LIBERTY is used to providing separate reports, or providing unique identifiers in our encounter reports that allow for separate populations of membership to be identified and reported (e.g., Medicaid and Nevada Check Up). We look forward to working with DHCFP in meeting your reporting requirements, and have the flexibility to make modifications in the event that requirements change as your program evolves.

We regularly check with CMS to identify provider for Our MIS clearly identifies in-network providers and we can ensure that only those providers receive payment for services pursuant to 42 CFR 431.55(h) and 42 CFR 438.808. This information will be reported as part of the encounter submissions to the DHCFP.

The encounter data is usually submitted on a monthly basis to our clients, other timeframes can be arranged if different frequencies are needed. These are usually provided by the 5th of every month for the prior month's data. We will ensure that all the requirements outlined in section 3.13.4 (Encounter and Claim data) are met.

3.16.2 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.

3.16.3 Dispute Resolution Reporting

3.16.3.1 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.

3.16.3.2 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.

3.16.3.3 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.

We understand and agree to comply with sections 3.16.2 through 3.16.3.3.

With regard to the quality metrics reporting (QAPIS), LIBERTY will conduct testing of our report production during the implementation period using data from another state Medicaid program. Through this effort, we will share sample QAPIS report outputs with DHCFP to ensure that we have correctly programmed our MIS to generate this information accurately once live operations begin.

LIBERTY has established a robust grievance system to research and respond to grievances, appeals, fair hearing requests, and provider disputes in a prompt and fair manner. Our full grievance and appeals process is described in Section 3.9.16. We also retain and report on all occurrences of recipient grievances, appeals, fair hearing requests, and provider disputes and report these quarterly in California, Florida, Illinois and New Jersey where we serve the Medicaid population.

An example of our quarterly report on grievances and appeals can be found in Attachment 16. This report includes the total number of:

- ***Recipient grievances***
- ***Notices provided to recipients***
- ***Recipient appeals requests***
- ***Provider disputes filed***

This report also identifies the recipient grievance or appeal issue or provider dispute received and verifies the resolution timeframe for recipient grievances and appeals and provider disputes. We will share these reports with DHCFP during the implementation period to assure the content and formats are in line with your needs; we will make appropriate modifications to tailor the content and format to Nevada Medicaid and Nevada Check Up based on your input.

In addition, LIBERTY also produces logs of unresolved/ongoing grievances/appeals to track their status within the department. They are found below in Figures 3.16.3-1 and 3.16.3-2.

FIGURE 3.16.3-1. PENDING GRIEVANCE AND APPEALS SNAPSHOT

Tracking No.	Date Received	Date Resolved	Due Date	No. Days Open	Filed Against	Type	Category	Subcategory	Claim No.	Severity Level	Complaint Source	Analyst	Member Name	Member ID	DOB	LOB	Group No.	Group Name	State	Office No
FL08413105	09/19/16	Pending	10/19/16	25	Office	Grievance	Quality of Care	Appropriateness (Care/Diagnosis)		C3	M-T	Shelley Becerril	[redacted]		03/12/06	LDP Medicaid Child	000200	Los Angeles PHP	CA	002586
FL08418130	09/19/16	Pending	10/19/16	25	Office	Grievance	Quality of Care	Multiple Procedures		C2	M-T	Rachel Wegrzyn	[redacted]		04/02/72	LDP Medicaid Adults	PHP21FFS	Los Angeles PHP Adults	CA	002539
FL08418620	09/19/16	Pending	10/19/16	25	Office	Grievance	Access/Availability	Appt. Availability (SP)		N3	M-T	Lanette Guerrero	[redacted]		10/27/01	LDP Medicaid Child	GMC820	Sacramento GMC Age 8-20	CA	004575
FL08419200	09/19/16	Pending	10/19/16	25	Office	Grievance	Quality of Care	Endodontics		C3	M-T	Claire Solorzano	[redacted]		07/15/68	LDP Medicaid Adults	GMC21FFS	Sacramento GMC Adults	CA	011340
FL08420593	09/20/16	Pending	10/20/16	24	Office	Grievance	Coverage Dispute	Billing Discrepancy		N2	M-T	Claire Solorzano	[redacted]		10/19/63	LDP Medicaid Adults	PHP21FFS	Los Angeles PHP Adults	CA	009109
FL08423047	09/20/16	Pending	10/20/16	24	Office	Grievance	Access/Availability	In-Office Wait Time		N3	M-T	Shelley Becerril	[redacted]		09/07/12	LDP Medicaid Child	GMC07	Sacramento GMC 0-7	CA	009351
FL08423666	09/20/16	Pending	10/20/16	24	Plan	Grievance	Quality of Service	Rudeness (Plan)		N1	M-T	Lorena Aguilar	[redacted]		12/03/04	LDP Medicaid Child	GMC820	Sacramento GMC Age 8-20	CA	009318
FL08424231	09/21/16	Pending	10/21/16	23	Office	Grievance	Quality of Service	Other		N1	M-T	Claire Solorzano	[redacted]		09/29/65	LDP Medicaid Adults	PHP21FFS	Los Angeles PHP Adults	CA	004634
FL08425257	09/21/16	Pending	10/21/16	23	Office	Grievance	Access/Availability	In-Office Wait Time		N2	M-T	Cynthia Villa	[redacted]		07/05/78	LDP Medicaid Adults	GMC21FFS	Sacramento GMC Adults	CA	009318
FL08428008	09/22/16	Pending	10/22/16	22	Office	Grievance	Quality of Care	Fillings		C3	M-T	Lorena Aguilar	[redacted]		12/09/10	LDP Medicaid Child	GMC07	Sacramento GMC 0-7	CA	004704
FL08429585	09/23/16	Pending	10/23/16	21	Office	Grievance	Quality of Care	Multiple Procedures		C3	M-T	Claire Solorzano	[redacted]		09/04/64	LDP Medicaid Adults	GMC21FFS	Sacramento GMC Adults	CA	009318
FL08435139	09/26/16	Pending	10/26/16	18	Office	Grievance	Quality of Care	Dentures		C3	M-T	Rachel Wegrzyn	[redacted]		03/22/61	LDP Medicaid Adults	GMC21FFS	Sacramento GMC Adults	CA	013580
FL08438350	09/26/16	Pending	10/26/16	18	Office	Grievance	Quality of Care	Appropriateness (Care/Diagnosis)		C3	M-T	Lorena Aguilar	[redacted]		04/29/99	LDP Medicaid Child	GMC820	Sacramento GMC Age 8-20	CA	009318
FL08439897	09/27/16	Pending	10/27/16	17	Office	Grievance	Quality of Care	Crowns		C3	M-T	Lorena Aguilar	[redacted]		05/26/74	LDP Medicaid Adults	PHP21FFS	Los Angeles PHP Adults	CA	009057
FL08443755	09/27/16	Pending	10/27/16	17	Office	Grievance	Quality of Care	Multiple Procedures		C3	M-T	Claire Solorzano	[redacted]		11/22/01	LDP Medicaid Child	GMC820	Sacramento GMC Age 8-20	CA	009355
FL08447614	09/29/16	Pending	10/29/16	16	Office	Grievance	Quality of Care	Fillings		C3	M-T	Claire Solorzano	[redacted]		09/29/69	LDP Medicaid Adults	PHP21FFS	Los Angeles PHP Adults	CA	002605
FL08448009	09/29/16	Pending	10/29/16	15	Plan	Grievance	2nd Level Grievance	Previous Determination	FL08326589	N3	M-T	Lorena Aguilar	[redacted]		09/05/56	LDP Medicaid Adults	PHP21FFS	Los Angeles PHP Adults	CA	006197

FIGURE 3.16.3-2: PENDING PROVIDER APPEALS SNAPSHOT

Tracking No.	Date Received	Date Resolved	No. Days Open	Dispute Type	Complaint Source	Claim No.	Receipt for Original	Date Of Service	Initial Reviewer	Analyst	Member Name	Member	Line of Business	Group No.	Group Name	State	Office No.	Office Name	Contract Y/N	Date Dispute	Request for
FL08451808	09/30/16	Pending	14	Treatment Authorization	P-E	10600465	09/23/16	N/A	Dr. Cage	Gabriela Altamirano	[redacted]		LDP Medicaid Child	GMC820	Sacramento GMC Age 8-20	CA	010939	Pocket Dental	Y	10/07/16	10/07/16
FL08451810	09/29/16	Pending	16	Treatment Authorization	P-E	10480887	09/09/16	N/A	Dr. Nguyen	Gabriela Altamirano	[redacted]		LDP Medicaid Child	GMC820	Sacramento GMC Age 8-20	CA	010939	Poket Dental	Y	10/07/16	10/07/16
FL08476851	10/06/16	Pending	8	Claim	P-E	10431336	09/30/16	09/30/16	Claims	Shelley Becerril	[redacted]		LDP Medicaid Child	GMC820	Sacramento GMC Age 8-20	CA	010939	Pocket Dental	Y	10/07/16	N/A

As soon as a grievance is received in the G&A Department, an Intake Analyst logs it in the grievances and appeals log (our current grievance and grievance log), and the G&A log assigns the grievance a system-generated tracking number, marking the creation of an electronic case file. At this time, the system also automatically generates a written acknowledgement of receipt of the grievance to the complainant.

During this process, the Intake Analyst will identify any requests for fair hearings, as well as expedited appeals, even if not specifically requested as such. We do not currently have any State Fair Hearing cases open or pending, so the attached report does not show this information. Comprehensive grievance, appeal and outcome information shall be retained for each occurrence for review by the DHCFP.

3.16.4 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.

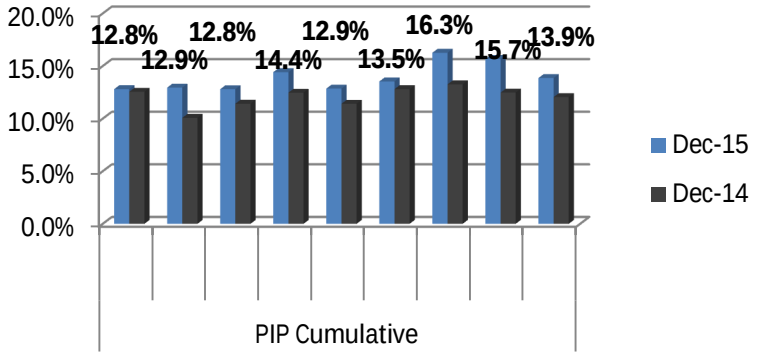
We understand and will comply with the provisions of section 3.16.4.

LIBERTY's Quality Management Improvement (QMI) Program is a comprehensive approach to Quality Improvement. The QMI Program encompasses an array of well-defined processes and functions that are critical to the delivery of dental services. Each quality improvement project is executed with the ultimate goal of maintaining or improving the overall health of members. The full description of LIBERTY's QMI Program and PIPs can be found in Section 3.9, but they rely on outcome-based clinical reports and Management Reports for evaluation and measurement to determine effectiveness or need for additional enhancement. LIBERTY currently gathers these reports for the California, Florida, Illinois and New Jersey Medicaid programs and can generate similar reports for Nevada, as well.

Table 3.16.4-1 below is an example of an annual tabulation for a PIP aimed at increasing the percentage of preventive services utilized in different regions in Florida. We compared December 2014 utilization results to December 2015 results to determine whether or not our PIPs have had any impact over the course of 12 months. Overall, we saw a 1.8% increase in utilization of preventive services. However, Regions 2 and 7 are the underperforming regions and would be considered for additional attention. These kinds of PIP reports are used in the evaluation and measurement of our projects and are an important component in our efforts to be a continuously innovating and improving organization.

TABLE 3.16.4-1. ANNUAL PIP TABULATION

	PIP Cumulative								
	2	3	4	5	6	7	8	11	Total
Dec-15	12.8%	12.9%	12.8%	14.4%	12.9%	13.5%	16.3%	15.7%	13.9%
Dec-14	12.6%	10.1%	11.4%	12.5%	11.4%	12.8%	13.3%	12.5%	12.0%
Change	**0.2%**	**2.9%**	**1.4%**	**2.0%**	**1.4%**	**0.7%**	**3.0%**	**3.2%**	**1.8%**



As a second example, in California Medicaid, LIBERTY implemented a PIP aimed at increasing sealant utilization among children. After measuring the percentage of children receiving sealant services to establish a baseline and comparing these rates at one and two year intervals, LIBERTY documented a positive impact of the PIP. Table 3.16.4-2, below, shows a snapshot of the sealant utilization results after two years of the PIP. Relative to the baseline data, the control group (HN PHP) experienced a 1.3% decrease in sealant utilization for ages 6-7 while the three experimental groups experienced an increase in sealant utilization of 1.9%, 13.6%, and 81.1%. Relative to the first year, all groups increased sealant utilization, but the experimental groups increased by a much larger amount. For ages 8-9, the control group and two of the experimental groups decreased sealant utilization from the baseline, but one of the experimental groups increased utilization by 15.7%. Compared to the first interval year, all groups increased sealant utilization, but the experimental groups outperformed the control group.

Each PIP is initiated with a charter that clearly establishes the goals, scope, timing, milestones and team roles and responsibilities of the PIP. These charters provide the team that is carrying out the PIP a clear reference in their day-to-to management and

operations for what needs to be accomplished and when. LIBERTY will compile these charters into an overall PIP report at the end of the year to summarize the annual results of each new and ongoing PIP.

While LIBERTY currently produces these PIP reports annually, the automatic capture of this information enables us to provide outcome-based clinical reports and Management Reports at the request of the DHCFP or its EQRO. Given this capability and commitment to adherence, we are confident that we will provide these reports to DHCFP in a timely manner. However, in a delay scenario, we acknowledge and agree 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 partner.

3.16.5 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.

We will submit the Recipient Satisfaction Survey results to DHCFP by the third quarter of each contract year, and we will work with DHCFP to ensure that the survey instrument and data collection approach is acceptable.

Our Recipient Satisfaction Surveys are adapted from the CAHPS survey. We routinely conduct satisfaction surveys following a recipient's office visit. The importance in gathering and analyzing recipient satisfaction is demonstrated through our dedicating an outbound outreach unit to this effort. We believe there is value in contacting the recipient by phone allowing the Member Services Representatives to ask questions regarding the recipient's experience at the dental office and to verify that services were rendered in accordance with the treatment plan presented and approved by the recipient. This avenue allows for discussion with the recipient to pinpoint areas of satisfaction and/or concern.

Daily survey results are tracked in workflows in the host system for trending and reporting purposes. Internal changes are identified and applied to improve recipient experience and satisfaction. Quarterly survey results, of all data, are reported to the Quality Management and Improvement (QMI) Committee for analysis and corrective action where appropriate when results are unfavorable.

We conduct focused review and analysis of offices identified with less than adequate recipient satisfaction scores, and implement strategies to outreach and counsel providers on how to improve. Examples of this would include concerns with appointment wait times or in-office wait times during appointments. We will provide survey results prior to the third quarter of each year and upon request from either DHCFP or a recipient.

3.16.6 Financial Reporting

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

As an already-operating Nevada-based dental care coordination entity, LIBERTY Dental Plan of Nevada, Inc. currently meets financial reporting requirements for the Nevada Division of Insurance and can meet the reporting requirements set forth in the Reporting Guide and as prescribed in Attachment T.

3.16.7 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.

We currently have the capability to and agree to report our transactions with other entities to the State or other agencies upon reasonable request from DHCFP.

3.16.8 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.

We understand that we must comply with additional reporting requirements upon DHCFP's request.

3.17 INFORMATION SYSTEMS AND TECHNICAL REQUIREMENTS

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3.17 INFORMATION SYSTEMS AND TECHNICAL REQUIREMENTS

3.17.1 Data Requirements

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

3.17.1.1 Enrollment;

1.17.1.2 Eligibility;

1.17.1.3 Provider Network Data;

3.17.1.4 PDP Assignment;

3.17.1.5 Claims Payment; and

3.17.1.6 Encounter Data.

We understand and agree to comply with sections 3.17 .1 through 3.17.1.6.

Overview of Data Collection and Storage Capabilities

We have experience monitoring and reporting on various types of performance and compliance measures. Our MIS System houses Claims, Estimate, Check, Provider/Office, Group, Billing, Member communications, and all other supporting data. Our reporting tools enable us to pull data from the core MIS system on a regular basis. We have many tools at our disposal that we can use to meet your data requirements:

- ***Datasets - (Pull from core system)***
- ***Data Warehouse – Medimart***
- ***Custom Applications***

These tools allow us to create reports that can be scheduled or run on an ad hoc basis. Currently, we deliver over 300 reports each quarter to meet both our client and internal requirements. All reports are entered into our "Compliance Reporting Tracking System" to ensure timelines are met. For the past two years, we have delivered 99% of our reports on time to our various clients. All data are stored within our MIS System.

Enrollment and Eligibility

Our MIS is tailored to provide dental care coordination to government populations and will fully accommodate the enrollment and eligibility requirements for the Nevada Medicaid and Nevada Check Up recipients. We will accept all recipients appearing in DHCFP's data file as eligible based on your specified coverage dates and parameters.

We will accept recipient eligibility and enrollment data each and every business day via standard electronic file transactions. All inbound eligibility data must be confirmed as submitted by the client or their designated administrator through an established

secure transfer method. File retrieval and upload will commence within six hours of file availability. Enrollment staff will process each file using our Member Load Protocol.

Our database allows membership data to be available on a real-time basis to all operational areas, including Member Services for eligibility verification and call center activities, claims processing, as well as our provider web portal.

All applicable parameters and interfaces must be programmed into the Member Load screen according to established protocol for that specific client or population; this allows for customization of various controls at the plan level. If corrupt data renders the file unloadable, the sender will be notified immediately. Upon successful loading, all files leave an electronic time stamp that includes the operator name, date and time; each affected member record is updated with these data elements for tracking and auditing purposes.

Our system assigns our own unique identification number to each enrolled individual, in addition to the ID number(s) that will be provided to us by DHCFP. This allows us to recognize recipients who are simultaneously enrolled in more than one plan, or have multiple coverages based on various eligibility factors, such as "dual eligible" enrolled in both Medicaid and Medicare.

Our system will capture all standard member demographic data, Medicaid or other unique membership numbers, language and ethnicity data, and any other data elements the client deems necessary to administer benefits accurately.

Our MIS System stores a wide array of data elements, as well as the ability to store custom or additional elements as needed. All data are stored and tracked for version control of the data. We can review audit trails of the data, to see modification dates, as well as the user performing the updates. All data are mapped to the various functions within the MIS System, including but not limited to:

- ***Claims***
- ***Providers***
- ***Billing***
- ***Groups***
- ***Reporting***
- ***Payments***

Our structure allows for all relevant data to be stored in an automated manner that facilitates integrated information sharing and a wide array of analysis and reporting activities. Our structure also ensures the integrity and accuracy of our data.

Updates are tracked for historical and auditing purposes. Data can be provided to DHCFP out of our core systems in various layouts, or customized if needed. Our Nevada data can be shared with DHCFP or its designated partners (Medicaid MCOs, quality review contractors, actuarial contractors, etc.) upon request or as defined.

Provider Network Data

Similar to the eligibility and other data within the MIS, we have sophisticated capabilities with regard to storing, tracking, and making optimal use of provider data. Our system is robust with the ability to store all elements to manage our networks. Some of these elements are listed below:

- ***Office data***
- ***Provider data***
- ***Reimbursements (Can hold unlimited per provider)***
- ***Fee Schedules***
- ***Contracts***
- ***NPIs***
- ***Assigned members***
- ***Capitation Setup and mappings***
- ***Taxonomy/specialties***
- ***Languages (Spoken)***
- ***Claims/Estimates***

Our MIS has the capability to manage Primary Dental Provider (PDP) assignments within the application. Assignments can be part of the enrollment loads, and manually assigned if required, or through an automated process. The automated process "Auto-Assign" has full system logic to ensure a member is assign to an "In Network" provider based on system logic. . As shown in Figure 3.17.1-1, this logic includes, distance, group contract mapping, language spoken (Both member and office), as well as other factors to ensure a member is assigned an appropriate provider.

All PDP assignments are tracked with effective dates and expiration dates. Each time the assignment is modified or changed, a new record is created, and the previous one is still visible. The system will not allow for overlapping coverages, and will map any claim coming in to the correct assignment based on the service date of the claim.

Claims Payment and Encounters

Our system ensures that claims are processed accurately. Throughout the system there are places that business rules are setup. These are at the benefit plan, service restrictions, and provider fee schedules to name a few. The data is stored in the application and made available to the various reporting environments. In the event a claim is reopened and adjusted, the system tracks these changes (Versions) and stores them for processing. Each version would be sent in our encounter data to our clients. There are timely filing settings to ensure claims pay on time, and in the event we are late, apply the appropriate interest as required.

We maintain internal auditing teams to review the data, and random sampling of all of our claims. This allows us to ensure business rules are setup properly, and ensure our various processing staff are making the right decisions when adjusting.

Our claims and encounter data will be shared with DHCFP (and/or its designated contractors) as requested and required to support your program management and evaluation efforts.

We will work closely with DHCFP during the implementation period to ensure that we are transmitting this information in the most usable manner for your purposes, as delineated in the ensuing subsections.

3.17.2 Interfaces

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

3.17.2.1 Health Plan - Encounter Data (encounter data reflects all services provided to clients for whom the health plan pays).

3.17.2.2 Health Plan - Network Data File.

3.17.2.3 Health Plan - Client Update File.

3.17.2.4 MMIS - Encounter Data Error File (HIPAA X12 837 and NCPDP).

3.17.2.5 MMIS - Encounter Data Informational Errors File.

3.17.2 6 MMIS - Health Plan Error File.

3.17.2.7 MMIS - Third Party Liability Update File.

3.17.2.8 MMIS - Client Demographic Data.

3.17.2.9 MMIS - Daily Health Plan Recipient File.

3.17.2.10 MMIS - Health Plan Recipient File.

3.17.2.11 MMIS - Network Data Exception File.

3.17.2.12 MMIS - Network Primary Dental Provider (PDP) Updates.

3.17.2.13 MMIS - Client PDP changes.

3.17.2.14 MMIS - Client Enrollment Updates.

3.17.2.15 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.

We understand and agree to comply with sections 3.17.2 through 3.17.2.15.

We also understand that timely and accurate reporting is critical to DHCFP for its own program management and evaluation efforts. We will work closely with DHCFP, your fiscal agent and your other designated contractors (as applicable) to establish a schedule and process to meet the various reporting requirements. Upon being awarded the Nevada Medicaid contract, a project team will be established to systematically address each of the requirements as outlined. We will work with DHCFP to set up the various interfaces to transfer data between the two of us (and with your designated contractors where applicable).

We will develop automated processes to ensure all applicable parameters and interfaces are preprogrammed according to the established protocol for DHCFP and its population. This programming allows for the customization of various controls at the benefit plan level. As an example, LIBERTY processes 834 files in all 50 states. Our Member Load Protocol is designed to facilitate the standardization of inbound data into the ideal format for our processing system while allowing DHCFP maximum control of the outcome. Upon successful uploading, all files leave an electronic time stamp that includes the operator name, date, and time. Each affected member record is updated with these data elements for tracking and auditing purposes.

An important feature of LIBERTY's eligibility and enrollment database is our thorough data pre-scrubbing process to establish controlling mechanisms to validate and ensure standardization of member information, including member age, address, and other numeric data. Our scrubbing process also considers duplicate entries and utilizes filters to identify the duplicate members across multiple populations and systems, as described below. The application of these filters does not threaten the validity, security, or ability to modify data without prior approval from DHCFP. Further, we have in place additional data reconciliation procedures to demonstrate, validate, and confirm data integrity.

We also process encounter files (837D) for approximately 2.5 million members in both Medicaid and Medicare programs. These are automated to interface with each client and delivered on time and accurate at a 99% success rate.

Each business unit will work to identify and develop the various reports needed to interface with DHCFP, and will be part of automated delivery process. All items will be entered into our compliance database to ensure they are tracked and delivered timely.

3.17.3 Encounter Data Report Files

A. 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.

B. 3.17.3.1 Encounters must:

C. 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.

A. 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.

B. 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.

C. 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.

We understand and agree to comply with sections 3.17.3 through 3.17.3.1.

LIBERTY has a robust Claims and Encounter System with strong analytical tools built into our Core Application System. Checks and balances are in place to ensure that the data

entered are accurate, complete, and compliant with government, internal, and DHCFP standards.

Encounter data accuracy is one of our top priorities. During 2016 to date, we have reported encounter data on approximately two million recipients with 98% accuracy and timeliness, and will work with DHCFP to maintain this accuracy rate.

We can receive and review all 999 reports, 277 reports, as well as other error reports and verify that all applicable errors are resolved and resubmitted within required timeframes.

We will work with the DHCFP to ensure our encounter data passes your compliance editors. Any changes will be performed by LIBERTY at no cost to the client to ensure the 97% acceptance rate is met.

Provider Education

The encounter data we collect from providers and reports are grouped into member characteristics, provider characteristics, and services furnished to members. We work with our providers to educate and train them on claims submission, which includes encounter data elements. We also work with our providers to accept claims via electronic submission and paper submission. We receive encounter data in all standardized formats (e.g., paper, EDI, Clearing House, FAX, Portals).

Claims/Encounter Automated and Manual Review

Claims data are mined for encounter information, and in the event that there are data that are incorrect, no longer valid, or an element of a claim not identified as part of the original claim that needs to be changed, LIBERTY can easily adjust the encounter claim immediately. Similarly, if DHCFP's requirements change, we are accustomed to working quickly to correct or update the file layout, systems, or processes to meet those needs. Most corrections are data related, not format related, and therefore do not require a layout update.

Our internal audit team reviews claims processing and adjudication rules to ensure claims are processed correctly. Prior to going live, sample or test claims will be processed to meet all the scenarios that are likely to occur based on Nevada's program design. This testing will be run through the adjudication and claims processing within our core application to ensure that once we promote the plan and group to production, all issues have been addressed. Once production begins, we will continue to audit the claims. This includes, but is not limited to, group review, claims processor (to ensure adjustment accuracy), Lines of Business (LOB), and other packages that perform either random sampling or complete reviews. Reports are given to claims management for them to perform corrective action plans in the event unfavorable findings are found.

3.17.4 HIPAA Transaction Requirements

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

3.17.4.1 Premium payments (X12F 820);

3.17.4.2 Enrollment and disenrollment into a health plan (X12N 834);

3.17.4.3 Eligibility inquiry and response (X12N 270-inquiry and 271-response and approval of authorization);

3.17.4.4 Referrals and prior authorizations (X12N 278-both request and approval of authorization);

3.17.4.5 Claims encounter data (X12N 837 and NCPDP);

3.17.4.6 Claims status Inquiry and response (X12N 276-inquiry and 277-response); and

3.17.4.7 Payment and remittance advice (X12N 835-remittance advice).

In addition to complying with the requirements of the National EDI Transaction Set Implementation Guide, proposers will find EDI Companion Guides at the following website: https://www.medicaid.nv.gov/providers/edi.aspx. These companion guides contain HIPAA compliant technical specifications for each transaction.

We understand and agree to comply with sections 3.17.4 through 3.17.4.7.

Our management information systems customarily accept and transmit HIPAA 5010 compliant files. We are fully capable of meeting the 834, 820, 835, 837D requirements as described in the guides. For the 270/271, 276/277, and 278, we meet HIPAA 5010 requirements, but additional programming may be needed. Upon contract award, we will work with DHCFP to determine programming needs.

We continually ensure our systems are updated to meet requirements and timelines to implement new versions of HIPAA regulations or requirements.

LIBERTY has successfully updated our various EDI layouts to meet client-specific needs. Once we have the client's specifications, tailoring this functionality for our MIS typically occurs within a matter of days or at most a few weeks. Examples of our recent successful EDI accommodations include:

- ***State of Texas Medicaid – 837 changes (special needs population)***
- ***State of New Jersey Medicaid – 837 changes (wrap around payments to FQHC offices).***
- ***Covered California and Federal Exchanges – 834 changes to house various member identifiers, payment information, and other exchange specific data.***

3.17.5 NPI Transaction Requirements

3.17.5.1 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.

3.17.5.2 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).

3.17.5.3 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.

3.17.5.4 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.

We understand and agree to comply with sections 3.17.5 through 3.17.5.4.

LIBERTY maintains our own NPI, as required by DHCFP.

- ***NPI: 1932321551***
- ***Primary Taxonomy: Health Maintenance Organization***

We currently manage Medicaid business in the States of Florida, Illinois, Texas, and California that require us to ensure the NPIs within the LIBERTY MIS application match the data within the states' systems.

Upon award of the Nevada Medicaid RFP, we will work with DHCFP to put a process in place to obtain the state NPI file, and insure that our data matches what the state has on record. We will work with our provider network in the event there are any discrepancies identified to update the information we have on record, or update the information they provided the state. Our encounter data are submitted in the 837D HIPAA 5010 format, and currently pass with a 98% acceptance rate. Our Nevada submissions will include all claims data formats (EDI, paper, web, fax, or claims submitted by other means). We will ensure that the data we send to DHCFP is complete and contains the NPI information required (Billing NPI, rendering NPI, and rendering Taxonomy), as described in the companion guide.

As part of our provider credentialing policies and procedures (P&P's), all providers are required to have and provide a NPI. Unless this data is provided, they do not pass the credentialing process, and would not be part of the network. We also download the federal NPI directory at least twice a year, and validate the data in our systems.

LIBERTY is proactive in ensuring its MIS technology is up to date and HIPAA compliant. In the event of new or updated HIPAA standards are introduced, LIBERTY has processes in place to enhance our systems to ensure we meet the new requirements and timelines. These enhancements are made at no cost to our clients. Enhancements are managed through our "Project Activity Committee (PAC)", and compliance is the number one concern when prioritizing and ranking enhancements.

3.17.6 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.

Our MIS application is fully ICD 10 compliant. LIBERTY continues to use Current Dental Terminology (CDT) codes (the standard HIPAA data set for dental services) when building benefits, but we have the ability to include ICD 10 codes if required. In 2014 we partnered with our Medicaid clients in CA to develop and test the new ICD requirements. This was done to ensure our systems are ICD compliant in preparation for the eventual required use of ICD codes for dental procedures. After twelve months of preparation and testing, LIBERTY became fully ICD compliant in September, 2014.

We continue to maintain our MIS application to remain ICD compliant and will continue to ensure this capability in the future. In the event enhancements to the process are needed, LIBERTY will take full responsibility to enhance our MIS system at no cost to the DHCFP.

3.18 DHCFP RESPONSIBILITIES

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3.18 DHCFP RESPONSIBILITIES

DHCFP will be responsible for the following:

3.18.1 External Quality Review

DHCFP will contract, to the extent required by federal law, with an External Quality Review Organization (EQRO) to conduct independent, external reviews of the quality of services, outcomes, timeliness of, and access to the services provided by the vendor covered under the RFP. These reviews will be conducted at least annually.

3.18.2 Due Process

3.18.2.1 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.

3.18.2.2 DHCFP will receive all recipient requests for State Fair Hearings, arrange for the fair hearings and provide the fair hearings officer. Upon receipt of the fair hearing request, DHCFP will forward a copy to the vendor.

3.18.3 DHCFP On-Site Audits

The DHCFP may schedule on-site audits at the vendor's primary place of business. The purpose of these audits is to confirm contract compliance and to more effectively manage DHCFP contract monitoring and oversight responsibilities of the vendor. These audits will be scheduled in advance and will focus on contract sections prior identified by the DHCFP. The vendor will be informed of the scheduling, focus of the audit and the expectations regarding vendor's participation no less than thirty (30) days in advance of the on-site visit. The vendor will have all prior requested data and information available at the time the audit begins.

3.18.4 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.

3.18.5 Encounter Data Processing

The DHCFP will contract with an encounter data processing agent to accept, edit, process, and review encounter data submitted by contracted vendors. It is DHCFP's sole responsibility to determine the format in which the vendor must submit the encounter data. In addition, the vendor encounter data, when requested, must be submitted to the DHCFP's actuary.

We understand and agree to comply with sections 3.18.1 through 3.18.5.

We welcome the opportunity to facilitate DHCFP's program management and monitoring activities. We will provide all data relevant to our Nevada Medicaid and Nevada Health Check Up lines of business operations to DHCFP, as requested. We understand that in many instances our data transmission will go to a DHCFP designated contractor, such as your selected EQRO or actuarial consultant partners.

Our data transmissions will accommodate DHCFP's requested formats and timeframes for ongoing/routine reporting. We will make our best effort to respond in a timely manner to all ad hoc data requests – we will work with you at the point of those requests to determine your timing, content and format needs and will reprioritize our workload where needed to achieve a rapid turnaround.

3.18.6 Website Access

The DHCFP will maintain an Internet link on its official website at which the vendor's website can be accessed.

We understand and will comply with the provisions of section 3.18.6. We understand that the DHCFP will maintain an Internet link on its website at which our website can be accessed.

3.18.7 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.

We are committed to supporting DHCFP in all its program management and program monitoring efforts and activities, including those directly performed by DHCFP personnel and those occurring through one or more DHCFP contracting partners. We are accustomed to supporting oversight activities that:

- ***Span all aspects of our operations, including enrollment and disenrollment, grievance and appeals, and program integrity functions;***
- ***Cover a variety of contractual, state, federal, and industry requirements; and***
- ***Frequently include onsite audits, direct file and system reviews, and in-person interviews.***

We have participated in as many as 15 independent audits in any given month, which are conducted by our clients or by regulatory oversight agencies (e.g., CMS, DOI, DOH, etc.) via desktop, WebEx, or onsite. LIBERTY routinely receives scores of 100% (i.e., no findings) in these audits, validating our ongoing compliance with program requirements.

Given the rigor of our clients' oversight activities, we are accustomed to having auditors on site and have established effective protocols for providing appropriate access to personnel, records, systems, and materials. Auditors routinely compliment our open and engaging approach, our impressive facilities, and our knowledgeable staff. We will work with DHCFP to leverage our current framework, engaging our Quality and Compliance teams and utilizing established workflows, to efficiently respond to DHCFP's oversight requests.

Continuous third party oversight not only substantiates our ongoing compliance, it also enhances the number of ways our operations are being assessed. The "fresh eyes" assessments by external auditors can be of value in identifying areas where we can improve, and we welcome that input.

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3.19 COST CONTAINMENT AND/OR COST AVOIDANCE INITIATIVES

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3.19 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.

We understand and will comply with the provisions of section 3.19.

Our overarching goal is to achieve the highest quality services possible. We believe quality care means beneficiaries are receiving the most appropriate, or right care, in a timely and accessible manner and that the desired health outcomes are achieved. We believe that overall, achieving the best quality care also results in achieving the most cost effective care and the most effective use of limited funding resources. Therefore, the best cost containment initiatives can actually come from quality initiatives.

A primary cost containment strategy used by LIBERTY, which is also a significant quality strategy, is based on our provider profiling process. LIBERTY engages in a unique utilization management model that incorporates extensive provider profiling. Utilizing our extensive claims history data base, each individual provider's performance is measured against average patterns and numerous benchmarks. We utilize a proprietary Provider Profiling tool which combines tracking and trending of data from numerous quality indicators to compare providers to their peers. These quality indicators include utilization, grievances and appeals, access, availability and member satisfaction data, for different categories of service and patient demographics.

From our profiling we easily identify a provider whose performance deviates from our statistically expected utilization and identify deviations from appropriate standards of care. This includes over/under utilization of services as well as identification of inappropriate services or combinations of services that do not appear to be clinically appropriate. These types of services not only result in impacting quality but they are also not cost effective. Therefore, when these issues are addressed with a provider, not only does the level of quality increase, the costs decrease.

Corrective action plans are developed for the outlier providers including counseling by our dental directors and possibly desk audits and onsite reviews. Outlier activity can result in office closure to new patients, limitation of referrals, implementation of more extensive pre-authorization, compensation restructure or even termination if necessary. Normally, one of our first steps when we find a providers performance that deviates from

what is expected, is to counsel and educate the provider regarding their utilization. During these counseling sessions we are repeatedly told that we are the only plan that engages in that type of activity. We monitor the provider's performance subsequent to the counseling and normally, observe a change in their future behavior. That change results in beneficiaries receiving better/more appropriate care as well as care that is more cost effective. For example, identifying a provider with a low sealant to filling ratio, and then motivating the provider to increase their sealant usage, results in fewer fillings and fewer future caries, this leads to better oral health, and future cost savings/avoidance.

As part of our provider profiling, we also find providers that we feel present a serious threat to the well-being of our members such as excessive use of anesthesia or other quality issues and occasionally find the need to terminate the provider. Our profiling also enables us to excel at identifying issues such as extreme billing patterns, billing for services not rendered, and other aspects of fraud or abuse. We are able to quickly identify and stop inappropriate activity which results in cost savings/avoidance. LIBERTY's provider profiling effectively combines the process of evaluating medical necessity with the appropriateness of care and leads to better health outcomes. Over/under-utilization of services is reduced and members remain more engaged in the continuum of care. Our profiling places the focus on quality care including an emphasis on preventive care and rewards providers who provide quality and eliminates those who don't. Assuring that the right care is provided not only results in the most appropriate and efficient care, but also the most cost effective care. As a result, we not only improve the health of our members, we also assure the most effective use of the funding.

Through our provider profiling tool LIBERTY also identifies providers that it awards with a designation of Center of Excellence. COE's reflect providers who have met all of our practice patterns, grievance and appeals, access, and availability standards and provide high quality cost effective services. COE's receive enrollment priority so as to have as many members as possible receiving care from these cost effective quality providers.

While LIBERTY places considerable focus on quality initiatives to contain costs and eliminate fraud, waste and abuse, it also maintains all of the more routine claims processing controls and edits that assure timely, accurate and efficient claims processing. LIBERTY leverages both innovative technology and years of experienced professional expertise to develop and maintain dynamic solutions to claims

adjudication. Our average turnaround time for clean claims is 97.9% processed within 15 days while 100% within 30 days and our payment accuracy rate exceeds 99%.

Our adjudication system houses logic modules that are specific to each contract's benefit schedule. These logic modules drive efficient processing by allowing us to pre-determine the results with each CDT procedure code that is submitted. Preventative and diagnostic procedures, for example, would be subject to the benefit plan's limitations and exclusions while treatment such as extractions, dentures and crowns would be subject to clinical review by a licensed dentist for medical necessity. These types of rules and edits are set up and thoroughly tested before the first claim is ever received. Our adjudication system also has built in edits that deny duplicates, stop the unbundling of procedure codes, flag claims over a certain dollar threshold, and can connect multiple claims with the same member, provider and date of service when treatment is billed on separate claims. We also have edits and rules that can be placed on providers, provider offices, and provider organizations. Rules can be placed on particular fee schedules, procedure codes within a fee schedule, or on a group of procedures (such as extractions or dentures). The flexibility of the application allows LIBERTY to really dive into provider billing patterns and work to promote a consistent and clean claim submission/claim payment process.

LIBERTY also employs significant coordination of benefit processes that assure the identification of other insurance coverage and that such other coverage is billed accordingly.

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3.20 LIQUIDATED DAMAGES AND SANCTIONS

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3.20 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.

We understand and will comply with the provisions of section 3.20 including the terms delineated in Attachment O.

As an experienced dental plan administrator with over two million Medicaid members in California, Florida, Illinois, New York, New Jersey and Texas, LIBERTY is adept at assimilating and adhering to the terms and conditions of state Medicaid contracts, including a wide variety of reporting requirements.

Each year we assist clients and oversight agencies in monitoring us for continued compliance by producing over a thousand customized reports spanning various subject areas comparable to those outlined in the Nevada DHCFP Forms & Reporting Guide. Our proprietary Compliance Reporting Tracking System (CRTS) allows us to efficiently track thousands of reporting obligations and facilitates us in consistently producing complete, on time and accurate reporting. Leveraging CRTS, we will work with DHCFP to create a custom tracking system to ensure compliance with all reporting and related obligations under the Nevada contract.