3. SCOPE OF WORK

3.1 GENERAL

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.

UnitedHealth Group is a diversified health and well-being company dedicated to helping people live healthier lives and helping make the health system work better for everyone. We offer a broad spectrum of products and services through two distinct platforms: Health Benefits (UnitedHealthcare) and Health Services (Optum).

We serve 133 million individuals worldwide with a total workforce of more than 240,000 people. Together, UnitedHealthcare and Optum serve members in all 50 states in the United States and more than 125 other countries. Our work is aligned around basic values: integrity, compassion, relationships, innovation and performance.

UnitedHealthcare is a wholly owned subsidiary of UnitedHealth Group. Both UnitedHealthcare and Dental Benefit Providers, Inc. are wholly-owned subsidiaries of United HealthCare Services, Inc. which itself is a wholly owned subsidiary of UnitedHealth Group. UnitedHealthcare Insurance Company and Dental Benefit Providers, Inc. will hereby be referred to and marketed under the brand name “UnitedHealthcare”.

UnitedHealthcare is one of the largest administrators of Medicaid, CHIP, Family Health, and commercial dental benefits in the country and has over 28 years of experience administering dental programs to over six million members. We are among the top 10 carriers who cover 80 percent of all dental enrollees. We work with employer groups, health plans, state and local government organizations, insurance companies and third party administrators offering a variety of dental plans.

Leveraging current program expertise with the financial strength of UnitedHealth Group, UnitedHealthcare will be a strong partner to the Nevada Medicaid Dental Benefit Program (the State) We share a commitment to accountability – establishing dental homes, improving member and provider outcomes and experiences through outreach and technology, and creating a shared environment in which Nevada will have visibility into our operational and financial performance. It is our intent to build a successful partnership with the State. Because we recognize the importance of listening to the State and being responsive to your needs, we will provide an account management team (AMT) that is located in Nevada and specifically dedicated to the State of Nevada Medicaid Dental Program and its implementation and ongoing administration. This team will consist of experienced benefit management professionals committed to meeting the needs of the State’s program, inclusive of any special programmatic or network requirements that may arise. Additionally, we will develop specific protocols that will ensure that all project deadlines are met.

NEVADA EXPERIENCE

We bring extensive experience to the State, as outlined in **Attachment 3A2_Nevada State Experience Snapshot.**

NATIONAL EXPERIENCE

As one of the largest Medicaid and CHIP dental administrators in the country, we have extensive experience managing Medicaid, CHIP and Family Health plans with all categories of Medicaid membership, including long term care and special needs members.

UnitedHealthcare currently administers Medicaid and or CHIP programs in the following states: New York, New Jersey, Pennsylvania, Florida, Louisiana, Delaware, Texas, New Mexico, Arizona, Wisconsin, Kansas, Michigan, and Massachusetts, Mississippi and Rhode Island.

Additionally, we administer DSNP Medicare plans in the following states: New York, Pennsylvania, Tennessee, Georgia, The District of Columbia, Florida, Texas, New Mexico, Ohio, Wisconsin, Arizona, Washington, and Hawaii.

Please see the chart below*:

Medicaid/CHIP/FHP	Medicare DSNP
AHCCCS AZ – 452,511	AHCCCS AZ – 39,535
Florida – 313,124	Florida – 32,927
Texas – 83,367	Texas – 58,835
New Mexico – 85,392	New Mexico – 10,938
Pennsylvania – 258,649	Pennsylvania - 2,076
Wisconsin – 45,507	Wisconsin – 8,493
New York – 531,974	New York - 29,042
Delaware - 61,796	Oxford - 80,676
HealthNet AZ - 62,302	Tennessee - 43,735
AZ LTC - 9,857	Georgia - 6,542
Louisiana - 54,041	Ohio - 5,892
Mississippi - 285,649	CIP (12 states) - 334,080
Massachusetts - 16,379	Hawaii - 12,549
Michigan - 72,605	Washington DC - 3,697
Rhode Island - 90,705	Washington - 11,544
New Jersey - 487,495	
Kansas - 128,351	

*Membership is from Spring 2016

Although each state program has unique features, collectively they are substantially similar to the medically necessary covered services and program requirements of the Nevada Medicaid dental program. The creation of dental homes, servicing of diverse member and provider populations and the managing of annual maximums are shared core competencies. We will accommodate the unique needs of the diverse population in Nevada through member communication using many different methods (telephone, online, community-based programs, etc.), translation services, and focused contracting with providers who can accommodate diverse and special needs.

In all states, we develop critical member and provider outreach components designed to improve member education, create early dental interventions, and increase provider awareness and participation. These actions elevate the overall health status of program recipients, and are demonstrated assets that we will bring to the Nevada dental program.

As we have done for each of our clients, we have developed a program specific to the needs and requirements of the State of Nevada and its Medicaid Enrollees. This commitment to coordinated care and service, provider network development, utilization management and plan flexibility offers each of our clients the ability to honor their sincere commitment to provide critical dental care to their vulnerable Medicaid population and simultaneously meet their practical goal to effectively manage costs.

We have been recognized nationally for our organization's strength, commitment to improving health and commitment to the communities in which we operate. See below for a selection of awards and recognition that have been awarded to our organization.

RECENT AWARDS & RECOGNITION

- UnitedHealth Group was the top ranking company in the insurance and managed care sector on Fortune's 2016 "World's Most Admired Companies" list. This is the sixth straight year UnitedHealth Group ranked No. 1 overall in its sector and the seventh year in a row the company has been rated No. 1 in its sector for innovation.
- UnitedHealth Group is a member of the Dow Jones Industrial Average, a blue chip group of 30 companies deemed industry leaders.
- Fortune ranked UnitedHealth Group No. 6 in its 2016 rankings of the 500 largest U.S. corporations based on 2015 revenues.
- Fortune magazine ranked UnitedHealth Group No. 35 on its 2015 Global 500, a list of the world's largest corporations based on 2014 revenues.
- UnitedHealth Group has been listed in the Dow Jones Sustainability World Index and Dow Jones North America Index annually since 1999.
- UnitedHealth Group earned a top rating of 100 percent on the 2015 Corporate Equality Index from the Human Rights Campaign.
- UnitedHealth Group was recognized as one of America's 50 most community-minded companies for 2014 in the Civic 50, and ranked first in the health care industry for the second consecutive year.
- In the 2015 Newsweek Green Rankings, created in partnership with Corporate Knights Capital and HIP Investor, UnitedHealth Group ranked 11th out of the largest 500 U.S. companies and 17th out of the largest 500 global companies in corporate sustainability and environmental impact.
- UnitedHealth Group was named a 2016 Top 100 Military Friendly Employer and a 2016 Top 50 Military Spouse Friendly Employer by Victory Media, the publisher of G.I. Jobs and Military Spouse magazines.
- Brazil-based Amil received a Best Marketing Sustainability award in 2015 for "Say No to Childhood Obesity," its initiative to encourage physical activity and educate adults and children on dietary practices.
- UnitedHealthcare's Baby Blocks mobile, interactive incentive program for expectant moms, new parents and their babies enrolled in UnitedHealthcare plans received the following recognition: Business Intelligence Group 2015 BIG Innovation Award; 2015 American Business Awards (Stevie Awards); 2015 Connecticut Quality Improvement Award; Minneapolis/St. Paul Business Journal 2015 Eureka! Award.

- UnitedHealthcare's Advocate4Me customer service model received a Stevie award in the Sales & Customer Service category at the 2015 American Business Awards.
- Optum360, a leading provider of health care revenue management services, earned the No. 1 spot in the 2015 Black Book Rankings for revenue cycle and coding software and services.
- Catamaran, which formally combined with OptumRx in July 2015, was named to the World's Most Innovative Companies 2015 list by Forbes magazine.
- The Optum One intelligent health platform received the 2014 North American Frost & Sullivan Award for Product Leadership.

In addition to our experienced team, we have also created specific alignments to supply enhanced services that work in tandem with our internal expertise to create a stronger infrastructure for our clients. As required, we have entered into a written subcontract with Scion Dental, Inc. (Scion) who will provide their state of the art information technology and Medicaid expertise. The owners of Scion Dental, Inc. are industry pioneers in improving government program dental management. Scion's Enterprise System technology platform is woven throughout all of UnitedHealthcare Dental's workflow and processes, connecting providers, members, and our state agency clients in a single, real-time environment.

This contract fulfills the requirements of 42 CFR 438.230 that are appropriate to the service or activity delegated under this Agreement. As requested, we will make available all subcontracts for inspection by the State upon request for the State's prior approval. As the prime contractor, we also confirm that we will be wholly responsible for performance of the entire contract.

COLLABORATIVE PARTNERSHIPS

Internal Network Partner: In order to provide consistent support and to ensure the least disruption for the Nevada Dental Medicaid Program recipients, we are collaborating with our internal partner, UnitedHealthcare of Nevada, to lease their existing Medicaid network, Health Plan of Nevada (HPN), which has the longest-standing Medicaid provider network in the state.

UnitedHealthcare of Nevada has been offering health care coverage to Nevadans for over 20 years. With our strong presence in Nevada, we have an excellent understanding of what Nevada employers are looking for in their benefit offerings. More than 2,200 of our own employees are located right here in Nevada. They are your neighbors, your doctors, and your patrons. We are also your partners in making this community a better place to live, work and raise a family.

Offering several types of products and plans, UnitedHealthcare of Nevada has the ability to customize a product offering to meet your specific needs. Our lead product, Health Plan of Nevada, is more commonly recognized in the Las Vegas market and is the name you may be most familiar with in our portfolio. Sierra Health and Life (SHL) offers a variety of PPO plans that gives your employees the choice to use a contracted or non-contracted provider for services and still remain eligible for benefits.

Our location provides for a unique, local center of operations in Las Vegas. However, this doesn't limit our scope. As part of a larger organization, our customers benefit from the knowledge and technology of a national carrier, bringing strong resources and tools to the market.

Subcontractor Experience and History: UnitedHealthcare is aligned with Scion Dental, Inc. to capitalize on their state-of-the-art information technology system and Medicaid expertise. The Scion ownership team and many of the management team were the founders of Doral Dental in 1992 and played a key role in helping it grow to over 6,500,000 members. They managed capitation for over 5,000,000 members during that time and introduced a variety of industry innovations, improving Medicaid dental programs across the country. Scion was formed in 2009 and has quickly become a national leader, growing rapidly with new implementations every month. Scion is the first and only dental company in America to have been awarded full URAC accreditation for Claims Processing and is one of two dental companies to have been awarded full URAC accreditation for Health Utilization Management. The URAC accreditation process demonstrates a commitment to quality and serves as a framework to improve business processes, through benchmarking organizations that evaluate using nationally recognized standards. Their performance delivers lower administration and benefit costs for DHCFP and state clients, while at the same time improving both the recipient and provider experience.

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.

We are authorized to operate as a certified vendor in the state of Nevada as evidenced by our Certificate of Authority, which is included as **Attachment 1C4A_ Nevada Certificate of Authority.**

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.

As an experienced Medicaid vendor, we adhere to all authorities including Title XIX, Title XXI state plans and amendments, Code of Federal Regulations and the Medicaid Services Manual.

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.

As requested, we will provide dental services for eligible individuals in urban Clark and Washoe counties. Upon request, we have the capacity to expand to include additional geographic areas. We also look forward to the opportunity to expand coverage to additional Medicaid populations. Through our national markets, we have extensive experience providing services to varied state populations with specific challenges and needs. We will leverage our experience and expertise and tailor it to fit the specific needs of DHCFP and its Medicaid recipients.

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.

We have contracted Nevada Medicaid providers in the catchment areas in California, Arizona and Utah. Recipients who reside in the identified catchment areas in California, Arizona, Idaho and Utah are eligible to receive services from identified providers in who are licensed to provide Medicaid services. When contracted providers are not available, we execute single case agreements to provide access to recipients. Providers who support the identified recipients will be reimbursed at the agreed upon State of Nevada Medicaid reimbursement rate.

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.

As required, we will provide senior and support staff to participate in all designated key operational and stakeholder meetings including teleconferences, video conferences and quarterly on-site meetings. We agree to travel to meetings at the DHCFP's offices in Las Vegas and Carson City and other meeting locations as needed.

We will be an active partner in all meetings and conference calls as requested by DHCFP in the locations specified by DHCFP to fulfill the State's objectives of the Dental Medicaid Contract.

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.

The benefits package provided to Nevada recipients no less in amount, duration and scope than those covered services specified in the State Plan for Title XIX and XXI programs and the Nevada Medicaid Service Manual.

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/

We comply with providing the managed care benefit package to all enrolled recipients. We confirm all medically necessary services covered under the Title XIX and XXI State Plans are available and accessible to the covered recipients.

Vendors 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.

We are including our **Prenatal Dental Care Program** offers additional preventive and periodontal care for women throughout their pregnancy and for up to three months after the delivery date.

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.

As required, we have not and we will not issue any insurance certificate or evidence of insurance to any Medicaid or Nevada Check Up recipients. Our member handbook language states that it is not a certificate of coverage. We acknowledge that any insurance duty will be construed to flow to the benefit of DHCFP and not to the Medicaid or Nevada Check Up enrollee.

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.

As required, we will 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.

UnitedHealthcare will ensure that PDPs meet requirements for specialist referrals and care coordination through a combination of training, provisions in the Provider summary guide and ongoing monitoring. All network General Dentists and Pediatric Dentists participating as MDHPs will complete Webinar-based training before we designate them as Main Dental Homes and begin assigning them recipients. Training also will be available through individual follow-up and on-site visits.

The training provides a comprehensive review of State of Nevada requirements for providers functioning as MDHPs, including screening recipients for specialty care needs, making prompt referrals when needed and coordinating care with the specialist until treatment is complete. The training also will include information on resources available through UnitedHealthcare to meet these requirements.

For example MDHPs will be able to quickly find nearby specialty care for their patients by calling UnitedHealthcare's Provider Hotline or logging into the Provider Web Portal. MDHP requirements and support resources also will be documented in the Provider summary guide. To monitor provider compliance, we will track provider complaints and referrals by reviewing patterns in specialty claims data.

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.

We will ensure that all enrollees who are receiving orthodontic services are also receiving all medically necessary dental services that are covered in the dental care benefit package. Our tracking system will provide up-to-date information on compliance with EPSDT service provision requirements. We will also initiate follow up and outreach to remind recipients of upcoming visits and follow up on missed appointment.

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.

As noted, we are not responsible for orthodontic care; however, we will ensure coordination of care between the participant's orthodontist and their 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.

We will provide the full early and periodic screening, diagnosis and treatment related to dental services to all eligible children and young adults up to age 21 in accordance with the requirements outlined in 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.

We will also conduct all inter-periodic screening on behalf of recipients, as defined in MSM Chapter 1500 or as modified by the State during the period of this Agreement.

Integrating EPSDT: Our approach to developing and implementing a statewide Outreach Plan designed to increase Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) participation rates center around three pillars:

- Increasing awareness and education of good oral health
- Ensuring means to access dental care
- Reaching out to recipients in the most beneficial way possible

Screening: We will conduct inter-periodic screens on recipients. Additionally, we will conduct additional screens if determined to be medically necessary.

Diagnosis and Treatment: If a problem is detected through screening, the child will be evaluated for further diagnosis. Treatment will be determined based on the diagnosis.

Tracking: We have an established tracking system that provides up-to-date information on compliance with EPSDT service provision requirements in the following areas:

- A clinical dental examination at the eruption of the first tooth and no later than twelve (12) month
- Examination every six months thereafter, or as indicated by the child's risk status/susceptibility to disease.
- Diagnosis and/or treatment, or other referrals in accordance with EPSDT screen results.

Follow Up and Outreach: We will adhere to our established process for reminders, follow-ups, and outreach to recipients that includes:

- Written notification of upcoming or missed key points of contact within a set time period, taking into consideration language and literacy capabilities of recipients
- Telephone protocols to remind recipients of upcoming visits and follow-up on missed appointments within a set time period
- Protocols for conducting regularly scheduled outreach with noncompliant recipients and addressing access barriers such as arranging transportation, interpreters, connections with multi-lingual/multi-cultural service providers, etc.

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:

Through our comprehensive provider network and our robust utilization management (UM) programs, we confirm all medically necessary services are provided in the same amount, duration and scope as services furnished to recipients under fee-for-service (FFS) programs and will continue do so as outlined in this RFP. We authorize and coordinate services per guidance from the Medicaid Service Manual. If there is no guidance from Medicaid, we adhere to evidence-based criteria to evaluate all prior authorization requests. We authorize and coordinate out-of-area services if a local provider is not available.

VERIFICATION OF BENEFIT PACKAGES

We have numerous controls and processes to configure benefit plans correctly and reflect the same benefit package as outlined in this RFP. Our workflows provide for accurate automation of benefit plans and verify all medically necessary services are in the same amount, duration and scope as services furnished to recipients under FFS programs. The following is a high level overview of how this process works.

- All benefit plans scheduled are entered into our system by our benefit team
- The benefits are automated in our claims processing system
- These activities are tracked in a workflow database and completed within an internal turnaround time standard to allow for multiple levels of testing by two different quality teams
- Once the testing is completed, the product is fully deployed
- Additional audits are performed monthly by a quality team against adjudicated claims and benefit package configuration after deployment

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;

At the core of our UM program for the Nevada Medicaid and CHIP Programs is an interdisciplinary set of documented, integrated UM, quality improvement (QI) and care management principles, policies and systematic processes that manage the appropriate utilization of health care resources in the amount, duration and scope necessary to achieve desired health outcomes. The components of our UM program combine to ensure services are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. UM components include:

- Evaluating the efficiency and appropriateness of services through the adoption of evidence-based, nationally recognized guidelines and review criteria
- Implementing a prior authorization and medical necessity determination process that evaluates and confirms that a requested procedure, treatment or device meets established medical necessity criteria
- Implementing policies and procedures to conduct prospective and retrospective reviews that ensure the appropriate utilization of resources in the amount, duration and scope necessary to achieve desired health outcomes
- Monitoring overutilization, underutilization and inappropriate utilization using a multifaceted approach that evaluates recipient and provider utilization patterns so that we can assure the appropriate use of health care services, identify opportunities for improvement and develop interventions to combat aberrant trends
- Confirming we educate our providers on our criteria and clinical guidelines during initial provider training, when UM protocols or criteria and guidelines change, and when we identify providers who need assistance (e.g., difficulties submitting requests for prior authorization)
- Verifying the delivery of high-quality, clinically appropriate, efficient and cost-effective care through provider profiling, which identifies opportunities for reducing variation in practice patterns, provides us with a tool to discuss best practices and tracks practice-level improvements that improve recipient dental health which has a positive impact on overall health and wellness

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

We do not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the recipient. Our system offers the ability to provide a high level of customization to ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope. Currently, we use120+ generic clinical algorithms, which cover over 400 dental procedures. These can be modified to meet specific requirements of the State's plan.

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.

Our claims processing system will utilize custom-written business logic that will place appropriate limits on service based on the criteria applied under the Title XIX and Title XXI State plans. Complete digitization of incoming and outgoing documents provides efficient servicing of recipients and providers. Benefit plans are configured to automate all rules around code coverage, service limits and recipient responsibility. Utilization Management / Authorization setup ensures that fraud and abuse rules are enforced, and clinical guidelines are carried out in uniform manner.

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).

Our standard definition for dental medical necessity consists of the following criteria:

- Necessary to meet the basic dental needs of recipients
- Rendered in the most cost-effective manner and appropriate type of setting
- Consistent in type, frequency and duration of treatment with accepted dental practice
- Consistent with the diagnosis of the condition

This definition is consistent with state and federal guidelines. We will customize, if necessary, our clinical criteria to meet the specific requirements of the Nevada Dental Medicaid program, if there is any deviation from our standards.

We have been providing medically necessary dental services Medicaid and CHIP members for over 20 years, resulting in significant improvements in utilization, while promoting member oral health and ensuring that providers deliver services that are appropriate to members' needs. We will use the same utilization management (UM) guidelines and processes for the Nevada Medicaid Dental Program.

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.

UnitedHealthcare uses our proprietary Appropriate Care Criteria to ensure appropriate utilization and quality of services for recipients participating in the Nevada Medicaid Dental Program. Our guidelines are consistent with evidence-based dentistry and the requirements in the Nevada Dental Practice Act's requirements, Nevada State Board of Dental Examiners rules, and national guidelines from the American Dental Association (ADA) and the American Academy of Pediatric Dentistry (AAPD).

Guideline sources for the Appropriate Care Criteria include the ADA; specialty organizations, such as the American Academy of Periodontology; the American Academy of Pediatric Dentistry and the American Association of Oral and Maxillofacial Surgeons; evidence based clearinghouses, such as the Cochrane Oral Health Group and National Guideline Clearinghouse; American and international governmental agencies, such as the National Institutes of Health, the Centers for Disease Control and Britain's National Health Service; evidence based journals, such as the Journal of Evidence Based Dental Practice; and reputable public health recommendations, such as Healthy People 2020.

Our authorization guidelines are algorithms programmed into the Enterprise System, our claim and authorization management platform, which ensures consistent medical necessity authorization determinations. The prior authorization requirements can be customized for different providers to manage outliers or as an incentive for providers with good utilization patterns. The algorithms present the clinical criteria in a decision tree format that is clear, easy to understand and transparent to ~~the~~ providers and review staff.

The initial criteria were reviewed and accepted by the corporate Clinical Policy and Technology Committee (CPTC), which includes clinical staff, dental consultants and participating providers. The approved criteria were then reviewed and endorsed by the corporate Clinical Affairs Committee, which oversees the work of the CPTC. Our UM Program description documents the UM guidelines we are using to determine medical necessity and the methods for periodic review and updates. The CPTC reviews the Appropriate Care Criteria and Authorization Guidelines annually, although changes can be made at any time if the State changes the program design, or if other overarching utilization patterns emerge that require a program change. Additionally, the CPTC meets quarterly to consider new developments in evidence-based care, improvements and changes in dental materials and new technology.

Based upon these reviews the CPTC will propose additions or changes to the Appropriate Care Criteria and Authorization Guidelines to the clinical affairs committee. We document the process in written policies and procedures that are reviewed annually by the CPTC and updated as necessary. We will review guidelines and have them accepted at the Nevada level by our Nevada Peer Review Committee. We will submit any changes to the State for review and approval prior to implementation.

To ensure that providers understand our determinations, we make the Appropriate Care Criteria and Authorization Guidelines available to providers online through the UnitedHealthcare Provider Web portal and in hard copy, upon request.

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.

Our utilization review protocols meet all required standards outlined in the State of Nevada Dental Medicaid Guidelines. UnitedHealthcare uses our proprietary Appropriate Care Criteria to ensure appropriate utilization and quality of services for recipients participating in the Nevada Medicaid Program. Our guidelines are consistent with the requirements in the Nevada Dental Practice Act's requirements, Nevada State Board of Dental Examiners rules, and national guidelines from the American Dental Association (ADA) and the American Academy of Pediatric Dentistry (AAPD). Our Authorization Guidelines are algorithms programmed into the Enterprise System our software platform, which ensures consistent medical necessity authorization determinations and can be customized for different providers as an incentive for good utilization patterns.

To ensure that providers understand our determinations, we make the Appropriate Care Criteria and Authorization Guidelines available to providers online through the UnitedHealthcare Provider Web portal and in hard copy, upon request.

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.

To ensure a consistent application of clinical review criteria we use review procedures for our review specialists and consultants and claim system edits.

All clinical review staff members who are responsible for determining benefits are required to participate in these evaluations in which a minimum of 10 cases are reviewed and evaluated. Opportunities for improvement in training are identified and individuals identified with deficiencies are reevaluated within 90 days to measure the success of the additional training. The results of the evaluation are reported to the Quality Improvement and Compliance Committee.

Requiring all professional reviewers to employ the same clinical algorithms ensures the consistent application of clinical criteria. Providers are presented with these same algorithms when they submit authorization requests through the Provider Web Portal.

The Enterprise System includes a full set of proprietary, dental-specific edits that evaluate and validate authorizations and claims, as well as the ability to incorporate custom edits for unique business requirements and cost containment objectives. These edits and business rules can be tailored to the clinical guidelines and documentation required for each procedure code and patient age limitations.

When claims are processed, the system checks for the appropriate authorization requirements schedule to determine whether each service requires an authorization. If a service requires an authorization, the system checks whether an authorization exists. If so, the authorization is consumed (decremented) and the claim is updated with the associated authorization number. If no matching authorization is found, or if the matching authorization is already fully consumed or expired, the appropriate exception is recorded on the claim service.

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.

To effectively monitor prior authorization requests, each service decision is stored with the corresponding authorization record and is automatically cross-referenced with its claim. The Enterprise System software platform automatically links claims to specific pre-authorized services and decrement (consume) prior authorizations and service items based on specific encounter data submitted by the provider. The rules will be tailored to match claims to specific pre-authorized services as outlined in the State's specific requirements. Links between real-time claim details and corresponding authorizations are available online, any time, through the Enterprise System user interface.

We will work with the DHCFP to align prior authorization procedures across delivery entities and will revise if it is determined that the revision is necessary for the proper administration of the 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.

All denials for dental service necessity are reviewed and signed off by the Chief Dental Officer or licensed dental consultant, as required by state/plan.

As part of our Utilization Review Plan, utilization management decisions are based only on appropriateness of care and service. We do not reward dental consultants or other individuals conducting utilization review for denying authorizations or for decisions that result in underutilization. All personnel involved in the decision-making process, both our employees and independent, licensed dental consultants, must sign an attestation that no part of their compensation is contingent on decisions made. We do not prohibit providers from advocating on behalf of recipients within the utilization review process.

All utilization review determinations are made on the basis of medical necessity and appropriateness, recipient's individual circumstances, and the applicable contract language concerning benefits and exclusions. Denial decisions specifically include the clinical reasons and the specific contractual basis for the decision. Recipients are given instructions on how to file an appeal and/or State Fair Hearing, as appropriate.

An impartial group of non-network dental consultants will make final appeals determinations. To ensure appropriate guidance and impartiality, the provider issuing the appeals determination will hold the same specialty or related specialty as the appealing provider, and the Dental Consultant reviewing the appeal will not be the same consultant involved in making the initial determination.

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

The Enterprise System's proprietary, dental-specific edits that evaluate and validate authorizations and claims, can incorporate custom edits that match the FFService program. These edits and business rules can be tailored to the clinical guidelines and documentation required for each procedure code and patient age limitations.

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 are not more restrictive than dental Medicaid FFS. We provide all required services outlined in this RFP and we have no moral or religious objections to any of the listed services.

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.

Because we understand the value of a dental home, to every extent possible and when appropriate each recipient will be given a choice in selecting their dental provider. This selection will help to ensure the comfort level of the enrollee and support the ongoing coordination of care and services.

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

Access to a dental home is a critical component of our patient centered dental services, as we understand the ongoing relationship between the dentist and the patient, including comprehensive oral health care beginning no later than age 1, can lead to an increase in oral health engagement in the household, which can improve the recipient's oral health and increase the likelihood that they will establish a dental home and maintain regular dental care. As such, all recipients will be automatically assigned to a primary care dentist or a Main Dental Home Provider (MDHP) based on their location. Within ten days of receiving the eligibility files, the assignment is coded by distance to an appropriate MDHP.

All family members will be assigned to the same provider. Recipients with a claim history with a provider will also be assigned to the same provider. If the provider is in our network but not a MDHP, the Provider Outreach Manager will contact the provider to provide education on the process for becoming a Main Dental Home. Recipients who wish to select a different Main Dental Home can call the Member Hotline to speak with a member service advocate.

Recipients with chronic conditions can choose a specialist as their primary care dentist as long as that specialist has been identified as an in-network provider. All providers in our network are credentialed; therefore the specialists by default would be considered an acceptable in-network provider.

PROMOTING OUR DENTAL HOME PROGRAM

All participating dentists will receive communication on the Nevada Dental Home program, including a description of the program, information on the Dental Home package and provider responsibilities to participating Dental Home members as described in the RFP Contractual Services Form including:

- Care that is comprehensive and includes acute, corrective, and preventative services.
- Care that is individualized to each participant based upon a dental exam for tooth decay and gum problems.
- Care that is preventative and includes information about proper care for the participant's teeth and gums, and correct diet.
- For children, care that prepares parents and guardians with guidance about what to expect for their child's age for the growth of teeth and the jaw.
- For children, care that is educational and helps parents and guardians learn about their child's dental health now and as their child grows.
- Care that is provided in a culturally competent manner.

Program information will be included in the Provider Summary Guide, on the dentist Web portal, in newsletter articles, and in follow-up letters. Our dental networks team will reach out to dentists individually to answer questions and encourage participation in the Dental Home program. Dentists who do not choose to participate will receive additional outreach on a regular basis to encourage reconsideration. Feedback will be solicited from both participating and non-participating dentists on the reasons for their choice, in order to help UnitedHealthcare improve its recruitment efforts.

UnitedHealthcare will develop a Dental Home package that provides a set of services meeting the needs of recipients, addressing their health and well-being. The primary focus will be on preventive health. s will be encouraged to obtain preventive services shown to positively impact both dental and overall health. UnitedHealthcare will employ various member education and outreach strategies highlighting the value of professional prevention and good home care designed to promote prevention and other needed care. In addition to improved health outcomes, prevention positively impacts costs, including medical costs in the form of fewer hospital visits for emergencies and treatments requiring OR care. Science is also increasingly demonstrating the positive impacts of good dental health on chronic medical conditions.

In addition to prevention, the Dental Home package will include restorative, surgical and prosthetic procedures needed to restore oral health and function.

While we hope that general dentists can perform the bulk of services their patients will require, in the case of procedures that cannot be performed directly in the dental home, dental home clinicians will be provided resources to make referrals to specialists. UnitedHealthcare will recruit an adequate number of specialists and will make the lists of those specialists available to dental home providers.

UnitedHealthcare will also help to facilitate referrals to specialists through its member services department.

We will also provide information to both recipients and clinicians in areas that include clinical topics as well as information on Dental Homes and the dental plan. Information will be shared with recipients through newsletters, Web-based sources, and flyers that describe what a dental home is, how it works, the value of dental homes and their importance. As noted previously, we will also be offering information on UnitedHealthcare's Dental Home initiative to our network dentists in an effort to educate them on the Dental Home concept and to encourage them to engage in creating a Dental Home. Finally, where possible, we also provide dental home information to physicians, either in partnership with medical Managed Care Organization (MCOs) or directly with the State. Because primary care physicians (PCPs) see very small children, often many times, before they have had their first dental visit, they are often in a position to screen their patients and provide counseling on the value of establishing a dental home and getting routine preventive care.

We will also provide guidance on the management of acute dental trauma. While trauma is often covered as part of the medical plan, dental Homes are typically the first line of defense. Information will be shared with dental home providers that include both clinical protocols as well as plan procedures for immediate treatment as well as follow up and referral as needed. This will include reimbursement policies and procedures.

In managing our Dental Home initiative, special focus will be provided to those 3 and under. This is typically a vulnerable population with a low compliance rate. Targeted education and outreach will be provided the families of young children providing information on the importance of the age one dental visit, the value of protecting primary teeth as well as recommendations on good home care and nutrition. Information will also be shared with plan dentists, and if possible PCPs. If possible we will look to engage PCPs in screening very small children, and making follow up referrals to Dental Homes, either directly or with the help of UnitedHealthcare. Many children 3 and under have seen their PCP many times without having ever seen a dentist; therefore, the PCP plays an important role in identifying children at risk and encouraging all the families of all small children to find a dental home. Finally, we will look for opportunities to provide education to general dentists on treating very small children. There are not enough pediatric dentists to manage all children under 3, yet too many general dentists are not comfortable managing this population. Education will help provide them with the tools they need as well as information on the value of adding small children to their practices.

We will oversee these requirements proactively, through education and outreach, as already described. We will also perform retrospective oversight through measurement. Assignments will be continuously tracked along with member outcomes. This includes identifying those assigned recipients who have been brought in for care, those who received prevention and those who received non-preventive treatments (restorative, surgery etc.). Feedback will also be provided directly to dentists in the form of a "report card" providing information on the practice's success in getting assigned recipients in, particularly for prevention. Counseling will be provided to those who are non-compliant with requirements.

An additional opportunity to encourage dentist compliance with requirements is through incentives. As an example, incentives can be directed toward dentists, creating levels of reward based on the percent of assigned patients seen and receiving prevention.

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).

We will ensure continuity of care for new recipients whose main dental home provider (MDHP) is not currently participating in our network through several methods. If the main dental home of the recipient is not in our network, we will pay all claims at the Medicaid reimbursement rate for a period of 60 days after the go-live date, during which we will initiate targeted recruitment with the provider. Should the provider continue to remain out-of-network, we will honor claims by following the established procedures for out-of-network services. After 60 days, the recipient will be assigned to a new MDHP. The Provider Network Development Manager will run monthly reports to identify all out-of-network providers. They will be contacted periodically in an effort to recruit them into our network.

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:

The Provider Network Manager will ensure that UnitedHealthcare maintains a provider network sufficient to provide all recipients with access to the full range of covered services, as well a choice of provider as required under the contract. The provider network will be responsive to the medical, linguistic, cultural, and other unique needs of any minority or disabled individuals, or other special population in the State of Nevada Dental Medicaid Program. We will also make certain that providers meet all current and future state and federal eligibility criteria, reporting requirements, and any other applicable rules and/or regulations related to the contract through our comprehensive provider training program, ongoing provider outreach and the use of social media outlets to connect with providers. Our network will also be developed in accordance with the geographic requirements of the Medicaid enrollees in order to adequately address the distance and travel time to appointments as well as the physical access and means of transportation.

A. The anticipated DHCFP recipient DBA enrollment;

The provider network manager will ensure that we maintain a network sufficient to provide all recipients with access to the full range of covered services, as well a choice of dentist or specialist as required under the contract.

We have specific monitoring mechanisms in place to assess compliance with our availability standards for the number of practitioners and geographic distribution of practitioners in the provider network. The quarterly reports we will submit to the DHCFP provide ongoing evidence that we monitor the following factors to continue to meet the network requirements and maintain accessibility for our recipients:

- Anticipated enrollment
- Utilization of services
- Numbers and types of providers
- Geographic location of providers and enrolled recipients

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

The Provider Network Manager will follow our extensive step-by-step provider recruitment plan to ensure access to care and choice for State of Nevada Dental Medicaid recipients. The goal is to continue to build, maintain, and exceed the network requirements as identified by the State. The foundation of this recruitment plan is a complete understanding of the eligible Nevada population, including geographic distribution, language and/or cultural needs, and special needs requirements and comprehensive analysis of the distribution of both providers and recipients via mapping, enrollment and dentist population by ZIP code to understand the availability of dentists in each area.

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;

The Enterprise System is one of the most efficient, accurate dental processing solutions in the market. A standard set of edit and adjudicate rules may be augmented by custom-written business logic that executes natively when processing claims. Complete digitization of incoming and outgoing documents provides efficient servicing of recipients and providers. Benefit plans are configured to automate all rules around code coverage, service limits and recipient responsibility. Utilization Management / Authorization setup ensures that fraud and abuse rules are enforced, and clinical guidelines are carried out in uniform manner.

UnitedHealthcare maintains a written utilization management (UM) program description that documents the program's objectives, the UM organizational structure and qualifications of review staff, procedures to review medical necessity and notification procedures, UM guidelines used and the methods for reviewing and updating as needed.

UTILIZATION MANAGEMENT SYSTEM PROCESSES

The manager of the UM program supervises the day-to-day operation of the authorization program. Providers are instructed to submit a standard ADA claim form and supporting documentation, either by hard-copy, electronic claim submission or via the Web portal, to request authorization for procedures requiring medical necessity review. Dental review specialists are available 8 a.m. to 5 p.m. CT, Monday through Friday, to assist with any authorization requests. Callers may also leave a message, which will be responded to within one business day.

To facilitate the review, all documents and radiographs are converted to electronic images, if not already in electronic form, and the pertinent information is entered into the authorization module of the Enterprise System.

The authorization request is available to the reviewers either through the internal computer network or over a secure internet connection, protecting the privacy of the recipient and enabling a rapid review to be performed. We maintain the electronic radiographs indefinitely in the event that any future follow-up is required. In the event that additional information is required, UnitedHealthcare will request such information in written correspondence within three business days of receipt of the authorization request, or contact the provider by phone. The Authorization System is completely automated and the reviewers have access to all submitted documentation in electronic form.

UnitedHealthcare uses the following three levels of authorization review:

- **Level 1** - Automatic system reviews
- **Level 2** - Dental review specialist reviews
- **Level 3** - Dental consultant reviews

The **Level 1** review is performed automatically by the Enterprise System by applying hundreds of business rules via coded algorithms against the services to be authorized. The system rules automatically deny services for administrative reasons where appropriate, such as “member ineligible” or “service not covered.”

The **Level 2** review is performed by dental review specialists, who have extensive clinical backgrounds, and a minimum of 3 years’ experience as a dental assistant. The dental review specialist reviews each authorization request that has passed the Level 1 review to determine whether it meets criteria for medical necessity.

The reviewer has a number of system tools available to ensure consistent and sound clinical determinations including: scanned documentation available for electronic review, complete tooth, authorization and claim history for each recipient, all Level 1 results - including authorizations with business rule edits flagged for further consideration and over 100 proprietary dental clinical algorithms.

Please see the screen shot below from our clinical review module.

The dental review specialist approves requests that meet criteria. If the request does not meet criteria, the dental review specialist flags it for dental consultant clinical review and determination. The dental review specialist may also deny the authorization request for administrative reasons.

The **Level 3** reviews of authorization requests that could not be determined appropriate during Level 2 reviews are completed by consultants or internal dentist staff that are appropriately licensed and credentialed and report to the Nevada dental director. The Level 3 reviewer will make a final determination of either "approved" or "denied."

WRITTEN PROGRAM POLICIES AND PROCEDURES

The Level 3 reviewers call the requesting provider to resolve any questions on the request and use the Enterprise System to make automated requests for additional documentation. The dental review specialists and dental consultants each have separate, defined work queues in the Enterprise System to direct them only to those authorizations that require their attention.

UnitedHealthcare maintains written policies and procedures to govern all aspects of our UM program, including, but not limited to, policies and procedures to:

- Ensure operations refrains from any activities to influence clinical decision-making by any kind of financial or other incentives and that medical necessity determination decisions are based solely upon each recipient's specific needs, the Appropriate Care Criteria and the Authorization Guidelines
- Monitor the efficiency and results of each dental reviewer by review of the turnaround times, number of approvals, number of denials and reviews by code
- Ensure consistency of decisions through semi-annual inter-rater reliability reviews of authorizations determinations made by our dental review specialists and dental consultants. The goal is to maintain a score of 80 percent. In 2016, UnitedHealthcare's 20 consultants achieved inter-rater scores of 100 percent.
- Refer suspected cases of provider or recipient fraud, abuse, or waste to the Office of Inspector General
- Monitor the effectiveness of our UM program by assessing over and underutilization and compliance with all requirements, generating provider profiles that monitor provider utilization patterns, and comparing outcomes to benchmarks for comparable populations
- Target areas of inappropriate service utilization for medical necessity review.

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

We confirm that is sufficient to provide the number and types of providers required to furnish the contracted Medicaid covered services.

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 (PDP) or Primary Care Site may not be more than 25 miles from the enrolled place of residence without the written request of the recipient.

Our offered network exceeds the requirement of one PDP within 25 miles. Recipients enrolled in our network will have the benefit of having access to a provider close to home. On average, our network currently offers exceptional access which gives recipients the choice of a provider only 2.5 miles from their home. Nevada recipients will continue to have access to a provider network which has a 100 percent open panel, which exceeds the 50 percent open panel requirements.

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 allow the coordination and payment of services received by our Medicaid recipients from out-of-network providers. We state this provision in our Provider summary guide, located on our website and accessible to any provider. We adhere to these standards, as outlined in the RFP's Scope of Work. Additionally, whenever possible, we offer the opportunity for out-of-network providers to become part of the network due to the geographical location or services that they render.

When a recipient requires service and no suitable in-network provider exists within the contract access standards, a call center representative helps the recipient identify the nearest provider office meeting the recipient's needs. The representative may also assist by contacting the provider office to set up the appointment and/or arranging a transportation service for the recipient. When a patient is referred to a non-contracted provider, the representative documents the recipient interaction in our customer service system and creates a follow-up record for the network development team to review. In addition, intervention specialists will be available to assist recipients with more complex access and service needs.

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.

In the event that a second opinion is required or requested, we will provide a consultation from a dental provider within the network or if the situation warrants, obtain one outside of the network at no cost to the recipient.

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

As required, if our network of providers is unable to provide medically necessary covered services under this contract to a particular enrollee, we will adequately, and in a timely manner, cover these services using a non-participating provider for the enrollee for as long as we are unable to provide them. If that situation arises, we will require non-participating providers to coordinate with us as the contracting entity with respect to payment in order to ensure that the cost to the enrollee is no greater than it would be if the services were furnished within the network.

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;

Network providers are contractually obligated to offer hours of operations that are no less than the hours of operation offered to commercial recipients or comparable to Medicaid FFS. The Nevada Medicaid program has an accessibility standard which requires that a recipient must have an appointment scheduled within 24 hours for treatment of an urgent dental condition, or an appointment within six weeks for a non-urgent dental visit. We expect our network dentists to provide initial, follow-up and hygiene appointments within 21 business days. Dentists must provide emergency appointments within 24 hours. Network dentists must follow these access standards and we monitor their compliance.

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. Recipients 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.

All network providers are contractually obligated to provide 24 hour emergency care services. The member handbook that is distributed to recipients outlines the policies and procedures describing how recipients can obtain urgent coverage and emergency services after business hours and on weekends.

When a recipient calls because they are unable to reach their (MDHP) after normal business hours, the member services advocate will first determine the type of service that the recipient is seeking and if she needs to be seen immediately. In non-emergency situations, the member services advocate will advise the recipient to wait and attempt to contact her MDHP's office the following business day, or the member services advocate will make a referral to another in-network provider close to the recipient's location. The member services advocate can establish a three-way call with another provider location to schedule an appointment or to have the recipient's dental inquiry answered. If needed, the member services advocate can educate the recipient about the availability of transportation and coordinate transportation for the recipient as needed.

Emergency situations will be individually assessed by the member services advocate for appropriate actions. In the case of a life threatening emergency the recipient will receive instruction to hang up and dial 911. In the case of a dental emergency, which is not immediately life threatening, but is causing severe bleeding or pain, the member services advocate will instruct the caller to seek immediate treatment and will refer her to a suitable substitute provider location if her MDHP is closed. The member services advocate can establish a three-way call with the substitute provider location to schedule an urgent appointment, and can coordinate transportation for the recipient, if necessary. If no suitable substitute provider location can be found, the member services advocate will refer the recipient to the closest walk-in clinic. The member services advocate will create a reminder for the Provider Network Development Manager to contact the provider office to determine why there was no after-hours coverage process available.

If a recipient contacts the member hotline after hours, their call will be answered by our automated interactive voice response system (IVR) which will provide directions on what to do, based on the severity of the situation. The IVR system provides an option allowing recipients to locate another nearby network dentist by ZIP code.

Monitoring Emergency Services Access and Utilization

We define urgent or emergent authorizations as those requests for services to treat situations that involve pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury. We immediately grant emergent and urgent requests for authorization and the dental provider is encouraged to treat the recipient, then send the completed claim and any necessary documentation on a claim form marked “Retrospective Review.”

The chief dental officer or one of the dental consultants evaluates all retrospective reviews to determine coverage and also certify the services were emergent or urgent in nature.

If we note a pattern of abuse for any one practice, UnitedHealthcare will create a corrective action plan (CAP) and counsel the provider, which will include a discussion of the definition for urgent and emergent care.

We also have customized, prior-approved communications that are sent to recipients who visit the emergency room for oral pain. We provide this service in conjunction with participating clients who provide the data necessary for the outreach. The recipient receives education, a provider listing, and the toll-free number to help with appointment scheduling.

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.

Cultural competency is the foundation for meeting our recipients’ specific health needs, while honoring each individual’s unique circumstances, values and beliefs as we deliver superior services across the state. Therefore, we actively 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 (LEP) and diverse cultural and ethnic backgrounds. We currently comply with all State and federal regulations pursuant to MSM Chapter 100, Section 103.6 as well as 42 CFR 438.206(b)(2).

UnitedHealthcare encourages effective provider interaction with people of different cultures and socio-economic backgrounds. This includes an awareness of our own cultural worldview, attitudes towards cultural differences, knowledge of different cultural practices and worldviews, and the adoption of proactive measures to better understand, communicate, and interact with people across different cultures. Culturally tailored health care can reduce disparities among patient populations and reduce problems associated with linguistic barriers.

In order to meet the needs of our various state customers, we have developed a diverse and effective portfolio of provider training methods. UnitedHealthcare uses a range of training modalities to meet the information and learning needs of our providers.

It is our intent that the provider network will be responsive to the medical, linguistic, cultural, and other unique needs of any minority or disabled individuals, or other special population in the State program.

We will provide comprehensive training to ensure that providers understand the requirements and goals of the State and services available through UnitedHealthcare. These topics include but are not limited to:

- Specific Nevada State Medicaid Program requirements
- Comprehensive instruction on Medically Necessary Covered Dental Services in the State plan
- Cultural Competency Training

In addition to ensuring we offer a culturally diverse provider network, we offer all of our member material in English and Spanish, and ensure we have bilingual staff in our customer support team, and on our outreach team.

Individuals, who do not speak English as their primary language and have a limited ability to read, write, speak or understand English, may have LEP. We provide language assistance, either through direct translation services or through bilingual staff, to facilitate the recipient's ability to communicate effectively when he/she encounters our staff or providers, or receives a particular service or benefit.

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

As required, we will provide all medically necessary dental services as defined in MSM Chapter 1000 – Dental with the exception of orthodontic services. Provider types and services shall include all providers outlined in A-H.

Our existing provider network in Clark and Washoe counties is an open network which consists of approximately 400 contracted general dentists, pediatric dentists, endodontists, oral surgeons, oral and maxillofacial surgeon, periodontists and prosthodontists.

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.

We will require providers, through contract provisions or Provider summary guide, to provide all children enrolled in the program with medically necessary preventive services in accordance with the State dental periodicity schedule. We will use provider training, profiling and feedback to ensure that MDHPs follow these periodicity dental requirements for children.

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.

As required, limited medically necessary emergency extractions and palliative care will be provided for adults over the age of 21 to include dentures/partial dentures under certain guidelines and limitations as defined in MSM Chapter 1000 Dental.

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 are offering expanded preventive and periodontal care for women throughout their pregnancy and for up to three months after the delivery date.

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.

As requested, we will 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 sedation.

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 coordinate with a contracted Net Broker, if necessary to ensure NET services are secured on behalf of enrolled recipients.

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.

As required, we will provide coordination of services to ensure recipients who are receiving orthodontic care are also receiving medically necessary EPSDT services as well.

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 as outlined in the MSM Chapter 1500; as well a 1902(a)(43), 1905 (a)(4)(B) and 1905(r) of the Social Security Act, and 42 CFR 441.50 through 441.63.

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.

We will provide the full early and periodic screening, diagnosis and treatment related to dental services to all eligible children and young adults up to age 21 in accordance with the services listed in 42 U.S.C. § 1396 d(a) or as modified by the State during the period of this Agreement.

To ensure all medically necessary coverage is being provided under EPSDT, we will also provide care coordination. Our member advocates will work closely with parents, guardians and all identified agencies who retain guardianship or who provide services to enrolled recipients in order to provide outreach, education, and special support services. For example, we can develop and implement specialized education programs for parents and guardians, provide access to interpreters, help coordinate care with other health care professionals, help parents find appropriate services and accommodations for children who are in wheelchairs or who are homebound, and help arrange transportation for dental visits.

UnitedHealthcare will ensure that MDHPs meet requirements for specialist referrals and care coordination through a combination of training, provisions in the Provider summary guide and ongoing monitoring. All network General Dentists and Pediatric Dentists participating as MDHPs will complete Webinar-based training before we designate them as Main Dental Homes and begin assigning them members. Training also will be available through individual follow-up and on-site visits.

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 note that we are not required to pay for any treatments outside of the Title XXI state plan for Nevada Check Up recipients.

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 do not provide reimbursement for procedures that we consider to be experimental, investigational or unproven which include pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.

As new clinical guidelines and technology become available, our Clinical Policy and Technology Committee evaluates them against our established criteria, which are founded in evidence-based dentistry. New techniques are not considered experimental. They are incorporated into our benefits once they have been evaluated using clinical evidence based on their effectiveness and efficiency.

Additionally, appropriate limits will be placed on EPSDT services 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 participate in outreach initiatives that encourage people to become more proactive in their health and dental benefits, educate them about daily oral care and the impact that oral disease may have on chronic medical conditions. We educate recipients about prevention, wellness, and early detection.

UnitedHealthcare recognizes the importance of education and communication for parents to ensure that they are actively engaged in seeking screening, treatment and services that are critical in lowering their child's risk for future disease. Education will be provided both directly to parents as well as to clinicians, in order to provide as much opportunity to impact care early.

Through educational programs, we will focus on increasing general access to information, developing targeted prevention initiatives, and increasing participation in education and clinical programs that address conditions such as early childhood caries.

Direct Parent Education: Direct parent communication will include information on infant and child care, the importance of fluoride and sealants, the importance of finding a dental home (preferably by age one) and the relationship between good oral and overall health. This information can be delivered using multiple approaches, including online, newsletters, mailers and handouts. While much of the focus is on care for the general population, education also focuses on targeted conditions such as early childhood caries. UnitedHealthcare is also open to discussing with the State the possibility of expanding our efforts to include topics important to medical-dental integration specific to children, such as childhood asthma and diabetes.

UnitedHealthcare will also engage in outreach to recipients based on their dental visit history. For example, we suggest reaching out to those who have not seen a dentist in the previous 12 months or follow up with those who had a PDP screening in an effort to get them to see a dentist.

Provider and Community Education: UnitedHealthcare will work with clinicians, both dentists and physicians, in an effort to engage parents. We will provide information they can share with parents and will discuss potentially including clinicians in an effort to reach out to families who have not visited for regular care. UnitedHealthcare will engage community resources, including schools and Head Start programs, as a way of sharing information and potentially as opportunities to conduct fairs and/or screenings.

UnitedHealthcare will also develop collaborative partnerships with community advocacy groups, hospitals, FQHCs and others who are involved in increasing parent engagement.

As outlined in the informational requirements, we will prepare written member outreach materials using a Microsoft Word program that verifies that all content is easily understood and at an eighth-grade reading level.

All written materials will also be made available in the prevalent languages of the population groups served.

All written materials and outreach activities may be reviewed and audited by DHCFP.

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 are committed to achieving an extensive understanding of relevant community issues, delivering a high level or service and participating in health promotion and education initiatives by establishing strong working partnerships with the State and designated entities and programs serving recipients. For optimal communication and improved responsiveness, we will establish Nevada-based operations which will house our Executive Director, Dental Director and critical operational departments. Each of these units will be dedicated exclusively to the State dental contract. As we have in other states, we will work closely with the State's Dental Director and others managing the oral health needs of Nevada's citizens to align priorities and support the State's oral health objectives.

In addition to working closely with the State, another critical element in establishing our local presence is to build relationships with local community-based organizations in order to gain a deeper understanding of local needs and to explore opportunities for information sharing and collaboration. We have a history of community partnership and involvement. For instance, we are increasingly participating in State Oral Health Coalitions (ex. Rhode Island Oral Health Coalition, Pennsylvania Coalition for Oral Health), where we can better understand local oral health concerns, help to influence oral health policy, identify key stakeholder in the state and increase our visibility as community contributors. We look to partner with leading players in oral health policy in the State, such as the Head Start Association, or Kids Count. These relationships allow us to identify key issues facing the State's children and contribute to public policy solutions. For example in Rhode Island, we participated on the TeethFirst! leadership team, which developed and launched a successful state-wide website providing education to the State's citizens on the value of the year one dental visit and the importance of preventive care for children. To that end we also sponsor and attend local meetings and conferences (for example co-sponsoring a "mini-residency" in Rhode Island focusing on providing general dentists with tools to work with very small children), and contribute to community events such as Missions of Mercy, most recently in Rhode Island and Pennsylvania, as we look to broaden opportunities to serve the community and better understand oral health issues facing the State's citizens. UnitedHealthcare will look to build community partnerships in Nevada as well and as required in the RFP, we will develop processes and procedures and designate points of contact for collaboration with programs that serve recipients in the State.

We will work with the Nevada Office of Oral Health and Dentistry to promote preventative care particularly in children. As we have in other states, we will work closely with local government, local health departments, FQHCs and other community health centers and organized dentistry in the State, to help promote preventive health objectives, consistent with the Oral Health Access for Young Children (OHAYC) program including dental screenings, fluoride varnish applications, oral health education and dental referrals, focusing on children most at risk or more limited access to care.

UnitedHealthcare works not only to improve access and preventive health utilization for all children but also focuses in on those with targeted conditions, for example early childhood caries (ECC). As referenced in our description of these programs in other states, we focus caries-related education and outreach on local primary care physicians (PCPs), specifically pediatricians and family practice physicians. Education focuses on the etiology of caries, the efficacy of fluoride, the important role PCPs play in detecting caries and how they can incorporate caries screening and fluoride varnish into a well-child visit. Working together, UnitedHealthcare and its partners develop education, follow up to track patient activity at both the PCP and dental office and arrange for appropriate reimbursement, consistent with State rates.

Whenever possible, we will also work with other practitioners as we have in many other states where we have implemented physician varnish programs. UnitedHealthcare will work with local physician groups, educational institutions, advocacy groups and/or the State, to identify and implement PCP caries education programs, either online or in person. As part of our work with physicians UnitedHealthcare will also provide reinforcing messaging to PCPs to share with parents as well as direct reminders through newsletters, mailers and other communications tools on the value and importance of physician screening, fluoride varnish application and referral to a dental home for follow up, either directly if the PCP knows of a dentist or through UnitedHealthcare who can facilitate the referral. We can also provide PCPs with tools that can help them in their evaluation including Caries Risk Assessments like those developed by the AAP, CAMBRA and others.

We consistently measure and evaluate the number of eligible children who are screened by PCPs, provided fluoride varnish and then referred for follow up to a dental home. We also look at the distribution of participating PCPs and dentists, in an effort to increase physician participation and ensure an adequate referral source. UnitedHealthcare will make a special effort to reach out and work with practices, FQHC's and hospital programs that have clinical programs targeting early childhood caries, using methodology consistent with CAMBRA.

Supplementing our work on early childhood caries, to promote dental health as an integral part of overall health and wellness, we also engage community physicians in the following ways:

- We provide general clinical and service information for all physicians in our commercial network.
- We work with medical plans to identify high volume physicians where we can identify specific recipients for follow up.
- Specific focus will be placed on MCOs and FQHCs, where we emphasize the importance of dental screening and follow up with a dental home. The value of this initiative is that the FQHCs often provide both medical and dental services in the same facility.

UnitedHealthcare is also committed to working with local dentists to align our objectives and to work together on behalf of Nevada's children. The Nevada Dental Director, provider network Manager, Provider Outreach and Provider Network Development staff will communicate with the Nevada Dental Associations, dental societies and other provider groups in an effort to coordinate and promote our initiatives. Our associates are committed to developing a productive working relationship with the various members of professional societies and groups for the possibility of joint program and sharing. The endorsement of stakeholders maximizes awareness among providers of our training programs and promotes participation.

UnitedHealthcare is committed to ensuring that oral health is integral to overall health, all the more so for children who are vulnerable. Poor oral health leads to pain, infection, poor nutrition and even failure to thrive. Ensuring that children have access to good oral health is critical, particularly for those already experiencing other stressors. UnitedHealthcare will reach out to entities such as Together for Kids and Families, the Division of Behavioral Health and the Division of Developmental Disabilities in an effort to include oral health as part of the overall management of children being served.

Our member advocates will work closely with the Division of Children and Family Services and all identified agencies who retain guardianship or who provide services to enrollees with special healthcare needs in order to provide outreach, education, and special support services. For example, we can develop and implement specialized education programs for parents and guardians, provide access to interpreters, help coordinate care with other health care professionals, help parents find appropriate services and accommodations for children who are in wheelchairs or who are homebound, and help arrange transportation for dental visits.

To ensure that vulnerable recipients receive needed care we will provide a Community Coordinator to assist in care coordination and case management. The Community Coordinator will act in a liaison role with Nevada members and community partners to advocate for recipient needs, services and provide assistance in obtaining dental services. Specific functions might include:

- Advocate for recipient dental needs and services
- Help recipients navigate the Medicaid program to obtain needed dental services
- Partner with clinical program managers and care coordinators to resolve and remove barriers to care and access
- Support professional networks in coordinating access to out-of-network care when appropriate
- Intervene with care providers and other community based service groups on behalf of the recipient to assist in appointment scheduling or connecting with our member advocates for assistance when needed
- Recommend/refer cases to either UnitedHealthcare Nevada Dental Director for program exceptions based on clinical need or extraordinary circumstances
- Own any issue through to resolution on behalf of the recipient in real time or through comprehensive and timely follow up
- Research complex issues across multiple databases leveraging cross-functional support teams to resolve recipient issues and/or escalations

- Experience working with vulnerable children elderly and/or special needs recipients/patients

In addition to creating partnerships with local advocacy groups, we will look for additional opportunities with other community based organizations, (ex. Head Start); initiate or participate in existing health fairs and other community events; and explore opportunities to partner on community initiatives and/or events with hospital groups, MCOs, FQHCs and other large group practices to provide education, screenings and referrals.

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.

UnitedHealthcare provides both regionally located and regularly scheduled general education to its overall membership as well as more targeted education focusing on specific conditions and initiatives. General education is provided to recipients on the plan, including benefits, plan processes and procedures, member rights and other procedural topics. Education also includes a variety of oral health topics including: infant and toddler oral health, children's oral health, maternal oral health, fluoride varnish, sealants, early childhood caries, the medical-dental connection, avoiding the emergency room and the importance of finding a dental home. We use a variety of modalities to share general member information including the member welcome package, the member website, the dentist Web portal (for clinicians to share with members), handouts, letter and mailers.

Education is also provided to recipients on a more targeted basis. While this can be for specific conditions (for example, recipients that we know have chronic medical conditions shown to be connected to poor oral health), education can also be targeted to individual programs. Education is shared with families where children are not seen for their annual dental visit (HEDIS ADV) or for needed preventive services. Recipients receiving a physician varnish are provided education on the importance of following up with a dentist. Those who use the emergency room for non-traumatic dental emergencies are given information on the value of using community dentists. Targeted education is used in combination with outreach and is designed to encourage recipients to change their behavior.

UnitedHealthcare member outreach is targeted to specific programs and conditions and is designed, in combination with education, to improve recipient engagement. Our approach is technology- driven and recipient-focused to improve the health and dental status of the recipient. We identify recipients in need of outreach by data-mining our claims data and member utilization trend statistics recorded by our advanced technology platform. Outreach is tailored by program, condition, age band, and/or region, ensuring that outreach campaigns addresses specific membership needs. For example, in looking to encourage recipients to obtain their annual dental visit, preventive health services or a follow up dentist visit after receiving a physician varnish, those who do not have a previous claim, we will launch a customized automated call encouraging that recipient (or parent/caregiver) to contact a dentist for follow up. The call includes information on how to find a dentist and the recipient can opt to speak to a member services advocate.

In addition to direct outreach, we will conduct extensive community-based outreach initiatives and will work with local and regional organizations, to promote oral health. We will also work with local schools to disseminate information, and will engage local media for free placement of information and/or coverage of community outreach events.

Some of the specific approaches UnitedHealthcare utilizes to reach its recipient include:

Automated-calling. We use outbound IVR telephone campaigns to deliver messages about the importance of oral health and to remind recipients to schedule their annual dental visits and/or preventive care dental exams. These automated-calls are easily adaptable and can be customized to deliver a wide range of educational content. We analyze regional call trends through the Enterprise Customer Service Module (CSM), to determine the message of call campaigns per specific membership needs.

Text Messaging. We have pioneered an outreach strategy that leverages the widespread use and popularity of text messaging. Similar to outbound IVR campaigns, we use text messages to provide general education and to offer preventative dental care reminders. These text messages will be sent to participating recipients about a variety of health education initiatives and can be targeted to specific regions or audiences as identified by call trend and dental service utilization analysis.

Newsletters and Postcards. Because effective member outreach and education requires ongoing message reinforcement, we developed a system of delivering continued education to recipients through quarterly newsletters and monthly postcards. We mail newsletters the first month of every quarter and send supplementary postcards during the following two months, on a three-year rotational basis. Our library of oral healthcare newsletters and postcards covers a variety of educational topics, ranging from infant and child oral health, the importance of fluoride and sealants for children, and proper brushing techniques. In addition, we use our reporting systems to track various recipient concerns by region and to tailor newsletter and postcard campaigns to specific community needs. In this way, we offer a customizable flow of information that provides recipients with the education they need most.

Interactive Member Portal. Our member Web portal is designed to meet the needs of an increasingly technology-oriented Medicaid and CHIP population that is accustomed to instant access to information. Our portal gives recipients immediate access to Nevada Dental Plan information and is accessible from any computer with Internet access. The portal will provide recipients with an interactive provider directory with real-time data, as well as general information on how the Nevada Dental program operates; medically necessary covered services, value-added Services, member cost-sharing obligations, benefit limitations, complaints and appeals processes, and prohibitions on balanced billing. Our portal will also offer educational content related to preventive care and the importance of oral health, including the relationship between oral health and systemic/overall health. We will continuously review all web portal content to ensure that it is presented in a culturally sensitive manner and at an eighth grade reading level.

Live Agents. As appropriate, UnitedHealthcare will use member advocates and other “live agents” to reach out to recipients who remain non-compliant after other forms of outreach as well as specific targeted populations such as vulnerable children. In addition to encouraging recipients, parents and caregivers to set up appointments, they can play a direct role in facilitating those appointments

EVALUATING THE OUTREACH PROGRAMS

Progress on the deployment of the interventions will be monitored by the member outreach group during their monthly meetings, as will the analysis for each intervention and the ongoing progress of the HEDIS measurement. This monitoring strategy will enable the group to deploy additional interventions, as well as measure success in meeting HEDIS milestones.

To evaluate the effectiveness of the programs, we use the following three tactics:

STATISTICAL ANALYSIS

We analyze and measure each member outreach tactic and compares the outcomes against outcomes for time periods (i.e. months) without intervention, as well as comparison against outcomes of alternative interventions, when applicable. The statistical outcomes are generated and monitored on an ongoing basis and reported to the State on an annual basis.

SEMI-ANNUAL COMPARISON

We analyze and measure the HEDIS performance of the first six months of each year against the last six months of that same year. Statistical data is reported to the State once annually within the first quarter following the measurement calendar year.

HIGH/LOW PRODUCTIVITY

After the end of the calendar year, we complete a review and measures the performance of each month, as it relates to the State's HEDIS score. We produce a list of the three highest performing months and the three lowest performing months. This measurement is used to compare against the other statistical measures.

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

General education is provided to recipients on the plan, including benefits, plan processes and procedures, member rights and other procedural topics. Education also includes a variety of oral health topics including: infant and toddler oral health, children's oral health, maternal oral health, fluoride varnish, sealants, early childhood caries, the medical-dental connection, avoiding the emergency room and the importance of finding a dental home. We use a variety of modalities to share general member information including the member welcome package, the member website, the dentist and physician web portal (for clinicians to share with members), handouts, letter and mailers.

A. How the dental program operates;

New recipients will also have access to the following educational tools which support proactive health choices:

Orientation Sessions – We will host at least one recipient orientation session in each community service area prior to program implementation. Dental specialists will be available to educate recipients on the specific details of the program, including an overview of the benefits structure and a review of the recipient handbook. Recipients will have the opportunity to ask additional questions about the plan and will be given the toll-free number for customer care to call if they have specific questions about coverage after the orientation session has ended.

Call Center Contacts - The call center is our primary vehicle for recipient outreach and communication, while also serving as a hub for information and resources. A major hurdle between a recipient and dental care can be the scheduling of an appointment. But personal trepidation and/or communication/language barriers should not be barricades that keep recipients from receiving appropriate care. To remove those barricades, the call center offers toll-free appointment scheduling on behalf of recipients who call and request it. Our member services advocates can provide recommendations on the most appropriate providers based on regional location, services required, and/or special recipient needs. When asked, a representative can supply contact information, general office information, and can even initiate a three-way phone call with the provider to schedule an initial office visit or appointment.

Member handbooks. We will mail member handbooks to each recipient household upon program implementation and to new enrollees. The handbook is an inclusive resource that provides details about Nevada Medicaid and CHIP Dental Program. We will also include oral health educational materials and discount coupons as part of the new recipient mailing.

Member Web Portal – We will provide a customizable, self-service Web portal that provides recipients with an intuitive information hub surrounding the dental services offered by the State dental program. Our member Web portal offers a communication vehicle beyond traditional telephone and mailed communications, providing recipients faster, easier access to education and services. After registering online, recipients can log onto the portal for direct access to a host of features, including relevant benefit information, educational links, online documents and education materials, links to online videos, as well as our provider search function and claims history.

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

We will provide information to recipients about all services, including the expanded benefits for women and any applicable benefit limitations.

C. Dental Exams and preventive care;

We utilize the following innovative methods to support proactive dental care for recipients:

Automated-calling. We use outbound IVR telephone campaigns to deliver messages about the importance of oral health and to remind recipients to schedule their annual dental visits and/or preventive care dental exams. These automated-calls are easily adaptable and can be customized to deliver a wide range of educational content. We analyze regional call trends through the Enterprise Customer Service Module (CSM), to determine the message of call campaigns per specific membership needs.

Text Messaging. We have pioneered an outreach strategy that leverages the widespread use and popularity of text messaging. Similar to outbound IVR campaigns, we use text messages to provide general education and to offer preventative dental care reminders. These text messages will be sent to participating recipients about a variety of health education initiatives and can be targeted to specific regions or audiences as identified by call trend and dental service utilization analysis.

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

Education is also provided to recipients on a more targeted basis. While this can be for specific conditions (for example, recipients that we know have chronic medical conditions shown to be connected to poor oral health), education can also be targeted to individual programs. Education is shared with families where children are not seen for their annual dental visit (HEDIS ADV) or for needed preventive services. Recipients receiving a physician varnish are provided education on the importance of following up with a dentist. Those who use the emergency room for non-traumatic dental emergencies are given information on the value of using community dentists. Targeted education is used in combination with outreach and is designed to encourage members to change their behavior.

UnitedHealthcare member outreach is targeted to specific programs and conditions and is designed, in combination with education, to improve member engagement. Our approach is technology- driven and recipient-focused to improve the health and dental status of the recipient. We identify recipients in need of outreach by data-mining our claims data and member utilization trend statistics recorded by our advanced technology platform. Outreach is tailored by program, condition, age band, and/or region, ensuring that outreach campaigns addresses specific membership needs. For example, in looking to encourage recipients to obtain their annual dental visit, preventive health services or a follow up dentist visit after receiving a physician varnish, those who do not have a previous claim, we will launch a customized automated call encouraging that recipient (or parent/caregiver) to contact a dentist for follow up. The call includes information on how to find a dentist and the recipient can opt to speak to a member services advocate.

In addition to direct outreach, we will conduct extensive community based outreach initiatives in which we will work with local and regional organizations, to promote oral health. We will also work with local schools to disseminate information, and will engage local media for free placement of information and/or coverage of community outreach events.

Some of the specific approaches UnitedHealthcare utilizes to reach its member include:

Newsletters and Postcards. Because effective member outreach and education requires ongoing message reinforcement, we developed a system of delivering continued education to recipients through quarterly newsletters and monthly postcards. We mail newsletters the first month of every quarter and send supplementary postcards during the following two months, on a three-year rotational basis. Our library of oral healthcare newsletters and postcards covers a variety of educational topics, ranging from infant and child oral health, the importance of fluoride and sealants for children, and proper brushing techniques. In addition, we use our reporting systems to track various recipient concerns by region and to tailor newsletter and postcard campaigns to specific community needs. In this way, we offer a customizable flow of information that provides members with the education they need most.

Interactive Member Portal. Our member portal is designed to meet the needs of an increasingly technology-oriented Medicaid and CHIP population that is accustomed to instant access to information. Our Member Web Portal gives recipients immediate access to Nevada Dental Plan information and is accessible from any computer with Internet access. The portal will provide recipients with an interactive provider directory with real-time data, as well as general information on how the Nevada Dental program operates; medically necessary covered services, Value-Added Services, member cost-sharing obligations, benefit limitations, complaints and appeals processes, and prohibitions on balanced billing. Our portal will also offer educational content related to preventive care and the importance of oral health, including the relationship between oral health and systemic/overall health. We will continuously review all web portal content to ensure that it is presented in a culturally sensitive manner and at a sixth grade reading level.

Live Agents. As appropriate, UnitedHealthcare will use member services advocates and other "live agents" to reach out to recipients who remain non-compliant after other forms of outreach as well as specific targeted populations such as vulnerable children. In addition to encouraging recipients, parents and caregivers to set up appointments, they can play a direct role in facilitating those appointments.

E. Oral health literacy; and

We will utilize the same targeted educational initiatives as described in Response D to increase oral health literacy in the general and targeted populations enrolled in the Nevada Dental Medicaid program.

F. Non-Emergency Transportation for Medicaid Members.

Recipients will receive information about non-emergency transportation services in the Recipient Handbook. In addition to being mailed to recipients during orientation, the Recipient Handbook will also be posted online and accessible 24 hours a day, 7 days a week via the member Web Portal. The member handbook will address all issues related to accessibility, recipient responsibility, and how to get assistance with any issue. The handbook will contain all required content and begin with a table of contents to provide readers with a quick method for finding content.

Recipients can also contact customer service to get information about non-emergency transportation contacts and resources.

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.

We are offering additional cost effective services to recipients who are pregnant. This will be offered at no additional cost to the State.

The Prenatal Dental Care Program is a component created to meet the unique needs of an expectant mother and her unborn child. Women who are in their second and third trimester and show evidence of gingivitis or periodontal disease are eligible for the additional benefits offered with the Prenatal Dental Care program. The program provides for additional preventive and periodontal services with no out-of-pocket costs.

WHAT ADDITIONAL SERVICES ARE COVERED?

Women in their second or third trimester are eligible to receive the following additional services at no additional cost:

- Additional routine adult prophylaxis (ADA Code D1110) above the standard two cleanings per year as prescribed by their dentist;
- One course (up to four quadrants) of periodontal scaling and root planing (ADA Code D4341/D4342) with a documented untreated periodontal condition and/or;
- Periodontal maintenance (ADA Code D4910) if warranted by a history of periodontal treatment
- Plan pays at 100% of the contracted allowable amount with no member coinsurance required for the additional benefits
- Additional benefits are not subject to the plan deductible for plans where a deductible applies
- Some restrictions and limitations may apply

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.

As required, if our network of providers is unable to provide Medically Necessary Covered Services under this contract to a particular enrollee, we will adequately and timely cover these services using a non-participating provider for the enrollee for as long as we are unable to provide them. The benefit package will include covered medically necessary services.

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;

If that situation arises, we will require non-participating providers to coordinate with us as the contracting entity with respect to payment in order to ensure that the cost to the enrollee is no greater than it would be if the services were furnished within the network.

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

The UnitedHealthcare Network team will work with the State and Health Plan partners to engage in targeted solicitation in an effort to recruit out-of-network providers and increase specialty participation.

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

When recipients access care from an out- of- network provider, our claims processing system applies specific edit rules to ensure services being rendered do not exceed the Medicaid FFS rate. During claims processing, proprietary edit rules are applied to verify recipient, provider, and dental service eligibility. These predefined dental claim rules are based on many years of industry experience, industry standard best practice, licensed consultant reviews, and past customer input. These proprietary edits can also be customized with client-specific business rules to automatically determine authorizations, match authorizations against related claims for automatic consumptions, deny claims, and flag authorizations and claims with descriptive exception messages for further review.

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.

If despite our best efforts and/or there are no providers/specialists available within the required access standards, we will contract with the nearest provider in a contiguous county. Should a recipient be unable to access care within the required access standards, they can work with call center staff to initiate a referral to an out-of-network provider. The recipient will be asked to provide their address. All referrals will be made in a timeline appropriate to the need for care, but will take no longer than five business days. Once the referral has been made, we will negotiate payment rates with the provider to ensure that there is no delay in care for the recipient.

For emergency care, recipients will receive an immediate referral. We will fully reimburse the out-of-network provider in accordance with the out-of-network methodology for Medicaid.

3.3.6 Emergency Dental Services

UnitedHealthcare has guidelines and policies regarding the care of recipients experiencing dental emergencies. Within the scope of dental care benefits under the recipient's benefit plan, emergency dental services are services required in the event of unforeseen medical conditions such as pain, hemorrhage, infection, or trauma, where immediate attention is necessary. In general, emergency services include relief of pain, swelling, infection, and/or bleeding by procedures to stabilize the emergency condition, and may include issuing prescription medications.

Emergency situations will be individually assessed by the member services advocate or appropriate actions. In the case of a life threatening emergency, the recipient will receive instruction to hang up and dial 911. In the case of a dental emergency, which is not immediately life threatening, but is causing severe bleeding or pain, the member services advocate will instruct the caller to seek immediate treatment and will refer them to a suitable substitute provider location if her MDHP is closed. The member services advocate can establish a three-way call with the substitute provider location to schedule an urgent appointment, and can coordinate transportation for the recipient, if necessary. If no suitable substitute provider location can be found, the member services advocate will refer the recipient to the closest walk-in clinic.

When a recipient needs non-capitated emergency dental services, the member services advocate will contact the recipient's MDHP or an appropriate dental specialist, advise them of the urgent issue and arrange for the recipient to be seen immediately. If the emergency service involves a service covered under the recipient's medical coverage, the member services advocate will attempt to coordinate treatment by contacting the medical plan. Member service advocates will have access to a contact list for all MCOs offering Medicaid and CHIP coverage to Nevada recipients.

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.

We will not deny payment for emergency services treatment for a recipient who was instructed to access emergency care by our member services staff or a network provider.

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

As required, we will 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.

We comply with all service requirements outlined in 3.3.6.3 Section A-D.

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.

As required, we will pay for emergency dental care with the exception of services performed under the medical benefit in a hospital, emergency room or an 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.

We will not deny payment for treatment obtained when a recipient 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.

As noted, we will not provide reimbursement 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.

As required, we will 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.

Network providers will follow national coding guidelines for any non-emergent services provided in an emergency room setting.

3.3.6.9 Post-Stabilization Services

Post stabilization care and services will be provided as outlined in Questions 3.3.6.9, Sections A-E.

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;

Confirmed.

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;

Confirmed.

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;

Confirmed.

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

Confirmed.

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.

Confirmed.

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)].

We will implement procedures to facilitate opportunities to improve health outcomes, quality and confirm continuity of care. We have comprehensive procedures to coordinate services that recipients receive from other vendors pursuant to 42 CFR 438.208(b) (2), (3), and (4). Our policies and procedures 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 and HIPAA.

We will communication and work in collaboration with other vendors to ensure continuity of care and ensure that services are not duplicated.

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.

We strive to build excellent working relationships with state agencies, local health departments, and FQHCs. By assisting these local and state bodies to meet their public health dental program goals, we gain access to another layer of information and data regarding recipients as well as another partner in recipient outreach and communication initiatives.

Our cooperation and coordination with all outside entities will comply with all applicable federal and state confidentiality requirements. We will protect the privacy of all recipients, and we will follow up with the recipient (or recipient's responsible party) when an outside entity (interested party) communicates a dental health need or issue regarding the recipient.

SUPPORT FOR RECIPIENTS WITH SPECIAL NEEDS

Our Member advocates and Utilization Management Teams will work closely with the providers, enrollees, guardians, advocates and assigned case managers to ensure recipients with disabilities receive necessary and appropriate care and services. Our teams have experience developing and implementing case management protocols for children and adults with special needs. We will draw on that expertise to implement a customized program that meets EOHHS's specific requirements. For example, we can develop and implement specialized education programs for parents and guardians, provide access to interpreters, help coordinate care with other health care professionals, help parents find appropriate services and accommodations for children who are in wheelchairs or who are homebound, and help arrange transportation for dental visits. If necessary, we will coordinate arrangements with dental facilities that specialize in treating patients with special needs. To accommodate other recipients, we have contracted with facilities specializing in the care of patients with mental retardation, autism, epilepsy, and cerebral palsy. We also work with participating dental offices to help them become comfortable treating recipients who have special needs. This includes providing educational material to office staff, as well as opportunities for earning continuing education credits at our expense for providers and dental hygienists.

SCHOOL-BASED AND HEAD START OUTREACH

Reaching children early—and in their everyday environments—is an important aspect of our outreach. We can provide a cross-analysis that compares recipient home addresses against local schools and Head Start program locations, and can recommend these specific locations for outreach campaigns designed to build alliances and collaboration. We recognize that education and healthcare professionals working in school-based and Head Start settings are the first line of defense for reaching and influencing children, parents, and caregivers about the importance of oral health. Because these professionals see children and their families nearly every day, we consider them to be effective conduits for distributing educational materials, including toothbrushes and fluoride toothpaste samples.

TRANSPORTATION SERVICES

To provide assistance to recipients who require transportation services, we will make information about transportation services and resources available from:

- Recipient welcome packet

- **Member Web Portal**. We can display customized messages approved by the contract on web pages, and we can attach approved resource information available for online viewing and/or printing.

- **Call Center Content Management System.** The call center staff is fully trained in client-specific details, policies, and procedures. We store resource materials, including information about transportation services, in an online content management system, to provide quick and easy online access when representatives are on the phone with recipients.

PUBLIC HEALTH OUTREACH AND EDUCATION PROGRAMS

We work closely with state agencies, local health departments, FQHCs, and other local service agencies to educate parents and care givers about the importance of dental services for children with unmet and/or urgent dental needs.

Communication pieces, whether written or verbal, include educational information as well as contact information for the recipient's PCD and two other nearby dental providers that meet the recipient's requirements. As always, the call center is available to assist recipients with overcoming communication/language barriers, scheduling appointments, and arranging transportation services.

PEDIATRIC AND FAMILY PRACTICE COMMUNICATIONS

On average, by the time a child visits a dentist for the first time, that same child has visited a physician seven times. That is why educating physicians who specialize in treating children (pediatricians and family practices) is another important tactic. These physicians are targeted either in cooperation with participating managed care organizations or with state assistance. The communication provides education about the link between oral disease and medical disease, and provides a toll-free number to the call center to obtain a current list of participating dental locations.

FLUORIDE VARNISH PROGRAM

In the truest spirit of medical-dental integration, the state of Nebraska allows for primary care physicians to apply fluoride varnish to the teeth of young children. We have developed a web-based education program for participating physicians. Physicians are directed to a customized website where they can register and review interactive educational materials on fluoride varnish. After reviewing the training resources, a competency test can be taken. A certificate for one Continuing Medical Education (CME) credit is awarded upon satisfactory completion of the evaluation.

The primary goal of our fluoride varnish web portal is to provide a consolidated resource center that provides physicians with all the requisite information needed to begin administering fluoride varnish. The portal explains the benefits of non-dental professionals applying fluoride varnish and how to properly administer it to children's teeth. For active encouragement and convenience, the site includes a directory identifying locations where all required materials for the procedure can be purchased. The site also provides a current listing of participating dental practitioners, so physician's offices can easily make referrals when necessary.

EMERGENCY ROOM DENTAL VISIT OUTREACH

We have customized, prior-approved communications that are sent to recipients who visit the emergency room for oral pain. We provide this service in conjunction with participating clients who provide the data necessary for the outreach. The recipient receives education, a provider listing, and the toll-free number to help with appointment scheduling.

DENTAL SCHOOL PARTNERSHIPS

Dental school relationships are excellent opportunities to improve access to care. These schools often participate in Medicaid programs and welcome new patients, and some even have portable dental equipment or a network of clinic locations that can be used for outreach and/or general screenings.

HEALTH FAIR PARTICIPATION

We participate on behalf of clients at local health fairs. These events offer an important opportunity to reach and educate recipients. Local representatives often volunteer in order to improve the effectiveness of our outreach activities.

MANAGED CARE ORGANIZATION PARTNERSHIPS

We develop excellent relationships with participating Medicaid managed care organizations. These clients have recipient communication requirements and are in routine communication with their provider network, which offer many opportunities for collaboration, with a goal of promoting education about the benefits of good oral health to both recipients and healthcare professionals. We can provide content for client newsletters or targeted communications to selected provider groups.

DISEASE MANAGEMENT PROGRAMS

There is significant primary and auxiliary research to support the premise that good oral health is intrinsically linked to good physical health. As such, we work closely with the disease management groups within MCOs that share data on recipients who suffer from various diseases or have conditions impacted by oral health. In these specialized cases, identified recipients receive targeted outreach communications that discuss how oral health directly affects them and lists available provider locations that could help them attain and/or maintain good oral health. These customized, prior-approved communications are specifically tailored to highlight the benefits of oral care from the particular perspective of the recipient. We cooperate in receiving the eligibility information and conditions of certain recipients who benefit from a specific care or disease management intervention. These are the same recipients that MCOs tend to case manage as well, including cardiac cases, diabetics, pregnant mothers, and persons with prosthetics.

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.

Our member services advocates and utilization management teams will work closely with the providers, enrollees, guardians, advocates and assigned case managers to ensure recipients with disabilities receive necessary and appropriate care and services. Our teams have experience developing and implementing case management protocols for children and adults with special needs. We will draw on that expertise to implement a customized program that meets the State's specific requirements.

For example, we can develop and implement specialized education programs for parents and guardians, provide access to interpreters, help coordinate care with other health care professionals, help parents find appropriate services and accommodations for children who are in wheelchairs or who are homebound, and help arrange transportation for dental visits.

If necessary, we will coordinate arrangements with dental facilities that specialize in treating patients with special needs. To accommodate other recipients, we have contracted with facilities specializing in the care of patients with mental retardation, autism, epilepsy, and cerebral palsy. We also work with participating dental offices to help them become comfortable treating recipients who have special needs. This includes providing educational material to office staff, as well as opportunities for earning continuing education credits at our expense for providers and dental hygienists.

UnitedHealthcare will utilize various strategies to improve access by ensuring continuity of care between primary health care physicians and dentists:

- UnitedHealthcare will provide information on various dental health topics to physicians including information on the importance of following up at a dental home. This will include specific focus on FQHC's and hospital programs.
- As appropriate, UnitedHealthcare will work with the State and the program MCOs to identify children seen in medical settings who may not have received dental follow up. We will then provide those families with communication on the importance of dental follow up. Those families will also be selected to receive appropriate outreach in the form of postcards and similar communications in an effort to further encourage dental engagement.
- Specific to an at-risk condition, such as early childhood caries, parents whose children have been seen by a PDP for screening and varnish application will receive a letter from UnitedHealthcare reminding them of the importance of follow up with a dental home

IDENTIFYING MEMBERS WITH SPECIAL NEEDS OR DISABILITIES

Once a recipient with special needs is identified in an eligibility file load, during initial enrollment contact, or through other intake methods (including a call to member services requesting specialized care), the information is referred to our Customer Care Advocate team for follow up. We work with enrollees individually to evaluate needs and coordinate specialized care.

The Enterprise System, our benefits administration software platform, has built-in features that support a care advocate approach for recipients with special needs. Enterprise System can track details for each child, including disability type, diagnosis code, and effective/termination dates.

The system can also track details about each enrollee's primary dental providers, specialty providers, health care facilities, and protected health information

IDENTIFYING PROVIDERS, SPECIALISTS, AND CLINICS THAT CAN ACCOMMODATE SPECIAL NEEDS

The Enterprise System can track any number of customizable, specific details about providers and specialists who treat patients with special needs, including whether they are accepting new patients, whether they treat patients with particular conditions, and whether they will travel to treat homebound patients. The Enterprise System can also track details about clinic locations that are accessible for patients with special needs.

Any of the information stored in the Enterprise System database can be extracted and packaged to support care advocate tasks. For example, provider directories that include details about accommodations for special needs and access restrictions can be generated on demand and made available to recipients, parents, and guardians.

CUSTOMER SERVICE SUPPORT

Complete details about an enrollee's special needs, along with information about providers and clinic locations that can accommodate those needs, are available online to member services advocates. The Find-a-Provider feature allows member services advocates to quickly search for providers, specialists, and clinic locations that meet a member's particular needs within a defined search radius.

In addition, member services advocates can initiate three-way calls with guardians or other designated assistants for members with mental illness or cognitive impairment. Information about individuals who have been granted access to an enrollee's Protected Health Information (PHI) can be stored with the enrollee record in the integrated enrollment system. This information is immediately available to member services advocates when a call record is opened for the member.

3.3.6.11 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.

We currently have contracts with the following FQHCs:

- Community Health Alliance- Dental Group in Northern Nevada
- Eastern Family Medical and Dental Center- Nevada Health Centers Southern Nevada
- University Medical Center of Southern Nevada
- The University of Nevada, Las Vegas Dental School

Our provider relations department will also engage additional FQHCs and make a good faith effort to include all qualified facilities and providers in our network.

3.4 ENROLLMENT REQUIREMENTS AND LIMITATIONS

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.

We understand that eligibility and enrollment functions are the responsibility of the DHCFP and DWSS. As one of the nation's leading Medicaid managed care plans, our state partnerships support ongoing, widespread experience with establishing and implementing enrollment procedures and maintaining applicable enrolled member data. We will operate and manage the data exchange and processing requirements through the Enterprise System which optimizes our performance in receiving, loading and processing electronic enrollment files, in addition to reconciling eligibility and capitation records. We have a dedicated team for enrollment file processing and the reconciliation of capitation payments, and we work with the DHCFP to maintain accurate and timely eligibility and capitation records.

We accept each recipient who is enrolled in or assigned to us by the DHCFP and/or our enrollment sections and/or for whom a capitation payment has been, or will be made, to us by the DHCFP. The first date a Nevada Medicaid or Nevada Check Up recipient will be enrolled will not be earlier than the applicable date in our specified contract.

Highly qualified technical staff members have over 20 years of experience handling Medicaid/Medicare EDI files. We import, process, and manage Medicaid/Medicare eligibility EDI files, understanding and applying different electronic file formats required by each state.

The data file import process manages enrollee updates through eligibility change files submitted in HIPAA-compliant 834 v. 5010 transaction sets and through full file data imports, which reflect full membership. Full files can be imported and processed on any schedule that meets each customer's needs, including periodic replacement at the discretion of the State. Built-in logic compares full files against membership records stored in the processing system database, and customizable business rules are applied to correct any discrepancies. The process generates reconciliation reports that can be customized to meet the State's requirements.

RESOLVING DISCREPANCIES

We take advantage of built-in efficiencies in our benefits administration software platform to import, process, and manage data file imports, including eligibility files.

Business rules can be applied against the imported data to ensure it matches the original file data, and customized data edits can be applied to meet specific client requirements. Incoming data files that cannot be loaded can be suspended, corrected, and reprocessed or they can be returned to the client for correction, depending on each customer's requirements and preferences.

We will accept daily enrollment/disenrollment updates and provide weekly reconciliation of the data. We will provide written notification to the enrollment broker of any data inconsistencies within 10 calendar days of receipt of the file. We will also reconcile the monthly file against internal records and notify the State of any inconsistencies within three months of file receipt.

Data updates can be automatically loaded into the system based on business rules. For example, rules defined for various functional sets of data control how matching records and unmatched (new) records are handled: they can be merged, completely replaced, or ignored. Likewise, rules can also be defined down to the individual field level to control update actions for each field.

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.**

We acknowledge that enrollment is mandatory except in the case of voluntary enrollment programs that meet the conditions set forth in 42 CFR 438.50(a). We do not, and will not, discriminate against individuals based upon health status or the need for health care services.

We do not, and will not, discriminate against individuals based upon race, color or national origins, and we do not, and will not, use policies or practices that may initiate discrimination in any form or manner. Our organization follows written policies and procedures in each of the states we serve for enrolling all eligible populations and accepting the enrollment of all individuals appearing on monthly enrollment reports. We respect and recognize cultural, linguistic, gender, sexual orientation, socioeconomic, and spiritual- and faith-based differences, and how they influence an individual's desire and ability to engage in his or her health care decisions. We do not encourage recipients to dis-enroll due to health care needs or a change in health care status and we will never consider health care utilization patterns as a basis for disenrollment. Our goal for the Nevada Medicaid and Nevada Check Up Programs is to provide all segments of the member populations with the resources and information they need to understand the programs and take charge of their health.

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.**

We understand we are responsible for services rendered during a period of retroactive enrollment in situations where errors have caused an individual not to be properly enrolled.

Our capabilities enable us to routinely process manual transactions within the same day of receipt. Further, we understand that in such a case, we are only obligated to pay for services that we would have authorized had the individual been enrolled at the time of the services. In addition, we understand that in these circumstances we must pay:

- In-state providers for services only in the amounts that would have been paid to a contracted provider in the applicable specialty
- Out-of-state providers according to a negotiated rate between the vendor and the out-of-state provider

We acknowledge that the time frame to make these corrections is limited to 180 days from the incorrect enrollment date and the DHCFP will be responsible for payment of applicable capitation for the retroactive coverage. We are experienced with retroactive enrollment and we have demonstrated our abilities to meet these requirements within the states we serve.

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

We will comply with the requirements outlined above by having an established benchmark for the Nevada Medicaid and Nevada Check Up Programs to determine provider capacity and consider the number of patients a provider can treat. We will use this calculation as part of our access and availability monitoring and will submit Access and Availability reports to the DHCFP quarterly. Providers who reach maximum capacity have closed panels as indicated in our online provider directory.

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

We comply with the requirements above by transmitting PDP data nightly to the DHCFP through the Provider Supplied Data File.

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 PDP 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.

We comply with all PDP notification requirements stated, processing all PDP selections within five business days, but typically within 48 hours, which exceeds the stated requirement expectations. We process enrollment and assign PDPs in the following manner:

- When we receive the enrollment files (monthly and weekly), we enter the new enrollment information into the Enterprise System. The monthly file captures all current enrolled, new and dis-enrolling recipients for the next month's eligibility.
- The daily file reports new updates (adds, terms, changes) that miss the cutoff date for the monthly file.
- From there, we initially auto-assign PDPs to all recipients to meet the State's requirement for having PDPs assigned within five business days of receiving the enrollment file (PDP assignment is not provided by the State on the enrollment file it sends to us). Auto-assignment involves our use of a ZIP code to align with the member's geographical area. PDPs with higher quality scores are placed at the top of the auto-assignment algorithm.

- Following this initial auto-assignment, we send a new member welcome packet to new members. It includes a welcome letter that provides the member with the name, contact information of his/her assigned PDP, and with instructions to contact members services if he/she wishes to change his /her PDP.

- When member services receive a call from the recipient, they assist the recipient in locating, selecting and changing the PDP. Then they make the change to the member's record. In addition, recipients are allowed to change their PDP at any time, which involves a call to member services (who assists and makes the system change to the member's record).

Dental Home Scorecard – Regular reporting will be offered to dentists participating in the Dental Home program providing them with regular feedback on their member roster, member turnover, how many of those members have been in for a dental visit, how many of those members have been in for preventive care and/or therapeutic care etc. Information on the scorecard will be shared with participating dentists as part of the overall communication on the Dental Home program, which will include information on what Dental Home is, Dental Home criteria, the mechanics of the Dental Home program and how feedback will be provided. This will be shared through the Provider summary guide, on the dentist portal, newsletter articles, mailers and individual contact with provider advocates.

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.

We realize that continuity of care is as important for recipients who leave our dental services plan as it is for our new recipients. We are committed to seamless transitions and follow formal written policies and procedures, in compliance with RFP Statement of Work Section 3.4.6 to confirm coordination, assuring a transfer of services with a positive outcome and no disruption to the recipient's care.

As required in our dental contract, all providers will transfer of Insured's dental records to another dental provider. This provision is intended to apply only when a treating dentist or dentists has a need for such dental records. The contracted provider must cooperate with the FFS provider in transferring the recipient's records, upon written request, within thirty (30) calendar days of request. The provider must provide one (1) copy of dental records free of charge, in a timely manner.

To maintain compliance with all confidentiality requirements, we obtain the member's signature on the Member Authorization to Disclose Protected Health Information (PHI) form before releasing any information.

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.

Our approach to providing health care is always person-centric, taking into account the recipient's environment, background and culture. We provide our members with appropriate resources and support to promote communication and foster an inclusive, compassionate, accessible environment that includes member advocates who are fluent in Spanish and free interpretation services that are always available to meet member communication needs.

The written materials we provide to our Nevada recipients are fully compliant with the requirements specified in Section 3.5.1.1.

Our written materials are designed to help recipients understand their dental benefits and to encourage them to access dental care on a regular basis. It also explains the impact their dental health has on their overall health and wellness.

To enhance understanding of member materials for Nevada Medicaid and Nevada Check Up members, we provide written materials in both English and Spanish, and will provide materials in other prevalent languages within the State. We also accommodate recipient requests for translations. We solicit, verify and document our recipients' needs for interpreter and translation services during welcome calls and other member interactions with our staff.

We monitor our Nevada member communications for effectiveness and we will also review feedback from the State and our members about our materials, making sure they resonate with individuals in the communities we serve.

MEMBER HANDBOOK

As required in the RFP we will mail the handbook to all recipients within five (5) business days of receiving notice of the recipient's enrollment. In order to protect member's PHI, the Handbook is sent under separate cover from the ID card. Recipients will receive orientation protocol and procedures in the welcome kit. The welcome kit contains information about their benefit plans, how to utilize their dental benefits, how to register a complaint or file a grievance and additional information related to Federal and State legal requirements and guidelines. Recipients are also able to contact customer service to have any of their questions answered. Our culturally competent and responsive member services advocates will engage the recipient and help them to understand their benefits and services. Additionally, our member services advocate team will be able to provide any necessary translation services or support at the time of the call.

We will also utilize a combination of automated and live dialing and make at least four attempts on different days and different times to make a welcome call to all new recipients within thirty days of enrollment. An important feature of our automated calling system is that recipients have the option to opt out of the automated message when they are on the call and instead speak to a live representative. That initial call is very important, because it is our opportunity to not only engage our recipients, but also provide important information about the plan benefits. During that call, we will provide recipients information about the importance of their plan benefits, assist them in selecting a dentist, and answer any questions that they might have about access or care.

ONLINE MEMBER MATERIALS

We offer a customizable, self-service Web portal that provides recipients with an intuitive information hub surrounding the dental services offered by the Nevada Medicaid dental program. Our member Web portal offers a communication vehicle beyond traditional telephone and mailed communications, providing recipients faster, easier access to education and services. After registering online, recipients can log onto the portal for direct access to a host of features, including relevant benefit information, educational links, online documents and education materials, links to online videos, as well as our provider search function and claims history. The site meets all stated RFP requirements and is in compliance with all State and Federal regulations.

This dedicated member website grants recipients immediate access to relevant benefit information, educational materials and videos, links to relevant websites, and an online provider directory. By logging on to the member Web portal, recipients can:

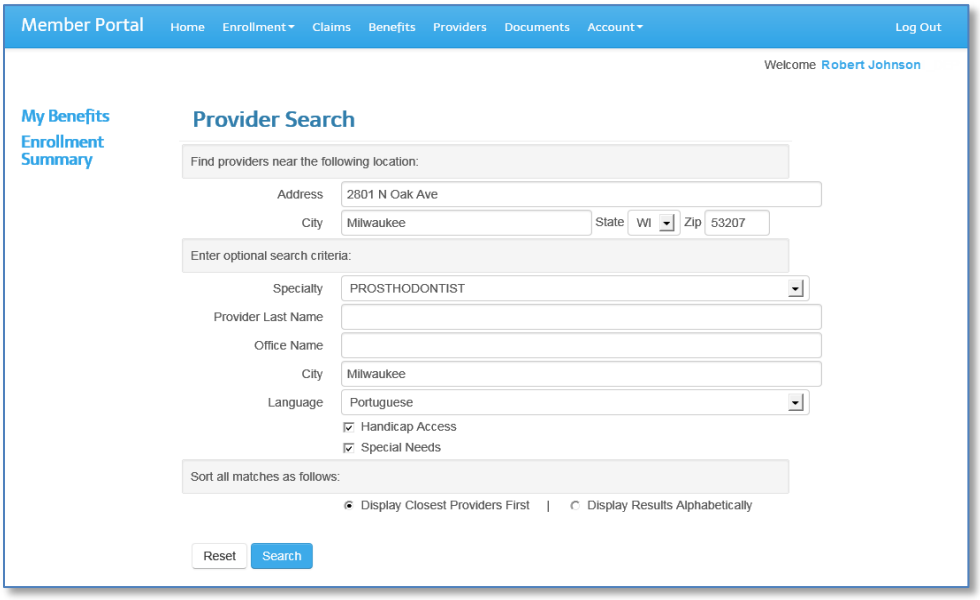
- Access information on covered services and benefits.
- View, save, and print Recipient Handbook, educational materials, and other electronic documents
- Review complete claim history.
- Manage account information (add email address, change password, update coordination of benefits, etc.).
- Search for providers by geographical location and other criteria and view office business hours.
- Request ID cards.
- Read news content and bulletins.

With the Provider Search feature in the member Web portal, recipients can search provider data, updated in real-time, to find providers by:

- Geographic location
- Type of practice/specialty
- Panel restrictions
- Foreign language fluency
- Accommodations for patients with special needs

- Handicap-accessible office locations

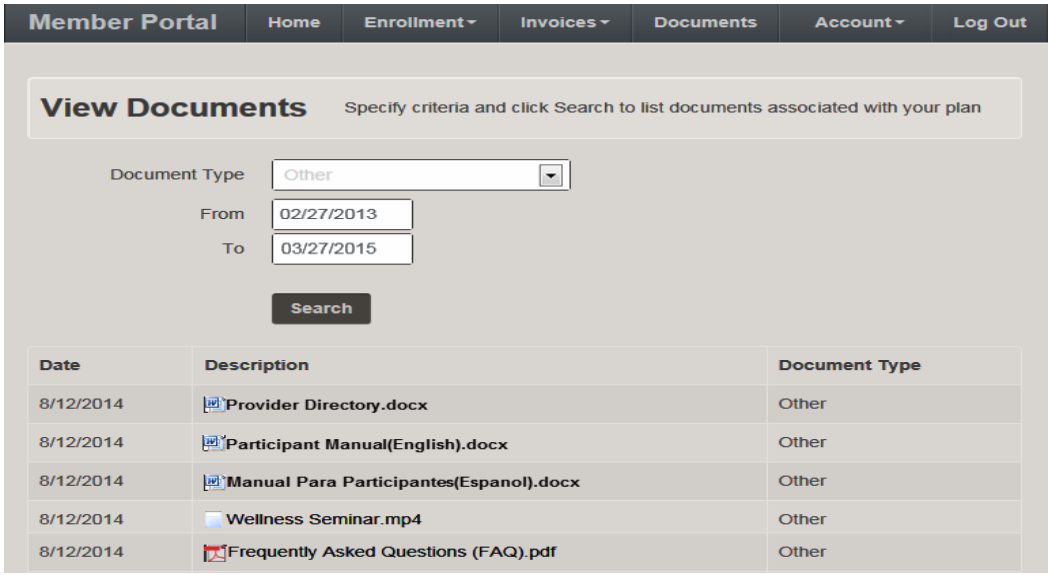
The entire provider directory will also be available as an online PDF document, which can be viewed and/or downloaded and printed. An example as a screen shot is below:



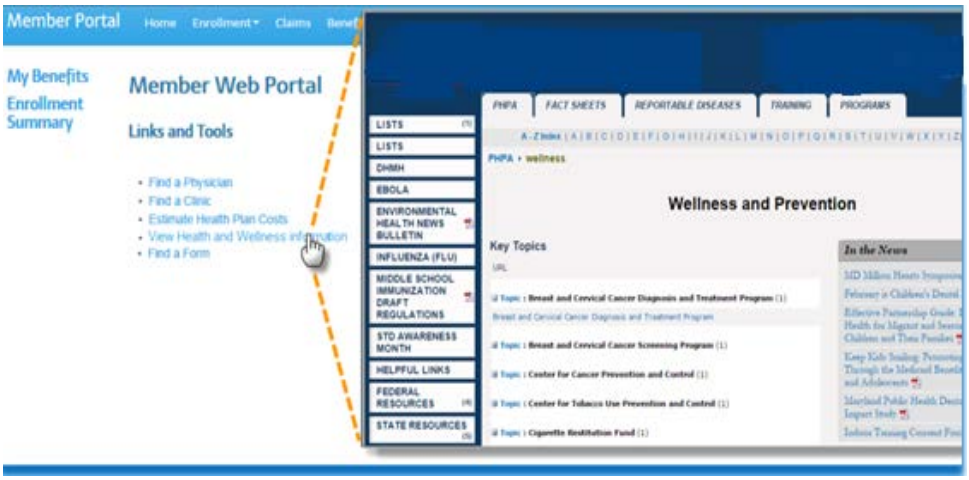
Images in this response are subject to change and show fictitious provider, location, and recipient information.

Benefit summary and eligibility history reports, available through the member Web portal, allow patients to review their covered benefits.

Recipient handbooks, provider directories, educational materials, outreach initiatives, and other documents can be uploaded to the appropriate web portal, providing online access 24 hours a day, seven days a week. Recipients can view, save, and print any available documents. A sample screen shot is shown below.



Beyond searchable documents, we can also incorporate educational materials directly in portal pages and/or provide hyperlinks to the State of Nevada's web page, if approved by the Contract Monitor, inviting recipients to explore a rich variety of valuable content.



Images in this response are subject to change and show fictitious provider, location, and recipient information.

The member website will provide the names, telephone numbers, and addresses for those who should be contacted with respect to the services being provided to the State of Nevada. This information can be displayed on any portal page for maximum visibility.

Our website will advise recipients and providers as to how they can obtain information about the State's dental program in non-English languages. To offer additional support for non-English speaking individuals, customized web portals can also include blocks of content written in Spanish or other prevalent languages.

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 promote the availability of interpretation services in our welcome mailing, the member handbook, on the member website and during the new member welcome call. Our culturally competent and responsive member services advocates will engage the recipient and help them to understand their benefits and services. Additionally, our member services advocate team will be able to provide any necessary translation services or support at the time of the call. We are committed to ensuring quality care when our recipients have language barriers that require interpreter assistance in order for them to access and understand their dental services. We use a language line which supplements our language capabilities when a recipient or provider calls the plan but speaks a language other than one spoken by the member services advocate. The member services advocate will first attempt to utilize in-house bilingual translators. If no in-house translator is available, or if the caller is speaking a language not supported internally, the member services advocate will contact Certified Languages International (CU). A three-way call will then be established with a representative from CU who will interpret for the recipient. CU provides translation capabilities in over 170 languages using interpreters trained in medical and dental health terminology and are available 24 hours a day, 7 days a week. In-person interpreter services are also available upon request from a recipient or a provider. We also provide American Sign Language if requested.

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.

To ensure our communications are easy to understand, we develop materials using our BlueBook, a glossary created as part of an internal initiative to improve health literacy through simplification of our communications. Our glossary contains health care and health insurance terms prepared in English and Spanish that are simple to comprehend. Our educational messaging is understandable, accessible and actionable. Our Nevada Medicaid and Nevada Check Up member materials will be written at no higher than an eighth-grade reading level where terminology permits (e.g., certain dental terms may be higher than an eighth-grade reading level). We also regularly review and update member materials to comply with any required reading-level changes in the program. We will consider member feedback on our written materials as we prepare for revisions, while maintaining Nevada-specific program requirements.

To confirm that member materials do not exceed the eighth-grade reading level, we use our proprietary readability tool, based upon the Flesch-Kincaid grade level formula. The tool rates and confirms that the materials we produce are easy to read, understand and act upon, and that they present information in a manner that most members can easily understand.

DISABILITIES ASSISTANCE

We identify recipients who require alternative formats for our written materials during our initial welcome call. This personalized outreach provides us with an opportunity to learn about our new recipients and consider other ways that we can help with their needs.

Recipients and their families learn about alternative formats through interaction with our member services department and member services advocates. We also communicate availability of alternative formats in the member handbook and on the member website.

The alternative methods we use to communicate with visually and hearing-impaired recipients and accommodate physically disabled recipients in Nevada meet the requirements of the Americans with Disabilities Act of 1990 (ADA).

The call center is also equipped to provide alternative forms of telephone communication to individuals who are deaf or hard-of- hearing. The member services advocates will assist recipients with their questions using a TTY machine. The TTY is a text display device used by individuals who are deaf to read voice communication converted to text by a communication assistant device. The conversation is typed rather than spoken and appears on the receiving end in written text or on an electronic screen. Alternative formats include Braille, large print, voice recorded audio formats and verbal explanations upon request.

For our recipients with cognitive deficits related to either disease states (e.g., Alzheimer's) or mental illness (e.g., depression, schizophrenia), our member advocates are trained to assist the recipient using empathetic listening and when necessary, engaging the assistance of a patient advocate for in-person member assistance.

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."

Once enrolled into the Nevada Medicaid Dental program, recipients will receive their identification (ID) cards and their member handbook within five days. The member handbook is an important comprehensive resource and engagement tool for recipients and family members that includes essential health education information. Our customized member handbook for the Nevada Medicaid and Nevada Check Up Programs is comprehensive, yet easy to read and navigate.

Our member handbooks are written at a reading level no higher than eighth grade. Per DHCFP requirements, our member handbooks customized for the Nevada Medicaid and Nevada Check Up Programs include the following statement 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 deliver the Nevada Medicaid and Nevada Check Up member handbooks in both English and Spanish, to accommodate the large percentage of native Spanish speakers currently residing in the State.

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 will submit the member handbook template to the State of Nevada for the Department's approval 15 days before the go-live date and will make any required changes. Any revisions made to the member handbook will be submitted to the State for re-review and approval. We will submit the initial member handbooks to the DHCFP for its MCAC review prior to the contract start date and continue submission to the DHCFP for approval of annual updates prior to publication and distribution.

We will ensure that our member handbook aligns with the State's goals and meets the unique needs of Nevada residents. We understand that, in consultation with the Medical Care Advisory Committee (MCAC), the DHCFP has the sole authority to approve or disapprove the member handbooks. We agree to make all modifications as requested by the DHCFP in compliance with the RFP requirements or as required by CMS or State law. We review and update the member handbooks at least annually and comply with all State and CMS requirements related to content. A team that includes our compliance officer, Medicaid operations director and Medicaid marketing staff internally reviews the member handbooks following updates. We maintain documentation that the member handbooks are updated at least annually. We will submit the initial member handbooks to the DHCFP for its MCAC review prior to the contract start date and continue submission to the DHCFP for approval of annual updates prior to publication and distribution.

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:

We include our member handbook in the new member welcome kit mailed to each new Nevada Medicaid and Nevada Check Up recipient's household within five business days of enrollment. For the convenience of our members, the member handbooks are also available online via our member website.

In addition to being mailed to recipients during orientation, the member handbook will also be posted online and accessible 24 hours a day, 7 days a week via the member Web portal. The member handbook will address all issues related to accessibility, recipient responsibility, and how to get assistance with any issue. The handbook will contain all required content and begin with a table of contents to provide readers with a quick method for finding content.

We will organize the handbook content with the information used most frequently by recipients first. More specialized information will be included later in the book. Our toll-free member services and TDD/TTY numbers will be prominent at the bottom of each page. The member handbook will open with a reminder that a recipient may request the handbook translated into another language or alternative format.

Our member handbook topics include, but are not limited to:

- Explanation of the relationship between UnitedHealthcare and you as a recipient
- How UnitedHealthcare dental member services can help you access a dentist, or to obtain appointment assistance
- Summary of benefits that are at no cost to you as a recipient and description of all covered services including: diagnostic and preventive services; basic services; major services; orthodontic services; alternative courses of treatment; benefit limitations
- Description of services not covered
- Information on the importance of oral healthcare and establishing a dental home
- A guide to dental visits and appropriate scheduling for routine care

- What to do in an emergency, including definitions of urgent and emergent care
- How to access transportation services
- Your Child's Oral Health (EPSDT)
- How to use the member Web portal
- Key telephone numbers, including the state's Enrollee Action Line, and how to obtain assistance for recipients with special needs, non-English speakers
- Oral health and hygiene tips, emphasizing preventive care (such as visiting the dentist regularly and proper brushing and flossing)
- Explanation of utilization management and how to detect abusive services
- What is fraud, waste, and abuse and how to report it
- Confidentiality and protecting healthcare information
- Recipient Bill of Rights and responsibilities
- How to file grievances and appeals
- Handy form for writing in your PDP/specialists phone numbers and location

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

Our member handbooks include an explanation of the member's right to obtain available and accessible dental care services covered under the contract, how to obtain dental services, including out-of-plan services.

Our welcome letter will highlight major program features and encourages the establishment of a dental Home. If the recipient has selected a Primary Dental Dentist (PDP), we will confirm that selection and provide the PDP's name, location, and telephone number. If a recipient has not selected a PDP during the enrollment process, the welcome packet will include the PDP selection form with clear instructions on how to select a PDP.

B. Role of the primary care dentist;

Our Member handbooks contain complete information on the role of primary care dentist as the coordinator of the member's dental needs.

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

Within the member handbook, we provide the days of the week that we are open, and information about the dental health care services available to recipients.

D. The address and telephone number of the vendor's office or facility;

Within the member handbook, we provide our office address, office hours and toll-free telephone numbers for member services.

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

Our member handbooks list all recipient benefits. Further, they list any applicable limitations or exclusions. Recipients who have questions regarding benefits are encouraged to contact our member services center via the provided toll-free number for assistance with benefits questions.

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;

The member handbook contains information on what to do in an emergency, including definitions of urgent and emergent care.

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

Our member handbooks contain comprehensive information on the grievances, appeals and fair hearing processes as specified in 42 CFR 438.10(g), including recipient's' rights to file a grievance, instructions for filing and what to expect after they file. We also advise recipients to contact member services via the provided toll-free number for assistance with filing a grievance.

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;

Recipients will be provided access to an online provider directory which includes a list of current providers who are and are not accepting new patients. A hard copy directory will also be made available to recipients upon request. With the Provider Search feature in the member Web portal, recipients can search provider data, updated in real-time, to find providers by geographic location, hours of operation, type of practice/specialty, panel restrictions, foreign language fluency, accommodations for patients with special needs and handicap-accessible office locations. The entire provider directory will also be available as an online PDF document, which can be viewed and/or downloaded and printed.

I. The provider list located on the vendor's website shall be updated by the vendor monthly;

Recipients know about changes immediately because our provider database is updated in real time. Changes entered into the system are reflected immediately in our online customer service platform, our toll-free interactive IVR system and our website. We update hard copy directories on a monthly basis.

J. Any restrictions on the recipient's freedom of choice among network providers;

We do not restrict recipients' freedom of choice among network providers and this is stated within our member handbooks.

K. Procedures for changing a PDP;

Procedures for changing a primary care dentist are simple and fully described in our member handbooks and on the new member welcome letter, which instruct recipients to contact member services for primary care dentist assignment assistance.

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;

Our member handbooks contain detailed information describing member rights and protections as specified in 42 CFR 438.100, in addition to member responsibilities. This information also appears on our member website.

M. Procedures for enrollment and disenrollment;

The member handbook outlines procedures for enrollment and disenrollment.

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

The member handbook outlines that a referral to a specialist is not necessary as long as the provider is a part of our dental network.

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;

This is not applicable. We do not refuse to cover counseling, referral or other services based upon moral or religious objections.

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

The member handbook provides information regarding cost sharing which may apply for a non-covered service.

Q. How to access Non-Emergency Transportation;

Our member handbook provides the vendor name, phone number and instructions on how to access non-emergency transportation for recipients.

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);

Our member handbook encourages recipients to contact member services to request information regarding the structure and operation of our dental plan and provider incentive plans. Member advocates document and forward requests to the appropriate area and we respond to the recipient by providing the requested information in writing.

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

The member handbook provides information that the recipient needs in order to decide among all relevant treatment options. The handbook also encourages recipients to contact member services if they have additional questions.

T. The risk, benefits, and consequences of treatment and non-treatment;

The handbook outlines general 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;

The member handbook clearly outlines the recipient's right to access treatment and their right to make 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;

The handbook contains a separate section that describes the EPSDT program and the services included that are provided at no cost. The handbook also provides a toll-free number to member services to get information about the services provided and to provide support and 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

The handbook outlines the recipient's responsibility to report any third-party payment service and the importance of doing so.

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.

The handbook provides clearly provide an explanation of fraud and abuse and information regarding how to report suspected abuse including hotlines, email addresses, and the address and telephone number of the fraud and abuse unit.

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 will provide each recipient with written notice of any significant change as defined by the State, in any of the enumerations noted above. We update the online version of our member handbooks regularly and the printed versions receive updates annually or more often as necessary to accommodate benefits changes or material changes. When there are material changes that affect access to services or providers, we mail inserts to recipients to file with their member handbook pending receipt of the updated version. Notices also appear in our member newsletter and we maintain documentation that verifies all member handbook updates.

When significant changes to the provider network occur, recipients receive notification by letter within 15 days of our notification of the changes. In addition, our online provider directory receives updates as soon as changes occur.

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.

Our member handbooks contain information about what happens following termination of a contracted provider. We notify recipients within 15 business days of our notification receipt so the recipient can choose a new provider. We include our member services department telephone number to assist recipients who need help finding and selecting another provider. In addition, our member handbooks inform recipients about our in-person concierge services, or changing a provider/PDP, scheduling an appointment and any other issues they may have.

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.

Nevada recipients will have access to member services advocates who will personally assist recipients to find a service provider. Our member services department is sufficiently staffed with qualified individuals who can assist recipients in accessing the services and support that they need.

Complete details about an enrollee's special needs, along with information about providers and clinic locations that can accommodate those needs, are available online to member services advocates. The Find-a-Provider feature allows member services advocates to quickly search for providers, specialists, and clinic locations that meet a member's particular needs within a defined search radius. In addition, member services advocates can initiate three-way calls with guardians or other designated assistants for recipients with mental illness or cognitive impairment. Information about individuals who have been granted access to an enrollee's Protected Health Information (PHI) can be stored with the enrollee record in the integrated enrollment system. This information is immediately available to member services advocates when a call record is opened for the recipient.

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 service center provides live support for inbound phone calls, email, fax, and standard mail on business days, Monday through Friday, 8:00 a.m. to 5:00 p.m. PST, excluding holidays.

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 hotline telephone number is operated at a minimum, Monday through Friday, 8:00 a.m. through 5:00 p.m. PST, excluding holidays, for recipient access.

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

A. Explaining the operation of the vendor;

UnitedHealthcare has a customer service center that provides comprehensive service to the State's recipients and providers. The Plan addresses the needs of the customers to include accurate member benefit and eligibility information in a compassionate and efficient manner.

Recipients that are new to our health plan, or new to managed care, often have a number of questions during their transition. We provide detailed information during our welcome call to new members, while also making sure that our member services staff deliver comprehensive information and detailed explanations about our operations and/or managed care to recipients and families. Our member advocates receive training to provide an overview of the program that includes covered benefits and services including how to access services, the role of the dental home, network information, how to obtain assistance in other languages and receive materials in alternate formats, and more.

In Nevada, our well-trained and experienced member advocates are available to assist our members via in-person, telephonic and electronic support. We employ accurate staffing levels, innovative technology and a member-centered service philosophy to deliver prompt and positive experiences. We leverage our national and local experience and expertise to deliver exceptional member services for the Nevada Dental Medicaid program.

B. Explaining covered benefits;

During member services training, we emphasize effective communication of benefits and coverage because we understand that new members are often unsure of their benefits and how to access them. Member services advocates use desktop tools and have access to appropriate systems, and the member's record, to provide accurate information about covered services and services that require authorization. In addition we explain the dental home's role, how to obtain a specialist and services that require authorization.

Complete details about an enrollee's special needs, along with information about providers and clinic locations that can accommodate those needs, are available online to member services advocates. The Find-a-Provider feature allows member services advocates to quickly search for only providers, specialists, and clinic locations that meet a recipient's particular needs within a defined search radius.

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

Our members' rights are important to us and we support and work with members to provide assistance with resolving, recording and tracking grievances and appeals in a prompt and timely manner. Our member advocates work to resolve any issues or grievances the recipient is experiencing and, as often as possible, remain with the member as a single point of contact until the member's issue is resolved. They support recipients with the grievances and appeals process, including preparing, submitting and recording a written complaint or grievance. Our member handbook encourages members to contact our member services department for assistance with filing a grievance. In addition, member advocates are trained and able to access the appropriate system for tracking member grievances.

D. Responding to recipient inquiries;

To ensure that inquiries are handled not only quickly but also accurately, we have a comprehensive five-week training program in place that includes classroom coursework, Customer Service technology training, telephone system hands-on practice, and extensive on-the-job training with realistic scenarios and monitored, live call practice. Our seasoned in-house experts—who are on the phones every day interacting with recipients and providers—help coordinate our training courses.

We require our member services advocates to be fully trained in dental programs details, as well as policies and procedures specific to each client we serve. All member services advocates assigned to the Nevada Medicaid Dental Benefits program will be fully trained in the State of Nevada dental benefits programs and on State-specific requirements for handling inquiries from recipients and providers.

E. Providing Concierge Services; and

Our policies and procedures meet RFP Statement of Work Section 3.5.3 requirements, including provision of concierge service for personal assistance with locating appropriate service providers, obtaining appointments and additional support as discussed further in our response to this section. Our member advocates deliver assistance, education and advocacy services to our members while also addressing inquiries from potential members, community-based organizations and the public. We consider each individual's unique needs including culture and language by employing bilingual member advocates and providing free interpretation services in more than 200 languages. To facilitate communication with hearing-impaired callers, we use the 711 National Telecommunications Relay Service (TRS) TTY line and print the contact information on our materials.

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**

Our member advocates assist recipients with their needs, including access to care. They assist recipients with locating providers, selecting and changing PDPs or primary care sites. We report all PDP/primary care site changes electronically to the DHCFP.

Member advocates assist our members with making appointments, obtaining in-area, out-of-area, in-network and out-of-network care and prior authorization. The member advocates also assist with transportation if they perceive that the recipient is in need of help or the recipient makes a request.

We find that empowering our member advocates to deliver this level of service, rather than transferring recipients to specialized staff, produces more efficient call handling that leads to higher member satisfaction. Our member advocates remain with the call-in as a single point of contact while resolving the recipient's issues, thus focusing on trust, compassion and relationship building.

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. Recipients 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.**

   Our Member handbook contains policies and procedures on emergent and urgent care and instructions on obtaining this care, including after-hours care 24 hours a day, seven days a week. The procedures clearly specify what actions the recipient should take in case of a life threatening emergency, an emergency dental situation and non-life-threatening situations that require urgent care at an urgent care provider.

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 recipient will be given a choice in selecting their dental provider. This selection will help to ensure the comfort level of the enrollee and support the ongoing coordination of care and services. Recipients can also change providers as often as they like. To help recipients understand our network, a provider directory is available hard copy or online via the recipient website and they can contact customer service to get guidance and support in choosing a primary dental provider that is convenient and meets their dental health 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.

Recipients, who don't already have a primary dentist, as evidenced by their claims history, will be assigned to a dentist within five business days of the effective date of enrollment; typically a pediatric dentist for small children and a general dentist for remaining recipients. Because most plans are not capitated, these assignments are typically not fixed (i.e. "soft assignments"), allowing recipients the freedom to change providers. The name and contact information of the dental home is provided to the recipient. The practice is likewise given information on those recipients assigned to that practice that includes contact information. Sharing of information with dentists is predicated on the State allowing this for those who don't already have an established patient-dentist relationship. Recipient information is updated on a regular basis as new recipients come on the plan, exit the plan, change dental homes etc.

We understand that a recipient with a satisfactory dental home relationship is more likely to participate in his/her own dental care by scheduling and attending appointments, and following the provider's plan of care. We often need the recipient's input to achieve successful dental home assignment. The first step to obtaining input from our Nevada recipients is communicating their ability to select a new primary care provider at any time, for any reason. We do this via our welcome letter, welcome call, our member handbook and member website where recipients are encouraged to contact our member services department for personal assistance with locating and selecting a primary dental care provider (dental home) to meet their needs.

The concierge services provided by our member advocates are available telephonically and our staff receives training to make sure that the chosen provider is appropriate to the care needed and that the practice is designated as open or accepting new patients. Member advocates perform all of the steps necessary to complete a dental provider change in addition to assisting recipients with scheduling appointments.

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.

As required, we will comply with the outlined distance requirements and offer every enrolled recipient a PDP located within a reasonable distance from their place of residence.

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;

If information is available, the enrolled recipients will be assigned to the previously chosen PDP.

Because most plans are not capitated, these assignments are typically not fixed (i.e. "soft assignments"), allowing recipients the freedom to change providers. The name and contact information of the dental home is provided to the recipient. The practice is likewise given information on those recipients assigned to that practice that includes contact information. Sharing of information with dentists is predicated on the State allowing this for those who don't already have an established patient-dentist relationship. Recipient information is updated on a regular basis as new recipients come on the plan, exit the plan, change dental homes etc.

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

If the enrolled recipient does not choose a PDP, enrolled recipients will be assigned to a geographically accessible dental home. Those who don't already have a primary dentist, as evidenced by their claims history, are assigned to a dentist, typically a pediatric dentist for small children and a general dentist for remaining recipients.

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

To encourage continuity of care, and for the convenience of parents, all children within a single family will be assigned to the same PDP.

3.5.4.4 Changing a PDP or Primary Dental Care Site

A. 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.

Enrolled recipients have the option to change their primary dental provider or primary dental care site for any reason. The member handbook outlines the recipient's right to choose a provider and provides information on how to change their provider assignments. Additionally, recipients can call our member service center and speak to a representative or a customer care advocate who will assist them in finding a dentist.

C. 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.

We notify our recipients in writing of any PDP termination within 15 business days of the termination effective date, based upon when our dental plan receives notice of the termination. We follow State-specific written policies and procedures to promote continuity of care when a provider terminates from our network and will deliver timely assistance to recipients in securing a transfer to an appropriately credentialed, contracted provider and address individual dental needs that may arise from the transfer. Our member advocates work with recipients to choose a new provider and to obtain approval in releasing information to the new provider. We are typically able to quickly reassign and notify recipients; however, we work within our network to provide for urgent care for our recipients until they are reassigned to a new and appropriate PDP.

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

Any written notification to a recipient related to a PDP reassignment includes contact information where recipients and their families can obtain assistance from member advocates who explain the process and work with our recipient to select another PDP or PDCS within our network. We may initiate a PDP change for a recipient based upon certain circumstances as follows:

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;**

   The enrolled recipient's residence has changed such that distance to the PDP is greater than 25 miles: We only make a PDP change of this kind with our member's consent. If a member relocates to a residence that is greater than 25 miles from his/her PDP, he/she selects a different PDP by contacting our member services department. Our member also has the choice to remain with his/her PDP, but this requires that he/she contact us in writing. However, if approved by DHCFP, we also have the ability to accommodate verbal requests to ease any undue burden or hardship on members. Information about residence changes and PDP reassignment are communicated verbally to members and their families through member services and in writing via our member handbook and member website.

2. **The PDP ceases to participate in the vendor's network; or**

   The PDP ceases to participate in the vendor's network: We notify our recipients in writing of any case of PDP termination within 15 business days of the termination effective date, based upon when our dental plan receives notice of the termination. Member advocates work with recipients to choose a new provider and to obtain approval in releasing information to the new provider.

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

   If the provider is excluded from provider participation due to legal action against the PDP, we notify our recipients in writing within 15 days of the termination effective date, based upon when we receive notice of the termination. Member advocates work with affected recipients and family members to assist them with locating a new provider and addressing any questions or concerns about their health and existing care.

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

We track the number of PDP change requests and the reasons for the requests, providing this information to the DHCFP as needed.

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.

Because we understand the value of a dental home, to every extent possible and when appropriate each recipient will be given a choice in maintain or selecting their dental provider. This selection will help to ensure the comfort level of the enrollee and support the ongoing coordination of care and services.

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

To increase communication and oversight, we will utilize a primary care assignments feature as an enhancement to the provider web portal to promote the main dental home. Providers would now have 24 hours a day, seven days a week access to view each recipient who had selected them as their primary care provider, including eligibility, the enrollment plan, and the effective date of the primary care relationship. Creating this feature, which now exists for all clients to use when primary care relationships are used, allowed the providers to communicate and work with our Care Coordination Team, as well as the several different state agencies and provider associations interfacing in that program. This is just one of many recent examples where new systems functionality was created to improve a program.

We will continue to develop innovative strategies that promote member provider relationships. It is a core strategy today to use best practices available in encouraging preventive care with appropriate specialist referrals. We educate providers on these practices and promote their continued use through ongoing education and reminders, and our clinical initiatives.

We will require providers, through contract provisions or Provider Manual, to provide all children enrolled in the program with preventive services in accordance with the State of Nevada dental periodicity schedule. We will use provider training, profiling and feedback to ensure that MDHPs follow these periodicity dental requirements for children.

All network general dentists and pediatric dentists participating as MDHPs will complete Webinar-based training before we designate them as Main Dental Homes and begin assigning them members. Training also will be available through individual follow-up and on-site visits.

The training provides a comprehensive review of the State's requirements for providers functioning as MDHPs, including screening recipients for specialty care needs, making prompt referrals when needed and coordinating care with the specialist until treatment is complete. The training also will include information on resources available through UnitedHealthcare to meet these requirements.

For example MDHPs will be able to quickly find nearby specialty care for their patients by calling UnitedHealthcare's Provider Hotline or logging into the provider web portal. MDHP requirements and support resources also will be documented in the provider manual. To monitor provider compliance, we will track provider complaints and referrals by reviewing patterns in specialty claims data.

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

Dental home participation is also supported by other dental clinical programs. Efforts to reach our HEDIS Annual Dental Visit target, to help patients avoid using the Emergency Room and physician screening programs, each contribute to increasing member visits to dental homes.

An additional option is incentives. This could include member incentives for visiting their dental home and getting preventive care. Incentives may also be directed toward dentists, creating levels of reward based on the percent of assigned patients seen and receiving prevention.

UnitedHealthcare has employed these approaches in its existing dental home programs, for example in Arizona, where all recipients who don't already have a primary dentist are assigned a dental home, and in New Jersey where a pilot is being completed and, prior to scaling up more broadly. The primary challenges centered on creating a rationale for both members and clinicians on the value of dental homes, ensuring data integrity (specifically member contact information), and the management of this complex process. Our experience in other states prepares UnitedHealthcare well for creating a successful dental home program in Nevada.

3.5.5 Children with Special Health Care Needs (CSHCN)

For individuals with special health care needs, we have developed a strategic approach that incorporates system of care values to provide integrated delivery of care and interventions that are relevant to all populations including special needs populations.

Access for Members with Special Needs: Our member advocates and Utilization Management Teams will work closely with the providers, enrollees, guardians, advocates and assigned case managers to ensure recipients with disabilities receive necessary and appropriate care and services. Our teams have experience developing and implementing case management protocols for children and adults with special needs. We will draw on that expertise to implement a customized program that meets the State's specific requirements. For example, we can develop and implement specialized education programs for parents and guardians, provide access to interpreters, help coordinate care with other health care professionals, help parents find appropriate services and accommodations for children who are in wheelchairs or who are homebound, and help arrange transportation for dental visits. If necessary, we will coordinate arrangements with dental facilities that specialize in treating patients with special needs. To accommodate other members, we have contracted with facilities specializing in the care of patients with mental retardation, autism, epilepsy, and cerebral palsy. We also work with participating dental offices to help them become comfortable treating members who have special needs. This includes providing educational material to office staff, as well as opportunities for earning continuing education credits at our expense for providers and dental hygienists.

Identifying members with special needs: Once a member with special needs is identified in an eligibility file load, during initial enrollment contact, or through other intake methods (including a call to member services requesting specialized care), the information is referred to our Customer Care Advocate team for follow up. We work with enrollees individually to evaluate needs and coordinate specialized care. The Enterprise System, our dental's benefits administration software platform, has built-in features that support a care advocate approach for members with special needs. Enterprise System can track details for each child, including disability type, diagnosis code, and effective/termination dates. The system can also track details about each enrollee's Primary Care Providers, Specialty Care Providers, Health Care Facilities and Protected Health Information.

Identifying providers, specialists, and clinics that can accommodate special needs: The Enterprise System can track any number of customizable, specific details about providers and specialists who treat patients with special needs, including whether they are accepting new patients, whether they treat patients with particular conditions, and whether they will travel to treat homebound patients. The Enterprise System can also track details about clinic locations that are accessible for patients with special needs. Any of the information stored in the Enterprise System database can be extracted and packaged to support care advocate tasks. For example, provider directories that include details about accommodations for special needs and access restrictions can be generated on demand and made available to recipients, parents, and guardians.

Customer Service Support: Complete details about an enrollee's special needs, along with information about providers and clinic locations that can accommodate those needs, are available online to member services advocates. The Find-a-Provider feature allows member services advocates to quickly search for only providers, specialists, and clinic locations that meet a member's particular needs within a defined search radius. In addition, Member advocates can initiate three-way calls with guardians or other designated assistants for recipients with mental illness or cognitive impairment. Information about individuals who have been granted access to an enrollee's Protected Health Information (PHI) can be stored with the enrollee record in the integrated enrollment system. This information is immediately available to member services advocates when a call record is opened for the member.

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:

Our Member advocates will work closely with the recipients, guardians and all identified agencies who retain guardianship or who provide services to enrollees with special healthcare needs in order to provide outreach, education, and special support services. For example, we can develop and implement specialized education programs for parents and guardians, provide access to interpreters, help coordinate care with other health care professionals, help parents find appropriate services and accommodations for children who are in wheelchairs or who are homebound, and help arrange transportation for dental visits.

To ensure that vulnerable recipients receive needed care we will provide a Community Coordinator to assist in care coordination and case management. The Community Coordinator will act in a liaison role with Nevada recipients and community partners to advocate for member needs, services and provide assistance in obtaining dental services.

Specific functions might include:

- Advocate for member dental needs and services
- Help guide the recipients navigate the Medicaid program to obtain needed dental services
- Partner with clinical program managers and care coordinators to resolve and remove barriers to care and access
- Support professional networks in coordinating access to out-of-network care when appropriate
- Intervene with care providers and other community based service groups on behalf of the recipient to assist in appointment scheduling or connecting with our member advocates for assistance when needed
- Recommend/refer cases to either UnitedHealthcare Nevada Dental Director for program exceptions based on clinical need or extraordinary circumstances
- Own any issue through to resolution on behalf of the member real-time or through comprehensive and timely follow-up
- Research complex issues across multiple databases leveraging cross-functional support teams to resolve recipient issues and/or escalations

- Experience working with vulnerable children elderly and/or special needs members/patients

A. Developed by the recipient's primary dental provider with recipient participation, and in consultation with any specialists caring for the recipient;

The treatment plan will be developed by the primary dental provider and any specific specialists in collaboration with the recipient and all appointed guardians and representatives that are working in the best interest of the recipients.

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

Our goal is to understand the child's and family's needs and coordinate the delivery of services. Once the recipient's care treatment plan has been created, the Customer Care Advocate authorizes, arranges and coordinates the services and supports identified in the care plan. For services that require prior authorization, the customer care advocate works with the provider to ensure that they submit all services to our UM intake team for a determination of medical necessity.

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

Our treatment protocols are in adherence with all applicable State quality assurance and utilization review guidelines. Our authorization guidelines are algorithms programmed into the Enterprise System our software platform, which ensures consistent medical necessity authorization determinations. The algorithms present the clinical criteria in a decision tree format that is clear, easy to understand and transparent to the providers and review staff.

The Appropriate Care Criteria and Authorization Guidelines were developed using principles of evidence based dentistry and our extensive experience in managing dental services for Medicaid and CHIP programs and will adhere to all applicable Nevada state guidelines.

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.

Our member advocates will work with the primary care dental office to facilitate needed referrals as required; however, specialist referral is not required as long as the provider has been identified as part of our provider network. UnitedHealthcare will also ensure that MDHP meet requirements for specialist referrals and care coordination through a combination of training, provisions in the Provider summary guide and ongoing monitoring. For example MDHPs will be able to quickly find nearby specialty care for their patients by calling UnitedHealthcare's Provider Hotline or logging into the Provider Web Portal. MDHP requirements and support resources also will be documented in the Provider summary guide. To monitor provider compliance, we will track provider complaints and referrals by reviewing patterns in specialty claims data.

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.

Health Plan of Nevada (HPN) has the longest-standing Medicaid provider network in the state. Since 1997, HPN has provided recipients with a stable network of contracted and committed providers dedicated to delivering high quality services. HPN is committed to ensuring this same level of exceptional service and to further expanding its network of Medicaid providers throughout the term of this contract.

Our existing provider network in Clark and Washoe counties is an open network which consists of over 400 contracted General Dentists, Pediatric Dentists, Endodontists, Oral Surgeons, Oral and Maxillofacial Surgeon, Periodontists.

Below is a grid showing the number of contracted providers in both Clark and Washoe counties:

Contracted Network	Clark County	Washoe County
Dentists	309	100

Our provider network offers a wealth of advantages to recipients, including:

- Access to high quality dental providers
- Providers who are geographically located in ZIP codes heavily populated by recipients and conveniently located in proximity to public transportation corridors
- A culturally and linguistically diverse provider network to meet the unique recipient needs

As evidenced by the table below, the number of providers participating in HPN's provider network has continued to grow annually for the last several years. This constant growth provides recipients enrolled in HPN's Medicaid plan with access to the best dentists within the state of Nevada.

Number of providers combined in Clark and Washoe Counties:

Year	# of Providers
2012	309
2013	326
2014	343
2015	362
2016	409

Our comprehensive provider access and availability policies and procedures have been audited by the DHCFP's External Quality Review Organization (EQRO) on several occasions with outstanding results. The following table highlights the most recent auditing scores from the EQRO regarding our exemplary provider access and availability.

Audit Scores from the DHCFP's EQRO Audit of the Provider Access and Availability Standard	
2000	100%
2002	100%
2004	98%
2006	97%
2009	99%
2011	100%
2015	98%

All providers who participate in our provider network are required to complete HPN's NCQA compliant credentialing process prior to executing an agreement. This rigorous NCQA approved credentialing process ensures that only highly qualified health care professionals render services to our recipients. Additionally, each provider is also re-credentialed every three years to re-certify all information is the most up to date and accurate and that the provider continues to meet HPN's requirements, as well as credentialing criteria and standards.

Our Provider Services department is responsible for management oversight of the provider network. HPN provider services advocates conduct comprehensive site visits with newly contracted providers, during which our policies and procedures (including practice guidelines) are reviewed and discussed. Providers also receive the latest version of the annual Provider summary guide and are instructed on how to use the online provider portal. The information available online includes policies and procedures, the provider summary guide, the provider directory (which is updated monthly), and the semi-annual provider newsletters. The provider portal allows providers to use an Internet connection from their offices to obtain benefit and eligibility information, check claims status and print EOP's as well as approved pre-determinations. Thereafter, we schedule provider site visits periodically for continuing education, ongoing assistance and support.

In the event DHCFP decides to expand the service area of this contract to include counties outside of Clark and Washoe, we are confident that our contracting will meet (and in most cases exceed) the provider network requirements in the expanded services areas. Our considerable network development experience, combined with our ample, dedicated resources and operational infrastructure supported the successful expansion into Washoe County in 2003 and 2004.

3.6.1 The vendor must adopt practice guidelines and protocols which:

HPN collaborates with network providers and our Dental Director to establish guidelines and protocols to which providers must adhere to remain in compliance with contractual obligations. As such, we have satisfied, and will continue to adhere to, the requirements as outlined throughout RFP section 3.6.1.

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

HPN has established a proven method for communicating and implementing meaningful provider education and evidence-based clinical guidelines. We encourage provider participation in the approval of nationally recognized guidelines, online provider conferencing, customized workshops, educational initiatives and quality initiatives. We have extensive experience in developing robust collegial relationships between providers to implement and monitor the use of evidence-based guidelines.

HPN has also established clinical guidelines which are published in our provider summary guide and posted to the provider website. Clinical guidelines are developed for the clinician's use in managing common and important dental conditions. In most cases, nationally recommended guidelines provided the basis for the HPN guidelines, which were then modified to fit our local environment. The guidelines are reviewed regularly by the dental director. These guidelines constitute a framework only, however. In all cases, the provider's clinical judgment can override the guideline if the provider feels that strict adherence is not in the patient's best interest. If the provider decides to deviate, the dental record should indicate the rationale for this variation.

3.6.1.2 Are adopted in consultation with contracting dental professionals; and

Our practice guidelines and protocols meet the requirements as stated in Section 3.6.1.2 of the Scope of Work. We are committed to continuously improving the health care and services for Nevada's Medicaid members. We have developed and continue to refine an internal Quality Improvement Program (QI Program) to verify we, as well as our providers, operate in accordance with all applicable state and federal regulatory and contractual requirements. We encourage contracted provider participation in the approval of nationally recognized guidelines, online provider conferencing, customized workshops, educational initiatives and quality initiatives. We have extensive experience in developing collegial relationships between providers to implement and monitor the use of evidence-based guidelines. Our provider advocates conduct site visits with contracted providers to obtain and discuss any feedback the provider may have.

We are committed to continuously improving the dental care and services we provide to our members. Through our 15 years of experience in the State of Nevada in coordinating dental care and services for members, we have developed and continue to refine an internal quality assurance program, our Quality Improvement Program (QI Program), to verify we, and our providers, operate in accordance with all applicable state and federal regulatory and contractual requirements. Nevada continues to benefit from the extensive experience we have gained through administering the Medicaid plan in the state as well as from our flexibility to address the unique needs of the Medicaid and Nevada Check Up programs.

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

HPN currently reviews and updates our practice guidelines and protocols regularly as outlined in the Scope of Work and, upon execution of the new contract; we will continue to adhere to these standards.

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;

The HPN Provider summary guide contains the Practice Guidelines and is updated and provided to the HPN network of providers annually. The guide is provided via hard copy during annual site visits and posted on the HPN provider website. When the clinical guidelines are updated or changed, Provider Services sends out the updated guidelines via email and/or fax notifications to all network providers. Additionally, updates are incorporated into the online Provider summary guide. For providers with limited or no Internet access, our provider relations advocate will provide a hard copy of the Provider summary guide by either sending via U.S. mail or hand delivering to the provider office.

To promote provider use of standardized evidence-based clinical guidelines, we provide the following resources to our network providers:

- **Hard Copy** - Hard copy provider communications and related training materials are distributed to specific providers who are treating recipients with conditions targeted by disease and chronic care management programs
- **Provider Website** - Websites provide current resources and educational tools for provider access, which are user-friendly, accessible and readily available

- **Verbal Communication** - Verbal communication methods, both telephonic and face-to-face, for working with providers who are identified as not providing treatment within evidence based guidelines.

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;

We will continue to make certain that decisions for utilization management, member education, coverage of services and other areas are consistent with the required applicable practice guidelines and protocols. The provider advocates continually educate the network providers to ensure they understand how the Utilization Management department interacts with their offices to provide timely decisions. HPN encourages our contracted providers to access the provider portal to view real time updates on prior authorization requests for coverage determinations. Upon denial of a pre-service request, providers are provided with the appeal process.

We ensure that decisions for utilization management, member education, coverage of services and other areas to which the guidelines apply are consistent with the guidelines through multiple methods. These methods focus on all of the areas listed above.

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 have established the following standards for primary care, specialist care and dental care for our membership. We monitor compliance with these standards on a quarterly basis and review the provider network compliance with the following standards:

Practitioner Type	Provider/Member Ratio	Percent with Open Panels
Dentists	1/1500 members (at most 1/2000 per geographic area)	50%

Our dental network also includes, at a minimum, one pediatric dentist, one dental hygienist, one oral surgeon and one orthodontist for Clark and Washoe counties.

The HPN provider contracts contain the provision that all providers shall maintain 24-hour telephone service to handle emergency calls 24 hours per day, seven days per week and require providers to meet the state standards for timely access to care, taking into account the urgency of the need for services. Providers have a contractual obligation to comply with access standards set forth within their contract. Providers must adhere to the following criteria when scheduling patients:

- Dentist must be capable of scheduling appointments within three weeks for routine examinations, recall and preventive therapy.
- Routine hygiene appointments shall be scheduled within thirty days.
- Immediate care for dental emergencies
- Urgent care or referral appointments within three calendar days.
- Routine appointments within thirty calendar days.

Specialty providers must adhere to the following guidelines when scheduling patients:

- Urgent care or referral appointments within three calendar days.
- Routine appointments within thirty calendar days

Our policies outline the monitoring mechanisms used to assess compliance with HPN's standards for access to care. We monitor providers by performing quarterly member satisfaction surveys, on-going review of complaint/grievance data, annual and ad hoc office-site visits and annual after-hours telephone surveys completed by provider relations. The HPN Provider summary guide delineates that the Provider Services department conducts onsite visits and ongoing monitoring of providers to detect deficiencies and that corrective action is taken when determined necessary.

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;

HPN ensures that its network of providers offer hours of operation without discrimination based upon the plan the recipient has selected for his/her health care coverage. Specifically, we ensure that hours of operation offered to recipients are no fewer than the hours of operation offered to commercial recipients or any FFS recipient. Additionally, our provider contracts include a provision prohibiting providers from differentiating or discriminating in the treatment of recipients or in the quality of services delivered to recipients on the basis of race, gender, age, religion, place of residence, health status, health care needs, or source of payment, and to observe, protect and promote the rights of recipients as patients.

We monitor compliance with this requirement by performing member satisfaction surveys, monitoring complaint/grievance data, annual and ad hoc provider office-site visits.

3.6.2.5 Mechanisms to ensure compliance by providers;

We maintain and monitor the network to ensure that members have adequate and timely access to all services covered under the contract for members. We also monitor network providers' compliance with their adherence to guidelines.

We use the following mechanisms to ensure compliance by network providers:

- Office site visits conducted by our provider advocates – conducted, at a minimum, annually
- Member satisfaction surveys – conducted quarterly
- Patient satisfaction surveys – ongoing, results reviewed quarterly
- After-hours telephone surveys – conducted annually
- Complaint and grievance data – ongoing, as received

Our audit results have been favorable and demonstrate that our established mechanisms for ensuring our provider's compliance with our contracts and programs have been successful.

3.6.2.6 Monitor providers regularly to determine compliance;

The HPN Provider Services management team continually reviews the reporting and analysis obtained from member satisfaction survey results, complaint and grievance data, office site visit forms and the after-hours telephone survey to monitor provider compliance.

Provider services advocates are assigned to specific provider groups to assist providers with areas of education or inquiries that providers may have related to compliance with HPN's access and availability standards. Providers and their office staff have direct access to their assigned advocate who is responsible for ongoing education and support.

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

Presently, our policies contain the monitoring mechanisms to assess compliance with HPN's standards for access to care. We monitor provider compliance by performing member satisfaction surveys and monitoring complaint/grievance data, office-site visits and compiling information from an after-hours telephone survey completed by provider relations staff members. The HPN Provider summary guide indicates that the Provider Services department conducts onsite visits and ongoing monitoring of providers to detect deficiencies and that HPN takes corrective action as necessary. The results of the corrective action are presented to the Credentialing Committee for approval.

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 actively participate in state and federal efforts to promote the delivery of services in a culturally competent manner to all recipients. We focus our efforts on facilitating culturally competent care for all recipients, but especially for those individuals with limited English proficiency and diverse cultural and ethnic backgrounds. We comply with all state and federal regulations pursuant to MSM Chapter 100, Section 103.6 as well as 42 CFR 438.206(b)(2).

HPN has established a culturally and linguistically diverse provider network to meet the needs of the Nevada Medicaid population, including those with limited English proficiency and diverse backgrounds. We do not prohibit any act of discrimination to both recipients and providers. If we decline a provider request for participation, the provider is advised of our decision in writing.

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

We are dedicated to making sure that the services we provide take into account principles of cultural competency. We believe that cultural competency is at the heart of serving our recipients, meeting their special health needs and honoring their unique circumstances. Because we already have a strong and stable presence in Nevada, we have developed diverse community relationships with agencies and community organizations that have enhanced our understanding of the diversity within Nevada as well as the particular needs of underserved and financially disadvantaged populations. HPN continues to be dedicated to participating in the community we serve and in the larger scope of national efforts to incorporate cultural competence into all aspects of providing high quality, accessible health care to our recipients.

HPN currently submits and will continue to provide the state with access and availability reports on a quarterly basis. In the event of a significant change HPN will notify the DHCFP and ensure that our recipients to do not experience any disruption in the delivery of dental services.

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

We will provide the State with access and availability reports on a quarterly basis. In the event of a significant change, we notify the State and confirm our recipients do not experience any disruption in the delivery of dental care services.

B. Enrollment of a new population in the network.

Per DHCFP decisions and guidance, we have the capacity and operational capabilities to expand to additional Nevada populations and geographies.

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:

All participating dentists will receive communication on the Nevada Dental Home program, including a description of the program, information on the Dental Home package and provider responsibilities to participating Dental Home members as described in the RFP Contractual Services Form including:

- Care that is comprehensive and includes acute, corrective, and preventative services.
- Care that is individualized to each recipient based upon a dental exam for tooth decay and gum problems.
- Care that is preventative and includes information about proper care for the recipient's teeth and gums, and correct diet.
- For children, care that prepares parents and guardians with guidance about what to expect for their child's age for the growth of teeth and the jaw.
- For children, care that is educational and helps parents and guardians learn about their child's dental health now and as their child grows.
- Care that is provided in a culturally competent manner.

Program information will be included in the provider manual, on the dentist web portal, in newsletter articles, and in follow up letters. Our dental networks team will reach out to dentists individually to answer questions and encourage participation in the Dental Home program. Dentists who do not choose to participate will receive additional outreach on a regular basis to encourage reconsideration. Feedback will be solicited from both participating and non-participating dentists on the reasons for their choice, in order to help UnitedHealthcare improve its recruitment efforts.

UnitedHealthcare will develop a Dental Home package that provides a set of services meeting the needs of recipients, addressing their health and well-being. The primary focus will be on preventive health. Recipients will be encouraged to obtain preventive services shown to positively impact both dental and overall health. UnitedHealthcare will employ various education and outreach strategies highlighting the value of professional prevention and good home care designed to promote prevention and other needed care. In addition to improved health outcomes, prevention positively impacts costs, including medical costs in the form of fewer hospital visits for emergencies and treatments requiring OR care. Science is also increasingly demonstrating the positive impacts of good dental health on chronic medical conditions.

1. **Delivery of covered medically necessary, dental services and preventive services, including EPSDT screening services;**

   We will require providers, through contract provisions or provider manual, to provide all children enrolled in the program with preventive services in accordance with the State's dental periodicity schedule. We will use provider training, profiling and feedback to ensure that MDHPs follow these periodicity dental requirements for children.

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

   UnitedHealthcare will ensure that all PDPs meet requirements for specialist referrals and care coordination through a combination of training, provisions in the provider manual and ongoing monitoring. All PDPs will be able to quickly find nearby specialty care for their patients by calling the provider hotline or logging into the provider web portal. PDP requirements and support resources also will be documented in the provider manual.

3. **Continuity and coordination of the enrolled recipient's dental care; and**

   Upon enrollment in our dental program, selected PDPs and member advocates will work collaboratively with the recipients and/guardians of children to ensure the continuity and coordination of the enrolled recipient's care.

   UnitedHealthcare will also work to improve access by ensuring continuity of care between primary health care physicians and dentists – we have touched on some of these strategies elsewhere:

   UnitedHealthcare will provide information on various dental health topics to physicians including information on the importance of following up at a dental home. This will include specific focus on FQHC's and hospital programs.

   As appropriate, UnitedHealthcare will work with the State and the program MCOs to identify children seen in medical settings who may not have received dental follow up. We will then provide those families with communication on the importance of dental follow up. Those families will also be selected to receive appropriate outreach in the form of postcards and similar communications in an effort to further encourage dental engagement.

   Specific to an at-risk condition, such as early childhood caries, parents whose children have been seen by a PCP for screening and varnish application will receive a letter from UnitedHealthcare reminding them of the importance of follow up with a dental home

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.**

   Our provider summary guide and contracts indicate PDPs and specialists are responsible for appropriate documentation and maintenance of medical records. We retain responsibility for monitoring medical records to validate that providers are following the correct standards for record documentation, following HIPAA and record retention.

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 monitor providers by performing member satisfaction surveys, monitoring complaint and grievance data, office site visits and compiling information from an after-hours telephone survey completed by provider services. Our provider summary guide delineates that the provider services department conducts on-site visits and ongoing monitoring of providers to detect deficiencies and that we take corrective action as necessary

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.

HPN maintains comprehensive contracts with essential community providers to provide a comprehensive network to meet recipient needs. Moving forward, we will contract with the new providers as outlined in the RFP. The contracts offered to essential community providers do not differ from the contracts offered to other network providers. We will negotiate in good faith, as always, and will work to contract with these other essential community providers listed in this section upon contract award notification.

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);

We have contracts with the following FQHC and RHC:

- Community Health Alliance- Dental Group in Northern Nevada
- Eastern Family Medical and Dental Center- Nevada Health Centers Southern Nevada

B. The University Medical Center of Southern Nevada;

We currently have a contract with the University Medical Center of Southern Nevada.

C. The University of Nevada School of Medicine (UNSOM);

We currently have a contract with the University of Nevada Las Vegas Dental School.

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.

HPN maintains comprehensive contracts with essential community providers to provide a comprehensive network to meet recipient needs. Moving forward, we will contract with the new providers as outlined below in the RFP. The contracts offered to essential community providers do not differ from the contracts offered to other network providers. We will negotiate in good faith, as always, and will work to contract with these other essential community providers listed in this section upon contract award notification.

We are committed to achieving a level of excellence in service by establishing strong working partnerships with the State and designated entities and programs serving recipients. We will work closely with the State's Dental Director and others managing the oral health needs of Nevada's citizens to align priorities and support the State's oral health objectives.

In addition to working with the State, another critical element in establishing our local presence is to build relationships with local community-based organizations in order to gain a deeper understanding of local needs and to explore opportunities for information sharing and collaboration. We have a history of Community partnership and involvement. For instance, we are increasingly participating in State Oral Health Coalitions (ex. Rhode Island Oral Health Coalition, Pennsylvania Coalition for Oral Health), where we can better understand local oral health concerns, help to influence oral health policy, identify key stakeholder in the State and increase our visibility as community contributors. We look to partner with leading players in oral health policy in the State, such as the HeadStart Association, or Kids Count. These relationships allow us to identify key issues facing the State's children and contribute to public policy solutions. For example in Rhode Island, we participated on the *TeethFirst!* leadership team, which developed and launched a successful Statewide website providing education to the State's citizens on the value of the year one dental visit and the importance of preventive care for children. To that end we also sponsor and attend local meetings and conferences (for example co-sponsoring a "mini-residency" in Rhode Island focusing on providing general dentists with tools to work with very small children), and contribute to community events such as Missions of Mercy, most recently in Rhode Island and Pennsylvania, as we look to broaden opportunities to serve the community and better understand oral health issues facing the State's citizens. UnitedHealthcare will look to build community partnerships in Nevada as well and as required in the RFP, we will develop processes and procedures and designate points of contact for collaboration with programs that serve recipients in the State.

We will work with the Nevada Office of Oral Health and Dentistry to promote preventative care particularly in children. As we have in other states, we will work closely with local government, local health departments, FQHCs and other community health centers and organized dentistry in the State, to help promote preventive health objectives, consistent with the Oral Health Access for Young Children (OHAYC) program including dental screenings, fluoride varnish applications, oral health education and dental referrals, focusing on children most at risk or more limited access to care.

UnitedHealthcare works not only to improve access and preventive health utilization for all children but also focuses in on those with targeted conditions, for example early childhood caries (ECC). As referenced in our description of these programs in other states, we focus caries-related education and outreach on local primary care physicians (PCPs), specifically pediatricians and family practice physicians. Education focuses on the etiology of caries, the efficacy of fluoride, the important role PCPs play in detecting caries and how they can incorporate caries screening and fluoride varnish into a well-child visit. Working together, UnitedHealthcare and its partners develop education, follow up to track patient activity at both the PCP and dental office and arrange for appropriate reimbursement, consistent with State rates.

Where ever possible we will also work with other practitioners as we have in many of our other states where we have implemented physician varnish programs. UnitedHealthcare will work with local physician groups, educational institutions, advocacy groups and/or the State, to identify and implement PCP caries education programs, either online or in person. As part of our work with physicians UnitedHealthcare will also provide reinforcing messaging to PCPs to share with parents as well as direct reminders through newsletters, mailers and other communications tools on the value and importance of physician screening, fluoride varnish application and referral to a dental home for follow up, either directly if the PCP knows of a dentist or through UnitedHealthcare who can facilitate the referral. We can also provide PCPs with tools that can help them in their evaluation including Caries Risk Assessments like those developed by the AAP, CAMBRA and others.

We consistently measure and evaluate the number of eligible children who are screened by PCPs, provided fluoride varnish and then referred for follow up to a dental home. We also look at the distribution of participating PCPs and dentists, in an effort to increase physician participation and ensure an adequate referral source. UnitedHealthcare will make a special effort to reach out and work with practices, FQHC's and hospital programs that have clinical programs targeting early childhood caries, using methodology consistent with CAMBRA.

Supplementing our work on early childhood caries, to promote dental health as an integral part of overall health and wellness, we will also engage community physicians in the following ways:

- We provide general clinical and service information for all physicians in our commercial network.
- We work with medical plans to identify high volume physicians where we can identify specific recipients for follow up.
- Specific focus will be placed on MCOs and FQHCs, where we emphasize the importance of dental screening and follow up with a dental home. The value of this initiative is that the FQHCs often provide both medical and dental services in the same facility.

UnitedHealthcare is also committed to working with local dentists to align our objectives and to work together on behalf of Nevada's children. The Nevada Dental Director, Manager, Provider Outreach and Provider Network Development staff will communicate with the Nevada Dental Associations, dental societies and other provider groups in an effort to coordinate and promote our initiatives. Our associates are committed to developing a productive working relationship with the various members of professional societies and groups for the possibility of joint program and sharing. The endorsement of stakeholders maximizes awareness among providers of our training programs and promotes participation.

UnitedHealthcare is committed to ensuring that oral health is integral to overall health, all the more so for children who are vulnerable. Poor oral health leads to pain, infection, poor nutrition and even failure to thrive. Ensuring that children have access to good oral health is critical, particularly for those already experiencing other stressors.

Our member advocates will work closely with the Division of Children and Family Services and all identified agencies who retain guardianship or who provide services to enrollees with special healthcare needs in order to provide outreach, education, and special support services. For example, we can develop and implement specialized education programs for parents and guardians, provide access to interpreters, help coordinate care with other health care professionals, help parents find appropriate services and accommodations for children who are in wheelchairs or who are homebound, and help arrange transportation for dental visits.

To ensure that vulnerable recipients receive needed care we will provide a Community Coordinator to assist in care coordination and case management. The Community Coordinator will act in a liaison role with Nevada recipients and community partners to advocate for recipient needs, services and provide assistance in obtaining dental services. Specific functions might include:

- Advocate for recipient dental needs and services
- Help guide the recipients navigate the Medicaid program to obtain needed dental services
- Partner with clinical program managers and care coordinators to resolve and remove barriers to care and access
- Support professional networks in coordinating access to (Out-of-Network) OON care when appropriate
- Intervene with care providers and other community based service groups on behalf of the recipient to assist in appointment scheduling or connecting with our Customer Care Advocates for assistance when needed
- Recommend/refer cases to either UnitedHealthcare Nevada Dental Director for program exceptions based on clinical need or extraordinary circumstances
- Own any issue through to resolution on behalf of the recipient real-time or through comprehensive and timely follow-up
- Research complex issues across multiple databases leveraging cross-functional support teams to resolve recipient issues and/or escalations

- Experience working with vulnerable children elderly and/or special needs recipients/patients

In addition to creating partnerships with local advocacy groups, we will look for additional opportunities with other community based organizations, (ex. Head Start); initiate or participate in existing health fairs and other community events; and explore opportunities to partner on community initiatives and/or events with hospital groups, MCOs, FQHCs and other large group practices to provide education, screenings and referrals.

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.

As required, any subcontracts associated with the deliverables of this RFP will be submitted to DHCFP for advance written approval. All subcontracts will contain all applicable items and requirements as set forth in the DHCFP DBA Contract as amended and upon request will be submitted within the time frame as outlined in Section 3.6.4.1. As the prime contractor, we also confirm that we will be wholly responsible for performance of the entire contract.

For the purposes of this proposal, we plan to subcontract with Scion Dental, Inc. (Scion). Upon DHCFP approval, we will utilize Scion for the following contractual responsibilities:

- Eligibility management
- Encounter and standard reporting
- Member web portal
- Provider web portal
- Claims entry and payment
- Clinical claim review
- Complaints and Appeals
- Member communications production and distribution

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;

Member advocates, in collaboration with the PDP will ensure the coordination of care between the dental care provider and any orthodontia provider or specialist as needed.

B. For the evaluation of the prospective subcontractor's ability to perform the activities to be delegated;

Prior to selecting subcontractors, we complete a thorough review of their qualifications. In order to contract with us, vendors must agree to and meet specific service level expectations for quality, security, accuracy and pricing efficiency. We conduct both physical and electronic security checks of the vendors' facilities and secure information network to ensure their compliance with HIPAA regulations and our security standards, as established by our privacy office and information and business risk management teams. Additionally, where applicable, our standard vendor contract requires that vendors supplying critical services file a business continuity plan in demonstration of how they would continue processing business, should a force majeure event present a business interruption.

MONITORING AND EVALUATION

Our mechanisms for monitoring subcontractors are described below. Unless otherwise noted, we use these approaches for external subcontractors and for our affiliated entities within UnitedHealth Group.

Delegation Oversight: We are accountable for delegated functions and recognize the necessity of maintaining continued oversight of delegated activities to ensure consistent, quality performance, without compromise. Accordingly, our CEO, as well as our contract compliance officer, will monitor the performance of subcontractors to ensure contract compliance and operational excellence. In addition, our compliance staff, headed by compliance officer and in-house counsel, are responsible for ensuring that the services and functions performed by our subcontractors, including external vendors and affiliate segments, are completed in accordance with state contract requirements.

Operations Meetings: As appropriate, representatives from our subcontractors will be invited to Nevada plan operations meetings. These collaborative meetings promote the value of each respective function and a clear understanding of how each functional area is dependent on the success of the others. During these meetings our Executive Team will provide direction for our subcontractors and ensure that their quality and effectiveness is sufficient to meet our objectives.

Operating Agreements: We rely on the operating agreement for a description of the required functions and service levels; the process by which we will assess performance; the recourse we have if service standards or expectations are not met (including revocation of delegation or imposing other sanctions if the subcontractor's performance is inadequate); and the authority of our Chief Executive Officer and executive team to drive change. This agreement is put in place with the consent of UnitedHealthcare and the delegated subcontractor.

Sign-off Authority: In certain instances, our operating agreements include sign-off authority for our Chief Executive Officer and COO to approve or deny proposed changes in a subcontractor's policies or processes. If one of our partners wishes to change a policy, or their technology, or other key elements of their services for our recipients, part of this process must include explicit written approval from UnitedHealthcare and agreement that we understand the impacts for our constituents.

Statistics and Reports: Each subcontractor will be required to submit ongoing reports to UnitedHealthcare that illustrate their effectiveness at meeting contract requirement for those areas delegated. Key metrics and indicators used monitor our subcontractors and include provider and member call service levels, claims timeliness, and claims accuracy statistics, as well as utilization review metrics.

Surveys: We will perform member and provider surveys to gain feedback on the service of the designated subcontractors.

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.**

As outlined, we are responsible for subcontractors, and therefore, would be responsible for any and all claims payment liabilities owed to providers.

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;

Our legal department manages our subcontractor relationships to ensure their work is within our established standards, and we accept responsibility if one of our subcontracted vendors fails to meet a contractual obligation assumed by us.

We take responsibility for the services provided by our subcontractors in the same way we take responsibility for those services we perform without the use of a subcontractor. We will hold our vendors to the same standards and requirements to which we agree.

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;

Should we subcontract to any individual, firm, corporation or any other entity engaged to perform part or all of our responsibilities; the subcontract will be submitted to DHCFP for advance written approval by our Medicaid compliance officer. Before the award of any subcontract, we will provide information to the DHCFP regarding ownership of 5 percent or more in any delegated entity or subcontractor. We acknowledge and affirm all definitions listed above. We also affirm that we shall indemnify, defend and hold the state of Nevada, DHCFP and their officials, representatives and employees harmless from any and all liabilities.

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;

As required, we agree to 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

Our subcontractor contracts do not provide financial or other incentives to providers and subcontractors for denying, reducing or limiting medically necessary services. Any future subcontracts will not provide financial or other incentives to providers and subcontractors for denying, reducing or limiting medically necessary services.

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

Our subcontractor contracts do not include "gag" clauses and any future subcontracts will not include "gag" clauses.

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.

HPN has and will continue to, 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 the required access standards outlined in the Scope of Work.

APPROACH TO CORRECTIVE ACTION

Our Provider Services team, working in collaboration with other departments, has organizational responsibility for gathering, evaluating and trending provider input; prioritizing provider-identified issues; and developing effective intervention strategies to address them.

These multiple data points of provider information operate as a clearinghouse and an early warning system to identify issues as soon as possible and avoid escalation.

When an unsatisfactory trend or issue is identified, it is assigned to the appropriate functional area or interdisciplinary team for prioritization and end-to-end resolution. Necessary research is performed, leading to development of the following:

- Problem summary
- Root cause analysis
- Impact
- Proposed solution

Provider Services completed the initial reviews, with trended information reported to the HPN Quality Improvement Committee to identify performance improvement opportunities and to review corrective actions as determined appropriate. If monitoring indicates issues of noncompliance with requirements, provider advocates will increase face-to-face visits to assist the provider in determining a quick resolution and take corrective action if there is a failure to comply.

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.

As the state's leading and most experienced health insurer, HPN remains committed to ensuring recipients receive access to the same quality dental programs as those who are privately insured or have Medicare. Our primary focus has been, and remains, offering a dental care delivery and financing system that provides medical excellence at an affordable price to all Nevadans.

We take seriously our accountability for providing meaningful, well-orchestrated dental care programs. Nevada is both growing and increasingly diverse, which presents the State with unique challenges in financing and delivering dental care services. We are an experienced, successful contractor well versed in these challenges. Throughout the years, HPN has stepped forward to partner with the State to resolve issues recipients have faced with access and availability to services and to maintain or improve access to care for the publicly insured.

We collaborate with DHCFP routinely to address issues and opportunities to improve dental care access and availability to recipients, as well as providing education and outreach to our providers. We continually work with providers and stakeholders to ease administrative burdens and remove barriers to care.

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.

We will utilize a combination of automated and live dialing and make at least four attempts on different days and different times to make a welcome call to all new recipients within thirty days of enrollment. An important feature of our automated calling system is that recipients have the option to opt out of the automated message when they are on the call and instead speak to a live representative. That initial call is very important, because it is our opportunity to not only engage our recipients, but also provide important information about the plan benefits. During that call, we will provide recipients information about the importance of their plan benefits, assist them in selecting a dentist, and answer any questions that they might have about access or care.

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.

We comply with the above state requirements and have comprehensive provider access and availability policies and procedures in place, which help us ensure adequate physical and geographical access to medically covered services for enrolled recipients. On a quarterly basis, we use GeoAccess mapping and data-driven analyses to ensure compliance with the State's access standards. The report includes member-to-provider ratios, average driving distances to the nearest primary care dental locations and open/closed panel status for PDPs. We have extensive experience providing this to the markets we serve.

We can demonstrate, through quarterly access and availability reporting, the ability to exceed regulatory compliance requirements for the following access and availability measures, as contractually required by the DHCFP:

We currently meet or exceed the requirement of having at least one full time equivalent dentist per 1500 recipients per geographic service area.

As required, our dental network also includes the required providers to provide support in the identified geographic areas:

- Pediatric dentists
- Dental hygienist
- Oral surgeons

In addition, our offered network also exceeds the requirement of one PDP within 25 miles. Recipients enrolled in our network will have the benefit of having access to a provider close to home. On average, our network currently offers exceptional access which gives recipients the choice of a provider only 2.5 miles from their home. Nevada recipients will continue to have access to a provider network which has a 100 percent open panel, which exceeds the 50 percent open panel requirements.

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.

As required, prior to increasing capacity of any specific provider or provider group, we will submit a detailed plan as outlined to DHCFP for approval.

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.

UnitedHealthcare will perform routine monitoring of the network to include the FTE Requirements of one (1) full-time equivalent (FTE) dentist per one thousand five hundred (1,500) recipients per geographic service area. Additionally, all recipients will have access to a provider network which currently includes a 100 percent open panel, which exceeds the 50 percent open panel requirements

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.

Per geographic service area, HPN has more than fifty percent (50 percent) of all of the network providers who contractually agree to accept eligible recipients at all times. HPN has a contract with a Federally Qualified Health Center (FQHC) and/or the University of Nevada Las Vegas School of Dental Medicine, who also agree to accept eligible recipients at all times

3.6.5.7 Dental Specialists

The vendor must provide access to all types of dental specialists for PDP 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 PDPs) 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.

We provide access to all types of dental specialists for PDP referrals and are compliant with required specialists' ratios.

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.

If a recipient is unable to arrange specialty care from a network provider, we help arrange for services with an out-of-network provider via single case agreement.

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

HPN's Provider Services and Network Development policies include specific requirements related to network access and availability for appointment standards. Our provider advocates act as liaisons between HPN and the providers. Periodic site visits and after hour audit calls are conducted by the provider advocates to verify and ensure provider compliance with the required appointment standards. The network provider contracts outline the required appointment standards and adherence is mandatory by all network providers for the following services, including but not limited to: emergency services, specialists, and routine dental services. We use complaints/grievances, member satisfaction surveys, secret shopper calls, after hours audit calls and site visits to evaluate the adherence to the appointment standards. We identify performance improvement opportunities and addresses deficiencies for corrective action as determined appropriate. Provider services advocates conduct follow-up site visits and work with the providers on any compliance-related issues to assist the provider in a quick resolution.

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;

Recipients will be provided information on how to access emergency services during the initial welcome call. This information is also provided in the member handbook. Additionally, recipients may call member services and will be provided instructions about the availability and how to access emergency dental services.

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.**

We comply with the requirements as set forth in the Scope of Work for emergency services, therapeutic and diagnostic care, routine or preventive dental services and specialist appointments.

We maintain access and availability policies, which delineate the monitoring mechanisms used to assess compliance with our standards for access to care. Additionally, we continuously monitor appointment availability by performing member satisfaction surveys, monitoring complaint/grievance data and conducting office-site visits.

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 comply with the requirements as set forth in the Scope of Work for specialty referrals including, emergency services, urgent appointments, routine appointments.

As required, we will also provide access to a child/adolescent specialist if requested by the parent.

We maintain specialist access and availability policies, which delineate the monitoring mechanisms used to assess compliance with our standards for access to care. Additionally, we continuously monitor appointment availability by performing member satisfaction surveys, monitoring complaint/grievance data and conducting office-site visits. If access falls below the required limit, we will assist any recipients in obtaining treatment from an out of network specialist. Additionally, we will notify our network recruitment department so that they create a recruitment plan to the desired specialist.

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.

We will take a proactive approach to ensure compliance with appointment coverage beginning with provider education during recruitment. Once the provider has been screened and accepted into the network, they will receive thorough training on the specific program requirements which will include the expected hours of access. We will reiterate specific access requirements in the provider contract as well as outlined in the Provider summary guide that is given to all network providers.

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

Provider's adherence to the stipulated access requirements will be monitored through our complaint tracking and analysis process. The manager of provider operations will coordinate follow-up with providers on complaints and will provide additional training and education and if necessary will initiate a corrective action plan (CAP).

We will supplement our ongoing complaint monitoring with an annual Provider Access Survey, which will monitor compliance with the Nevada appointment availability requirements. We will use appropriate survey tools to record compliance on each review standard for follow-up and reporting. We will flag providers who do not meet requirements and provide follow-up education and send a letter or put them on a CAP to bring them into compliance. We will then contact the provider after the survey to conduct additional education on contract requirements and conduct follow-up surveys as needed to reassess compliance. If a follow-up survey indicates a continued problem, the provider will be removed from the provider directory and the dental director will contact the provider to resolve the non-compliance. Habitual non-compliance may result in provider termination based on material breach of contract. The director of quality management will present data to our Quality Improvement Committee for final recommendations.

Based on the results of the survey, our network team will determine if there are any gaps in access if a provider is terminated. If gaps are identified and additional recruitment is needed, our network team will create a recruitment campaign and add additional providers to fill identified gaps.

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

We take a proactive approach to ensuring compliance with appointment after-hours coverage by thoroughly training providers on requirements when they begin participation in the program and documenting requirements in the Provider summary guide.

We will monitor compliance through our complaint tracking and analysis process. The Provider Outreach Manager will coordinate follow-up with providers on complaints, including education and, if necessary, a corrective action plan (CAP).

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.

HPN's Provider Services and Network Development department has established policies for office wait times. The network provider contracts outline the required office wait time standards and adherence is mandatory by all network providers.

SERVICE DEFINITION STANDARD

- Office Wait Time Wait time in dentist's office is one hour from scheduled appointment time, except when dentist is unavailable due to an emergency
- Office Wait Time Wait time in specialist's office one hour from scheduled appointment time, except when provider is unavailable due to an emergency.

These service standards are monitored by complaints received.

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.

As a result of the breadth of our current established provider network, HPN currently exceeds access standards as stated in this Section 3.6.5 and is not requesting exceptions to the standards.

3.6.5.11 Provider Terminations

A. 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.

We comply with this requirement. It is our policy to notify recipients and our state partner of changes in the provider network. We notify the DHCFP of any significant network changes, including any pertinent information about the nature of the change and how the change affects the delivery of covered services. Our provider services department forwards the terminating provider's information and the number of impacted recipients to our compliance department as notice of a change. Our compliance department then reaches out to the DHCFP within the required time frame to advise of potential impact to recipients due to network change (e.g., changes that will substantially affect the ability of recipients to access services).

Affected recipients are notified in writing of PDP and specialist terminations within 15 days after receipt or issuance of the termination. Recipients are auto-assigned to another PDP until the recipient calls our member services center to change the PDP. For a recipient in active treatment, our case management staff uses information obtained from the prior provider to coordinate care and confirm that the recipient's care is not disrupted during the transition process. The case manager works collaboratively with our provider services department to verify that recipients have access to providers and covered services.

B. If the vendor de-credentials, terminates, or dis-enrolls a provider; the vendor must inform the DHCFP Provider Enrollment Unit within five (5) business days.

To satisfy requirements set forth by the State, we will be submitting monthly lists to the DHCFP of new and termed providers in the network. In the case of a termination, de-credentialing or disenrollment, we will provide the State with all the information applicable as required by law.

C. 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.

We will comply and follow DHCFP notification policies when we dis-enroll, de-credential, terminate or remove a provider from the provider network. We will provide the cause and documentation, as allowed by law, to the DHCFP within the required notification time frames set forth by DHCFP.

D. If the de-credentialing, 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.

Our policies are compliant with the DHCFP requirement that we notify our offices within 15 calendar days of the determination to deny a Medicaid provider credentialing or recredentialing due to concerns about provider fraud, integrity or quality. Similarly, we must notify within 15 calendar days if the Credentialing Committee de-credentialed, terminated or disenrolled a provider due to suspected criminal actions, or disciplinary actions related to fraud or abuse.

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:

We comply with this requirement. It is our policy to notify members and our state partner of changes in the provider network. We notify the DHCFP of any significant network changes, including any pertinent information about the nature of the change and how the change affects the delivery of covered services.

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

Our provider services department forwards the terminating provider's information and the number of impacted recipients to our compliance department as notice of a change. Our compliance department then reaches out to the DHCFP within the required time frame to advise of potential impact to recipients due to network change (e.g., changes that will substantially affect the ability of recipients to access services).

2. 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.

For a recipient in active treatment, our case management staff uses information obtained from the prior provider to coordinate care and confirm that the recipient's care is not disrupted during the transition process. The case manager works collaboratively with our provider services department to verify that recipients have access to providers and 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.

Affected recipients are notified in writing of PDP and specialist terminations within 15 days after receipt or issuance of the termination. The recipient notice will contain the name of the next 2 closest PDP. However, recipients may select any available PDP. If a recipient fails to make a new selection with the 2 week notice period, they will be auto-assigned to another primary care provider until the recipient calls our member services center to change their primary care dentist.

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:

All of our contracts contain the prohibited practice language outlined above and meet the requirements as stated in the Scope of Work for Section 3.6.5.13. As outlined in our Access and Availability policy and in all our provider contracts, covered services shall be provided to recipients without regard to race, national origin, creed, color, sex, sexual orientation, religion, age, disability or handicap condition (including AIDS and AIDS related conditions), or health status except where medically indicated. Additionally, we do not discriminate or promote discrimination, discourage enrollment, steer specific subsets of recipients to particular plans, or limit access to services based upon race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment.

The patient is centric in the model of care that our network provides for recipients, and when requested, their families are to be directly involved as much as possible in the decision-making process and the development of treatment plans.

Prohibited practices by contracted providers include, but are not limited to:

Denial of Services: Denying or not providing a recipient a covered service or available facility.

Covered Services: Providing a 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.

Segregation or Separation: Subjecting a recipient to segregation or separate treatment in any manner related to the receipt of any covered service.

Time and Place: The assignment of times or places for the provision of services on the basis of race, national origin, creed, color, sex, religion, age disability or handicap condition (including AIDS and AIDS-related conditions), or health status of the recipient to be served.

Denying Discussion of Details: We encourage providers to discuss with their patients pertinent details regarding the diagnosis of the patient's condition, the nature and purpose of any recommended procedure, the potential risks and benefits of any recommended treatment, and any reasonable alternatives to such recommended treatment, and any reasonable alternatives to such recommended treatment regardless of benefit coverage limitations.

Prohibited Payment: We do not contract with or pay for services rendered by providers who are excluded from participation under Title V, XVIII or XX or allow providers to order/prescribe services during a time period which they were excluded under Title V,XVIII or XX. We will comply with any state-issued suspension regarding paying providers suspected of fraud.

Charging for Medically Necessary Service: Through compliance with the provider contracts, network providers agree to collect only the applicable copayments, if any, from the recipients at the time of services. Except for the collection of copayments, providers shall under no circumstances attempt to collect any amount over the applicable copayment.

Subcontractor: We will not knowingly enter into an agreement with any subcontractor that would allow, encourage or permit a subcontractor to implement unreasonable barriers or restrictions. In the event we became aware of an existing subcontractor who was failing to comply with this section, we would immediately terminate the agreement with said subcontractor.

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

Provider contract language expressly prohibits providers from denying or providing and 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;

Provider contract language expressly prohibits 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;

Provider contract language expressly prohibits 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;

Provider contract language expressly prohibits the assignment of timers 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:

We encourage providers to discuss with their patients pertinent details regarding the diagnosis of the patient's condition, the nature and purpose of any recommended procedure, the potential risks and benefits of any recommended treatment, and any reasonable alternatives to such recommended treatment, and any reasonable alternatives to such recommended treatment regardless of benefit coverage limitations.

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

   All providers are required to provide recipient's information regarding their 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;**

   All providers are required to provide recipients the information that they need in order to decide among all relevant treatment options.

3. **For the risks, benefits, and consequences of treatment or non-treatment; and**

   All providers are required to advise recipients of the risks, benefits and consequences of treatment or non-treatment.

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.**

   All providers are required to advise recipients of their 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

We do not contract with or pay for services rendered by providers who are excluded from participation under Title V, XVIII or XX or allow providers to order/prescribe services during a time period which they were excluded under Title V, XVIII or XX. We will comply with any state-issued suspension regarding paying providers suspected of fraud.

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

Through compliance with the provider contracts, network providers agree to collect only the applicable copayments, if any, from the recipients at the time of services. Except for the collection of copayments, providers shall under no circumstances attempt to collect any amount over the applicable copayment.

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 will not knowingly enter into an agreement with any subcontractor that would allow, encourage or permit a subcontractor to implement unreasonable barriers or restrictions. In the event we became aware of an existing subcontractor who was failing to comply with this section, we would immediately terminate the agreement with said subcontractor.

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.

We understand the importance of bringing a fully qualified and accessible provider network to deliver care to Nevada's Medicaid recipients. We have mechanisms in place to monitor geographic distribution of primary care dentists. We review contracted providers on a quarterly basis, using GeoAccess mapping and data-driven analyses to monitor compliance with the State's access standards.

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.

Our contracts are compliant with all applicable state and federal regulations and any requests to submit contract information to DHCFP will be honored. We will communicate any changes directly to DHCFP for review and approval before implementation.

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.

We ensure that timing and other events associated with provider recruitment occurs in a manner that meets the objectives outlined by DHCFP. Provider recruitment efforts include outreach to providers who are not currently participating in DHCFP's medical assistance programs or those who have a signed agreement but do not actively accept eligible recipients. Through our contract and provider site visits, we ensure that each provider is aware of the unique features and requirements of the Medicaid program including network access, copayment, and balance billing and reporting. We closely monitor our Medicaid provider networks to assess our compliance with availability standards for the number of practitioners and geographic distribution of network practitioners. Quarterly GeoAccess reports are reviewed to determine locations where recruitment outreach may be necessary, if any, to maintain compliance with required access and availability standards.

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.

We have and will maintain written policies and procedures for monitoring our providers as outlined in the Scope of Work Section 3.6.6.4. Our policies contain the monitoring mechanisms to assess compliance with the health plan's standards for access to care. We monitor adequacy of appointments by performing quarterly member satisfaction surveys and ongoing monitoring complaint/grievance data.

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.

We understand the structure of the provider contract and we will comply with this section. Contract templates are submitted to the DHCFP for approval.

3.6.6.6 The use of "gag" clauses in Provider contracts is prohibited.

Our provider contracts do not include "gag" clauses and any future provider contracts will not include "gag" clauses.

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

All provider contracts will be made available to the DHCFP within five business days upon request.

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

We agree to support and participate in any future grants awarded to Medicaid that affect vendors or vendor recipients.

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

We are presently in compliance with all ACA requirements and confirm compliance in the future, as requested.

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.

We satisfy this requirement as set forth by the State. We update the provider directory in PDF format and post the document online monthly.

We maintain data on all participating providers within our provider networks. Provider additions, changes and terminations in the network are routed daily through our network operations team. At any point in which there is a change to provider demographic information, our online directory is updated weekly for the recipient's convenience. If a recipient does not have access to the internet or the website; he/she may contact the member services department for information. Further, upon contract award, we will provide at DHCFP's request the most current provider directory.

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.

As we contact our recipients, one thing is clear—we must provide information that is easy to understand. If our recipients are unable to comprehend the terminology of our communications, they cannot make appropriate health decisions and consequently cannot take appropriate action.

Our goal is to make educational messaging understandable, accessible and actionable. Our Nevada Medicaid recipient materials are written at no higher than an eighth-grade reading level where terminology permits (e.g., certain medical terms may be higher than an eighth-grade reading level). To confirm our recipient materials do not exceed the eighth-grade reading level, we use our proprietary readability tool, based upon the Flesch-Kincaid grade level formula. This tool rates the content and confirms that the materials we produce are easy to read, understand and act upon. Ultimately, we want to make certain we present information in a manner recipients will easily understand.

We understand the DHCFP must approve member communications, including 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. We will work in partnership with the DHCFP to define and follow a communication approval process that meets all required timelines and confirms our receipt of DHCFP permission prior to distribution. We understand if the DHCFP does not respond within 10 business days, we may consider the communication approved. In addition, we understand this provision does not pertain to communications on specific topics addressed to individual recipients.

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.

As required, we will provide copies of all general communications to providers; including mass mailings, fax-blasts, brochures, batch emails and communications specifically mentioned in this contract. In addition, we understand that this provision does not pertain to communications on specific topics addressed to individual providers.

3.6.10 Provider Policy and Procedure Manual

Distribution of the Provider summary guide typically takes place during the provider contracting phase of network development. All Provider summary guides will be distributed no later than five business days after a provider is included as part of the network.

3.6.10.1 The vendor must prepare a Provider Policy and Procedure Manual. The vendor shall document the approval of the Provider summary guide by the vendor's Dental Director, and shall maintain documentation verifying that the Provider summary guide is reviewed and updated at least annually.

Providers added to our network are given a Provider summary guide during the provider contracting phase. The Provider summary guide will be approved by the dental director and sent to the state yearly for approval prior to releasing to the network.

The dental director will receive information and guidance from our Dental Clinical Policy and Technology Committee (DCPTC) which researches, develops and implements recommendations on clinical guidelines and new technologies based on principles of evidence based dentistry. The Committee makes evidence-based recommendations on practice guidelines and new technologies based on scientific research meeting the highest levels of evidence available, as well as the recommendations of recognized experts such as organized dentistry, specialty societies and government organizations.

The Committee ensures that recommendations are available to dentists online as well as through our provider newsletter and the Provider summary guide. Recommendations serve as the foundation for clinical policy and coverage determinations as well as for the basis of new benefits and programs, (including our condition management and wellness initiatives), utilization review and claims criteria, underwriting and marketing materials. The committee reports findings to the CAC.

Upon approval from the state, all network providers are notified via email or fax blast that the new Provider summary guide is available on the website. Providers may also request a hard copy of the Provider summary guide. At a minimum, the manual will be reviewed and updated on an annual basis. When updates are added to the Provider summary guide, a notification is sent to the network via email or fax blast and posted to the online website.

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 summary guide 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 recipients 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 summary guide 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:

We will comply with the requirement to provide one hard copy of the Provider summary guide as well as an electronic copy. When updates are added to the Provider summary guide, a notification is sent to the network via email or fax blast and posted to the online website.

The Provider summary guide includes the following, but is not limited to:

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

The provider summary guide includes specific program requirements, policies and procedures to ensure compliance with all specific Nevada contract provisions.

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

The provider summary guide includes training tools and instruction for the provider to access our online portal which includes real-time member eligibility information.

C. Prior authorization procedures and requirements;

The provider summary guide provides instruction on how to submit for prior authorization submission and real-time prior authorization status.

D. The procedures for claims administration;

The provider summary guide provides complete information regarding claims information including:

- Detailed information regarding claim submission
- Real-time claims payment status instructions
- Claims appeal process and time frames

- Information on how to submit clean claims via paper or electronic method for payment

E. Provider credentialing criteria;

The provider summary guide provides complete information regarding credentialing process and procedures.

F. Provider network management;

The provider summary guide provides information about network management and contracting process.

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;

The provider summary guide includes benefit information and covered services/programs.

I. 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;

The provider summary guide includes administrative and billing instructions including:

- List of procedure codes, edits, units and payment rates
- Information on how to submit clean claims via paper or electronic method for payment
- Claims billing information, as well as any necessary documents that may be needed to process a claim for payment

I. Procedure to dispute adverse payment and contract decisions; and

The provider summary guide includes information about action, notice of action and appeals.

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

The provider summary guide includes all policies and procedures and expectations regarding quality improvement and utilization management.

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 comply with the requirements as stated in the Scope of Work Section 3.6.10.3 pertaining to provider and recipient communications activities. We are committed to supporting and training our provider network, and understand that continuing provider education is critical to the delivery of high-quality health care services.

In order to meet the needs of our various state customers, we have developed a diverse and effective portfolio of provider training methods.

Training for providers, who participate in our Nevada Medicaid network will include, but are not limited to:

- Specific Nevada program requirements
- Billing requirements
- Specific federal guidelines including but not limited to: Section 1877(E)(3)(B) of the Social Security Act which prohibits participating providers from making payments directly or indirectly to a physician or other provider as an inducement to reduce or limit medically necessary services provided to enrollees
- Comprehensive instruction on medically necessary covered dental services in the Nevada plan
- Instruction on specific technology, administrative and program processes.
- Use of the Web provider Portal and its features, including but not limited to: (a) checking eligibility; (b) submitting and checking claims; (c) viewing reports and fee schedules (d) accessing a PDF of the provider summary guide; and (e) registering for and receiving electronic funds transfer (EFT) payments
- Coordination with a clearing house for claims and authorizations and the frequency of payments
- Use of the IVR system to communicate with recipients and providers
- Instruction on how to contact a member services advocate for one-on-one assistance
- Comprehensive instruction on medically necessary covered dental Services in the State plan

PROVIDER TRAINING

We will maximize provider participation in training by ensuring that they are aware of the training schedule and by making training sessions convenient for busy Providers. We use a diverse array of communication techniques to increase provider awareness of upcoming training. These include sending invitations and reminders through: “blast-faxing,” e-mailing, direct mailing, automated and live outbound calls and reminders on remittance notices and envelopes. We also encourage participation by offering the convenience of webinar-based training, which providers can attend without leaving their offices.

We will make certain that providers meet all current and future state and federal eligibility criteria, reporting requirements, and any other applicable rules and/or regulations related to the contract through our comprehensive provider training program, ongoing provider outreach and the use of social media outlets to connect with providers. By meeting the different needs of various states, we have developed a diverse and effective portfolio of Provider training methods.

We use a range of training modalities to meet the information and learning needs of our providers. Examples include:

- Distribution of the provider summary guide to providers during the contracting phase
- Targeted mailings, including copies of online training programs and PowerPoint presentations
- “Blast-faxing” Frequently Asked Questions (FAQs) and Quick Reference guides to Providers offices
- Live outbound introduction calls by our provider Advocate to welcome Providers to the network and answer any preliminary questions from the Provider
- Webinars showing, use of the Web provider portal and its features, including but not limited to: (a) checking eligibility; (b) submitting and checking claims; (c) viewing reports and fee schedules (d) accessing a PDF of the provider summary guide; and (e) registering for and receiving electronic funds transfer (EFT) payments. Coordinate with a Clearing House for claims and authorizations and the frequency of payments
- Use of our IVR system to communicate with recipients and providers
- How to contact a member services advocate for one-on-one assistance, comprehensive instruction on medically necessary covered dental services.

FREQUENCY OF PROVIDER TRAINING

Go-Live Webinars will occur daily in the 30 days preceding activation and every day of the following week. Subsequent Webinars will occur monthly. We will schedule provider seminars before and after the network’s go-live date and we will hold one annual Town Hall forum per region. Quarterly meeting to discuss and identify issues related to claims, enrollment and other issues will also be held via Webinar. Training materials relevant to the agenda will be provided to all attendees. Distribution of the provider summary guide typically takes place during the provider contracting phase of network development.

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.

We meet the requirements as stated in the Scope of Work Section 3.6.11 pertaining to the network maintenance. Our provider contracts contain an initial term of one calendar year and then automatically renew for consecutive one-year periods providing predictability and stability to the network. Maintaining and managing our provider network involves many tasks, including initial and ongoing credentialing and recredentialing; adding and deleting network providers; periodic contract renewal; provider education; and, in some instances, discipline or termination. We take the provider discipline and termination process seriously and have an explicit policy in place to address such issues.

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.

UnitedHealthcare maintains policies regarding dental records requirements, such as required and recommended information to be contained in proper dental records. This includes appropriate treatment plans, timeliness of treatment, and continuity and coordination of care. We may perform dental record audits if concerns exist about quality or when the plan has concerns about dental recordkeeping. In addition, chart review may be involved in anti-fraud investigation.

Our provider contracts also require standardized dental record documentation. Through the Provider summary guide, site visits and ongoing interactions between provider advocates and our contracted providers, we validate that providers use the most current resources to maintain the confidentiality, accessibility and availability of all recipient dental records. Our provider contract templates contain the provision that providers comply with the confidentiality requirements as defined by state and federal law.

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.

Our Provider summary guide contains the dental record confidentiality standards that apply to provider office facilities. The standards include the requirement that a designated person(s) is responsible to maintain safekeeping of medical records or appropriate system backup for electronic medical records. In addition, the manual lists the medical record review standards assessed during on-site visits at provider offices to confirm compliance with confidentiality standards.

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.

Upon request, a recipient can call member services to request support in obtaining a copy of the recipient's dental records. As required, all records will be furnished in a timely manner, with a maximum time-frame of 30 calendar days from the date of the request. As cited, each recipient or parent/legal guardian is entitled to one free copy of the requested dental records. Fees 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.

As required, when a recipient changes provider, the contracted provider will forward all dental records in their possession to the new provider within 10 business days from the receipt of the request.

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.

As one of the largest Medicaid and CHIP dental administrators in the country, we have extensive experience managing Medicaid, CHIP and Family Health plans with all categories of Medicaid membership, including long term care and special needs recipients.

Leveraging current program expertise with the financial strength of UnitedHealth Group, UnitedHealthcare will be a strong partner to the Nevada Medicaid Dental Benefit Program. We share a commitment to accountability – establishing dental homes, improving recipient and provider outcomes and experiences through outreach and technology, and creating a shared environment in which Nevada will have visibility into our operational and financial performance.

In addition to our experienced team, we have also created specific alignments to supply enhanced services that work in tandem with our internal expertise to create a stronger infrastructure for our clients.

Upon contract award, we will finalize a written subcontract with Scion Dental, Inc. (Scion) who will provide their state of the art information technology and Medicaid expertise. The owners of Scion Dental, Inc. are industry pioneers in improving government program dental management. Scion's Enterprise System technology platform is woven throughout all of UnitedHealthcare Dental's workflow and processes, connecting providers, recipients, and our state agency clients in a single, real-time environment.

Although each state program has unique features, collectively they are substantially similar to the medically necessary covered services and program requirements of the Nevada Medicaid dental program. The creation of dental homes, servicing of diverse recipient and provider populations and the managing of annual maximums are shared core competencies. We will accommodate the unique needs of the diverse population in Nevada through member communication using many different methods (telephone, online, community-based programs, etc.) translation services, and focused contracting with providers who can accommodate diverse and special needs.

In all states, we develop critical member and provider outreach components designed to improve member education, create early dental interventions, and increase provider awareness and participation. These actions elevate the overall health status of program recipients, and are demonstrated assets that we will continue to bring to the Nevada dental program.

As we have done for each of our clients, we have developed a program specific to the needs and requirements of the State of Nevada and its Medicaid recipients. This commitment to coordinated care and service, provider network development, utilization management and plan flexibility offers each of our clients the ability to honor their sincere commitment to provide critical dental care to their vulnerable Medicaid population and simultaneously meet their practical goal to effectively manage costs.

We are dedicated to improving the health status of Nevadans by promoting improved access to quality health care. Our Nevada Dental Medicaid program is structured and staffed to enable us to systematically monitor and evaluate the quality and appropriateness of care and continually improve health outcomes for members in Nevada.

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.

We will adhere to both timelines and audit steps in working with the EQRO annually as they perform a HEDIS Report Validation of selected HEDIS measures to verify compliance with HEDIS methodology either on-site or electronically. The final reported rates will reflect all data updated as a result of those completed audits. Upon request, we will also conduct any special focus studies and provide reports on additional quality measures to DHCFP and the EQRO.

3.8.2.2 On an annual basis, vendors are required to report on all performance measures listed in the State Quality Strategy.

We have a process in place to provide reporting on all performance measures in compliance with DHCFP requirements and have many years of national experience in collecting, analyzing and reporting HEDIS measures for the Medicaid populations.

We have an unyielding commitment to improving the performance measures that indicate quality of care. We share this commitment with all employees throughout our organization—at the corporate level and in our individual health plans. Our QI Program provides an integrated, coordinated and quality improvement system to demonstrate compliance with contractual, state and federal requirements. We employ a knowledgeable, interdisciplinary QI team and proven structures and processes.

We carry out our commitment to continuous quality improvement by monitoring performance measures and tracking them over time. With a fixed objective of achieving year-over-year improvements, and achieving national and regional targets as quickly as possible, we compare our performance measures to state minimum performance standards, goals and benchmarks.

Dr. Michael Weitzner will be responsible for the oversight of the Quality Assurance Plan for the State of Nevada Dental Medicaid Program. As required by the State, the Quality Assurance Plan and Protocols will adhere to the following guidelines:

- It is implemented by professionals with adequate and appropriate experience in quality assurance
- The plan detect both underutilization and overutilization of services
- The plan assesses the quality and appropriateness of care furnished to enrollees.
- The plan provides for systematic data collection of performance and patient results
- The plan provides for interpretation of collected data to practitioners
- The plan provides for making needed changes when problems are found.

We have continually worked to improve each of our Medicaid and CHIP programs to achieve results that improve the oral and overall health of the recipients. As a data driven, quality focused organization, we collect data utilizing HEDIS* formulas and standards and other quality data to identify and address opportunities for improving the clinical quality of dental services provided to our recipients. Indicator measures are identified annually through the quality improvement program evaluation and included in the Annual Work Plan for periodic monitoring.

UnitedHealthcare will generate the following indicator measures for the State Program:

HEDIS Measure: Annual dental visit: This measure is a basic indicator of members' access to care. Results will be used to identify opportunities to increase member access. The measure is the percentage of enrolled recipients who had at least one dental visit during the measurement year and were eligible for coverage in each month of the measurement year.

Dental Utilization by Service Category Role-up: This measure is an indicator of our company's overall performance. We will use the results to identify opportunities to focus on provider and member oral health education, dependent on the percentage of service categories. This measure is the percentage of members enrolled for 11 or 12 months of the measurement year who received a covered dental service that is captured by one or more of the Service Category Role-up buckets during the measurement year. Service Category Role-up Buckets include: (a) Preventive; (b) Diagnostic; (c) Restorative; and (d) Other. We will break out utilization by age bracket and compare results to those of the previous measurement period to determine improvement.

Dental Procedures per 1,000 Member Months: This measure is an indicator of member access and delivery of services. We will use the results to identify over- and under-utilization of services. The measure will be calculated for each period within our examination period, which we define as the months captured by two full calendar years and any months in the current year that fall within the last 36 months of the measurement month. If the measurement month is December, the examination period would be all 36 months. The period can by a month, quarter, calendar year or year-to-date. We will break the results out by age bracket and service category role-up.

Dental Procedures per Claimant: This measure is an indicator of member access and appropriateness of treatment. We will use the results to monitor appropriate treatment, specifically over- and underutilization. This measure is the number of procedures received by a recipient who received at least one procedure. By utilizing industry leading data technology, innovative clinical models, enhanced provider recruitment and education and creative outreach and case management UnitedHealthcare is committed to increasing the number of children who have access to dental services before the age of 21.

Average Wait times for Appointments: This measure is an indicator of member access. The Nevada Medicaid program has an accessibility standard which requires that a member must have an appointment scheduled within 24 hours for treatment of an urgent dental condition, or an appointment within six weeks for a non-urgent dental visit. We expect our network dentists to provide initial, follow-up and hygiene appointments within 14 business days. Dentists must provide emergency appointments within 24 hours. Network dentists must follow these access standards and we monitor their compliance.

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

We have an established tracking system that provides up-to-date information on compliance with EPSDT service provision requirements in the following areas:

- A clinical dental examination at the eruption of the first tooth and no later than twelve (12) month and
- Every six months thereafter, or as indicated by the child's risk status/susceptibility to disease.
- Diagnosis and/or treatment, or other referrals in accordance with EPSDT screen results.

Our benefits management software platform is extremely comprehensive and flexible when it comes to customer reporting, and it can be customized to generate reports with real-time data. The software system can extract data and repackage it into formats required by the State of Nevada without programming changes to the system. We have experience creating customer-specific reports to monitor each recipient's profile. We track when the recipient last received treatment, what services were performed, who performed those services, any authorizations received for referrals to specialists, and when the recipient is due for their next preventive service.

We have sophisticated and customizable monitoring and reporting capabilities available to track member dental utilization. These include:

- HEDIS reports providing a snapshot summary of the Medicaid dental program's month-to-month performances by determining all recipients eligible for services, such as sealants, and those that have received preventive services, to provide a HEDIS score for each HEDIS-eligible age group.
- Real-time dashboards to track the percentage of patients accessing care. Our reporting tools are integrated into our benefits management software system to analyze and compare the types of services being rendered, including preventative and restorative services.
- Detailed analytical reports that track by recipients by county, by zip code, and by age to analyze which counties outperformed others, and where targeted outreach could be best implemented.

These report outcomes allow us to identify the opportunities to drive EPSDT rates and thereby allow us to create targeted, focused outreach programs to these targeted recipients. Our targeted outreach programs take into consideration factors that are likely barriers to service for recipients. This analysis allows us to adapt the outreach plan, as necessary, to address utilization and increase percentages of preventative and restorative services for recipients.

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.

In addition to best in practice clinical programs such as screening and fluoride varnish for early childhood caries, UnitedHealthcare employs various approaches to improve overall access as well as the utilization of preventive services, focusing on recipient/parents, schools, physicians and community agencies.

We participate in outreach initiatives that encourage people to become more proactive in their health and dental benefits, educate them about daily oral care and the impact that oral disease may have on chronic medical conditions. We educate recipients through prevention, wellness and early detection.

Dental Screenings and Clinics

We have made it a priority to participate in dental health screenings and clinics for children across the country to improve dental awareness.

Children from low- and moderate-income homes miss an average of 13 days of school each year due to dental problems.*

We have relationships with several state health departments, community organizations, and school boards to deliver annual screening and education programs. Because of our efforts, numerous children over the past few years have received a free screening from a staff dentist, classroom education and toothbrush demonstration by a dental professional. We also provide a dental package that includes parent educational material, a toothbrush and toothpaste.

Case Study: Sinclair Lane Elementary School, Maryland

Situation

- We conducted a school-based dental health clinic with a team of four dentists, four trained educators and 13 employee volunteers
- **253 of the 488 students examined had active caries**

Action

- We conducted an interactive discussion with the students on the importance of good oral health
- We provided instructions on proper tooth brushing techniques
- We gave each child a non-invasive dental screening

Results

- We gave each student a free toothbrush and toothpaste
- We sent the screening results home with the children, along with:
  - A letter explaining the results
  - A list of participating dentists in the area
  - Educational materials

State and Health Department Programs

We are involved in local and statewide panel discussions, committees and meetings to create delivery channels with health department staff in several key counties, so that individuals identified as needing dental care can be quickly and effectively referred.

For example, we began partnering with the California Dental Association Foundation in 2003 to develop and implement an expanded statewide training effort, Dental Professionals Against Violence (DAPV). This program raises health care and community awareness of family violence through patient risk assessment, clinical signs and symptoms, and dental professionals' legal requirements. It also includes action steps for dental professionals to use.

Family violence exists in every city, neighborhood and community. The dentist is often the first person to treat abuse victims.

Sixty-five percent of all physical child abuse and 75 percent of all physical domestic violence results in injures to the head, neck, or mouth.

DPAV educated 310 dentists at the CDA meeting in Anaheim, California and 45 dental professionals at two continuing education settings in the Sacramento, California area during its first quarter of operation. During 2004, we created posters for dental offices that the California Dental Association distributed with the publication of its April journal.

We are now working with CDAF to design and print posters for the front of the dental office (for patients) and for the back office (for dentists and staff).

Outreach Programs: Smile Starters®

We developed the Smile Starters® program as an outreach and prevention program in Connecticut. It encourages parents to bring their children to the dentist at an early age and promotes good oral health and regular check-ups throughout childhood. The program is geared towards parents of children under the age of 12 who are eligible for Medicaid.

Parents were mailed information about dental disease prevention and received a special certificate entitling their children to a free dental wellness kit after visiting the dentist. The kit includes a child's toothbrush and toothpaste and a refrigerator magnet designed to hold his or her photo and the date of the next dental appointment.

We also worked with general dentists and pediatricians to help educate this population about the importance of dental wellness. Creative and persuasive educational materials and dentist incentive packages were distributed and displayed in doctors' offices.

The program had an immediate and sustained effect upon utilization for both the bundled procedures and other services rendered to the Smile Starters®-eligible population:
■ Sealants administered in the first quarter of the program **increased by approximately 500 percent.**
■ Cleanings and fluoride treatments **increased by approximately 250 percent**.

The program had an immediate and sustained effect upon utilization for both the bundled procedures and other services rendered to the Smile Starters®-eligible population:

- Utilization levels have been sustained at **more than double** the pre-Smile Starters® levels. Over the same time period, our program produced 40 percent more dental visits than a similar carrier that had no wellness program for the same population.

This program was the first program in the country specifically targeted at the Medicaid population and has been incredibly successful.

Preventive dental health is one of our top priorities and through these programs we hope to increase customer awareness. We are committed to community projects and enjoy working with different organizations that offer solutions to ensure all people have access to quality dental care.

**According to U.S. General Accounting Office data.*

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.**

We have experience collaborating with states on EQRO reviews and look forward to participating in any desk or on-site reviews as needed to evaluate the current process in place and facilitate EPSDT implementation. This review could include an evaluation of policies and procedures, service delivery, data tracking and analysis, language in PDP contracts and the process of member notification. We have enhanced our national activities and confirm that the monitoring and evaluation of the referrals by providers are being done expeditiously. If the participation rates are less than the national baseline average, we are committed to submitting a plan of correction (POC) to the DHCFP indicating the enhancements that we make to all current activities focused on member outreach, provider education or case management, to make needed improvements.

Our tracking system monitors and evaluates the referrals that are the result of an EPSDT dental screening.

We provide all information required for the external quality review in the time frame and format requested by the EQRO designated by DHCFP. This enables verification that we maintain fiscally sound contracts, policies and procedures that adequately address quality issues and requirements, to provide technical validation of our performance improvement projects and to review our adoption, dissemination and adherence to clinical practice guidelines.

We incorporate any findings from the review into our current Quality Improvement Work Plan and the annual Evaluation, which further informs the development of the quality program and subsequent year's Work Plan. This approach provides the structure to not only address any findings immediately as documented in our current Work Plan but also to reflect the findings and monitor for sustained improvement and compliance with EQRO recommendations in upcoming years.

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.

We will provide the requested data and submit the CMS 416 EPSDT recipient report in the required time frame for each quarter.

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.

We will work diligently to confirm that our recipients are educated on the critical importance of EPSDT screenings and that they receive EPSDT services. Our goal is to exceed the participation rate of the Quality Improvement System for Managed Care improvement measures, as determined by DHCFP or its contracted EQRO. Our quality improvement team will monitor claims and encounter data to identify recipients who are non-compliant with complete periodic screenings continuously.

Our commitment to quality improvement drives our focus on EPSDT monitoring and evaluation. We use a variety of mechanisms to continuously measure, evaluate and improve the services provided to recipients, which are founded upon continuous quality improvement principles.

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;

Some examples which the QA team monitors and sends out Plan of Correction are quality indicators such as:

- Low encounter submissions
- Member appointment accessibility
- Facility and patient chart reviews (where applicable),

- Quality of care complaints

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

Examples of potential corrective actions may include:

Access: Providers may correct issues by adding hygiene days, adding associates, or closing offices to new recipients.

Low Encounter Reporting: Provider relations staff will engage providers to have them correct encounter submission or provide an explanation why their practice has low recipient access.

Facility and Chart Review and Quality Complaints: To resolve facility quality concerns providers may be advised to purchase emergency kits or oxygen tanks, correct basic patient chart documentation, take continuing education courses, respond to office procedure or recall recipients for re-exam when appropriate.

C. The goals of the corrective action;

The goals of the corrective action plans will be to have providers adhere to the plan guidelines related to documentation, recipient access and encounter utilization.

D. The time-table for action;

The time table for action may vary. Access surveys for general dentists are conducted every six months. Surveys for specialists are typically conducted once per year. We will abide by all state and federal requirements with regard to monitoring the quality of the services by providers in our network.

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

All identified change in processes, structure, or internal or external education will be documented in all POCs.

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

Providers are monitored as determined by each quality indicator.

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

The QA National Manager and his delegated staff personnel will be 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.**

We will adhere to all required schedules and requirements related to submission and resolution of identified POCs.

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 acknowledge all responsibility for compliance with the required services as outlined in this RFP and the General Terms of the contract.

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.

As a data driven, quality focused organization, UnitedHealthcare collects HEDIS and other quality data to identify and address opportunities for improving the clinical quality of dental services provided to our recipients. Indicator measures are identified annually through the quality improvement program evaluation and included in the Annual Work Plan for periodic monitoring. We continue to refine our quality management and performance improvement program to drive continuous improvement in the areas of clinical outcomes, operations and member and provider satisfaction. Our quality management structure and standards provide us with a solid foundation to operate in accordance with all applicable state, federal regulatory and contractual regulations.

We manage our IQAP tools and standards to achieve positive health outcomes for recipients using the following approach to quality standards:

- An enterprise wide commitment to quality management
- Independent quality assessment and performance monitoring through external quality review organization (EQRO) reviews
- Continuous quality improvement (CQI) and program documentation
- Quality Improvement (QI) Program assessment of member and provider satisfaction
- Compliance with additional State and federal requirements

UnitedHealthcare's Quality Improvement Committee (QIC) and our National QIC will be responsible for ongoing monitoring of indicators and for recommending actions to improve processes across multiple departments, as necessary, to improve the recipients' quality of care whether through improved access, member and provider education, or better application of services based on understanding of cultural issues. The QIC may also request additional drill down of the data to allow us to focus strategies on specific recipient groups based on the needs related to ethnicity, geographic location or provider utilization patterns.

By utilizing industry leading data technology, innovative clinical models, enhanced provider recruitment and education and creative outreach and case management support and services UnitedHealthcare is committed to addressing the CMS goal of increasing the number of children who have access to dental services before the age of 21.

QAPI PROGRAM

The QAPI Program is designed to assist in improving the quality of clinical care and service provided to recipients. The following are the objectives of the QAPI Program:

1. To develop, implement and coordinate all activities that support continuous quality improvement of the processes by which care is delivered.
    - Measure, trend and analyze QAPI activities against performance goals and/or recognized benchmarks.
    - Identify inappropriate practice patterns and opportunities to improve care.
    - Evaluate the effectiveness of implemented changes.
    - Continually assess the effectiveness of the QAPI Program.
- Ensure that Quality Improvement policies and procedures are reviewed, revised and approved, on at least an annual basis, by the Quality Improvement Committee (QIC).
- Develop and amend the QAPI Work plan to direct QI functions. Evaluate the QAPI Program and Work plan annually.
2. Ensure adequate availability and accessibility to general dental and specialty care.
3. Measure member satisfaction and implement interventions to correct areas of dissatisfaction.
4. Ensure compliance with all applicable Federal and State regulations.
5. Ensure effective credentialing and recredentialing processes that comply with applicable State and Federal standards.
6. Measure and implement actions to provide for appropriate utilization, continuity, and coordination of care.

Our board of directors is responsible for the quality of care and services provided to our recipients. The board delegates oversight of the operational components of the Quality Improvement Program (QIP) to the Quality Improvement Committee (QIC). The board receives quarterly reports at their meetings.

Each year, the board of directors reviews the quality improvement plan written report for the concluding year and approves it for the coming year.

Reporting Structure and Committee Activities

The QIC structure supports the QAPI Program through routine reporting, analysis, and identification of opportunities for improvement and implementation of interventions to improve the quality of care and service to recipients. Information from the Dental Clinical Policy & Technology Committee (DCPTC), the Credentialing Committee and the Peer Review Committee (PRC) report to the QIC, through the Clinical Affairs Committee (CAC) at least quarterly. The QIC presents reports to the Board of Directors.

Board of Directors

The Board of Directors retains ultimate accountability for the quality and safety of clinical care, and the quality of services received by recipients. The Board of Directors delegated the responsibility of oversight to the Plan President and the Dental Director to ensure that an effective QAPI Program was established, maintained and supported on a continual basis.

Dental Director

The Dental Director is responsible for providing direction and support to the QAPI Staff on all aspects of the QAPI Program.

Quality Improvement Committee

The QIC is a multidisciplinary, plan-wide committee that retains operational accountability for the design and implementation of the QI Program and monitoring all activities. The QIC oversees the quality of clinical care and service provided to recipients, and reports to the Board of Directors on a quarterly basis.

On-going committee tasks:

- The review, revision, and approval of the Quality Management Program Description by the QIC and the Board of Directors.
- The creation of an annual work plan that monitors quality of care items by removing barriers and measuring improvement.
- Evaluation of the quality improvement program at the end of the year.
- Monitor quality initiatives from the work plan on a quarterly basis and report up to the Board of Directors.
- Monitoring of membership volume

Clinical Affairs Committee

The committee meets quarterly. Responsibilities of this committee are to provide input to the QIC on all aspects of the clinical quality such as, but not limited to, access, dental record documentation, and preventive service, credentialing and re-credentialing processes, recipient complaints and utilization.

Credentialing Committee

The Credentialing Committee defines credentialing and recredentialing standards for the plan. The Credentialing Committee has authority over credentialing and recredentialing of providers and is overseen by the Clinical Affairs Committee (CAC). The Credentialing Committee meets monthly, or more often as necessary.

PEER REVIEW COMMITTEE

The Peer Review Committee (PRC) manages appeals received from providers because of termination or rejection of a provider by the Credentialing Committee. The committee also monitors quality of care cases, makes recommendations related to Fraud, Waste and Abuse, as well as reviewing site visits and chart audits that do not pass satisfactorily. The committee reports findings to the CAC.

DENTAL CLINICAL POLICY AND TECHNOLOGY COMMITTEE

The Dental Clinical Policy and Technology Committee (DCPTC) researches, develops and implements recommendations on clinical guidelines and new technologies based on principles of evidence based dentistry. The committee makes evidence-based recommendations on practice guidelines and new technologies based on scientific research meeting the highest levels of evidence available, as well as the recommendations of recognized experts such as organized dentistry, specialty societies and government organizations. The committee ensures that recommendations are available to dentists online as well as through our provider newsletter and the Provider summary guide. Recommendations serve as the foundation for clinical policy and coverage determinations as well as for the basis of new benefits and programs, (including our condition management and wellness initiatives), utilization review and claims criteria, underwriting and marketing materials. The committee reports findings to the CAC.

THE QAPI WORK PLAN

QAPI Activities will be documented in a work plan and will include the following areas:

Access and Availability: UnitedHealthcare will ensure that all requirements are met relating to the access and availability of our providers, and has filed the current access and availability standards with the state regulatory agencies as required. The plan monitors the following appointment availability: initial visits, routine visits, hygiene visits, emergency care and in office waiting times, through access surveys, grievance data, member and provider surveys, on-site audits and provider after hours accessibility

Member Satisfaction Survey: UnitedHealthcare will have policies and procedures to track and trend member satisfaction (specifics on this topic are addressed in a separate question)

Member Complaint I Grievance Resolution Process: UnitedHealthcare will have a grievance system and mechanism in place to allow for its members and/or their representatives to file grievances against both the providers and the plan.

Provider Disputes, Grievances and Appeals: Participating UnitedHealthcare dentists or formerly contracted dentists, who believe they have been adversely impacted by the policies, procedures, decisions, or actions of the plan, may have a right to file a dispute with the plan as provided by state regulation or provider contract. The Plan will acknowledge receipt of the dispute within fifteen (15) business days and resolve the dispute within forty-five (45) business days of receipt of all information necessary to make a resolution unless otherwise required by individual state requirements. Following notification of the plan resolution, if unsatisfactory, the provider may appeal this decision as provided in their provider contract.

Guidelines for Quality of Care and Quality of Services: UnitedHealthcare has developed and maintains criteria and guidelines for care and service to ensure that plan recipients receive all necessary, adequate and appropriate preventive, and restorative dental services which are consistent with generally accepted professionally recognized standards.

Quality of Care Oversight and Monitoring: UnitedHealthcare has various methods for monitoring quality of care to ensure recipients receive the necessary, adequate and appropriate preventive and restorative dental services which are consistent with generally accepted professionally recognized standards and within expected guidelines. These methods include, but are not limited to, On-Site Audits, Potential Quality Issue investigation, analysis of Grievances and Appeals, review of Credentialing issues, Utilization statistics, and Member Satisfaction surveys.

Identification of Clinical and I or High Risk Issues, Disparities: UnitedHealthcare looks to identify and prioritize quality issues, membership data is reviewed periodically to identify and prioritize potential disparities and quality issues using basic demographics, such as age and geographic location (including suburban, urban and rural) and comparing this data to available local and or national benchmark data. The data is reviewed to establish benchmarks for future health care study and quality improvement.

Customer Service: UnitedHealthcare has a customer service center that provides comprehensive service to the plan's recipients and providers. The plan addresses the needs of the customers to include accurate recipient benefit and eligibility information in a compassionate and efficient manner. The Quality Improvement Committee reviews the quarterly call resolution times, and accuracy of information provided as part of its quarterly reviews.

Credentialing/Recredentialing: UnitedHealthcare maintains a comprehensive credentialing process to verify the professional credentials of all contracted dentist providers. The Plan contracts with a NCQA Certified Credentialing Verification Organization (CVO) to assist in the required data collection to complete the credentialing, (and recredentialing) process. Recredentialing of all contracted providers is done on a three year cycle unless otherwise required by state regulation.

Provider On-Site Reviews: UnitedHealthcare has mechanisms in place for the evaluation of the structural aspects of care at participating dental offices. as well as mechanisms for evaluation regarding the clinical process of care rendered by participating dentists at dental plan offices, including audits of clinical records. The plan uses valid and reliable data collection and analysis methodologies to evaluate the clinical process of care at dental plan offices, and evaluates participating dentists against current professionally recognized standards of practice as promulgated by national dental professional associations. The clinical evaluations are conducted by qualified licensed dentists and overseen by the National Dental Director where such oversight includes regular training, calibration, and validation of results.

Dental Records: UnitedHealthcare maintains policies regarding Dental Records requirements, such as required and recommended information to be contained in proper dental records. This includes appropriate treatment plans, timeliness of treatment, and continuity and coordination of care. We may perform dental record audits if concerns exist about quality or when the plan has concerns about dental recordkeeping. In addition, chart review may be involved in anti-fraud investigation.

Provider Satisfaction Survey: UnitedHealthcare periodically conducts Provider Satisfaction Surveys to assess the provider perception of plan performance and to identify opportunities for improvement. Areas surveyed include, but are not limited to, the following: Provider Relations (internal and field representatives), Customer Service, specialty referrals, quality management activities, and Provider involvement in grievances and appeals. Survey results are presented to the Quality Improvement Committee for the identification of opportunities for improvement.

Preventive Care Guidelines and Dental Health Education: UnitedHealthcare's preventive dental activities are designed to identify and measure indicators of preventive health and to share feedback to the State, individual Providers, and internally. The goal is increase the utilization of preventive health services, in an effort to promote healthy behaviors and wellness of the recipient. Additional efforts are offered to educate recipients on the importance of preventive health and the services available in their plan, through communication and outreach, coordinated with the health plan. Primary responsibility is coordinated between QA and the Dental Director, with input from Client Operations, Network Development and Marketing.

Linguistic Access: UnitedHealthcare complies with all federal, state, and client mandated linguistic access requirements. UnitedHealthcare may make materials available in various languages, large print, and also offers hearing-impaired services when required, in accordance with all contractual, state, and federal requirements.

HIPAA Compliance: UnitedHealthcare adheres to all required HIPAA requirements in the processing of recipient's protected health information (PHI). UnitedHealthcare maintains HIPAA Policies and Procedures and performs the required training for all employees. UnitedHealthcare also requires all contracted providers to handle recipient health care information with the same sensitivity. Chart audits are reviewed for confidentiality issues.

Emergency Care I Emergency Dental Services: UnitedHealthcare has guidelines and policies regarding the care of recipients experiencing dental emergencies. Within the scope of dental care benefits under the recipient's benefit plan, emergency dental services are services required in the event of unforeseen medical conditions such as pain, hemorrhage, infection, or trauma, where immediate attention is necessary. In general, emergency services include relief of pain, swelling, infection, and/or bleeding by procedures to stabilize the emergency condition, and may include issuing prescription medications. Definitive procedures may need to be deferred to a more appropriate time.

Fraud and Abuse Program: A key component of the UnitedHealthcare's management of benefit costs is the identification and investigation of potential fraudulent, abusive, unusual services, or aberrant patterns of care. The program is comprehensive and managed in partnership with our Payment and Integrity Unit, a United Health Group subsidiary and the UnitedHealthcare Special Investigations Unit (SIU). The Fraud and Abuse Program is reviewed periodically as required by specific contract, state, and/or federal requirements. Cases that are verified as being "fraudulent", they are summarized at the appropriate internal committees, and referred to the appropriate authorities for further action. Annual reports of anti-fraud or abuse activity are filed with the state regulatory agencies when required.

Utilization Management: UnitedHealthcare maintains a comprehensive Utilization Management (UM) Program with supporting policies and procedures. Utilization data may be analyzed to ensure that recipients receive quality oral health services. UM activities identify aberrant utilization patterns, and provide source data for outcomes studies, allowing analysis of client performance which can suggest targeted QI interventions aimed at improving recipient oral health outcomes. UM is an additional source of quality indicators, which can be used to evaluate quality in the following four areas: clinical results or treatment choices, over and under-utilization compared to network base lines, accuracy of coding procedures, and cost of care.

ANNUAL QUALITY IMPROVEMENT ACTIVITIES AND WORK PLAN

UnitedHealthcare is committed to quality improvement activities to identify systemic quality of care and quality of service issues, and to create initiatives to improve identified quality parameters and hence to improve care and service.

The QAPI includes mechanisms to evaluate and report trends and patterns with plan and provider performance indicators, such as the result of performance improvement projects, clinical quality measures, utilization profiling, results of provider audits, complaints, appeals, and other data sources used to measure quality performance. Such reports are reviewed and acted upon by the Quality Improvement Committee. The QAPI uses established quality of care indicators relevant to its membership and based on current and sound clinical knowledge and practice, such as nationally recognized evidence-based guidelines and quality measures to evaluate the quality of care provided.

The Plan uses valid and reliable data collection and analysis methodologies to identify, track, and trend quality of care and quality of service issues. The Plan establishes performance goals for the quality of care and quality of service indicators to assess performance, identify and set priority areas for improvement, and determine desired level of improvement, as applicable. The Plan tracks and trends performance on quality of care indicators on both a Plan-wide and Provider-specific basis, as appropriate.

A written evaluation of the QAPI is prepared annually and submitted to the appropriate Clinical Committees for review and approval as well as to the State as appropriate. This evaluation focuses on strengths and weaknesses, trends and patterns, barriers to improvement, and demonstrated accomplishments in improving dental care and services to recipients. Input is obtained from the QAPI, CAC, QA staff, data sources, satisfaction indicators, and the Plan management.

A Quality Improvement Work Plan is prepared for the upcoming year for submission to the appropriate Committees and to the State for approval as appropriate. The Work Plan incorporates aspects of the QAPI annual evaluation, and revisions, if applicable, indicator requirements, and employer requests for monitoring and reporting. The Quality Improvement Work Plan is prepared and based primarily on the annual QAPI evaluation and identified improvement areas, but may also include client and regulatory requirements or other quality improvement initiatives.

If UnitedHealthcare does not achieve its quality of care or quality of service performance goals, the Plan performs quantitative and qualitative data analysis to identify barriers to the improvement of both clinical and non-clinical aspects of its health service delivery system. In order to improve performance UnitedHealthcare designs and implements interventions to address any identified barriers. UnitedHealthcare also re-measures our performance to determine to determine if we have seen improvement or have met our goals.

MECHANISMS FOR OVERSEEING PROGRAM EFFECTIVENESS

UnitedHealthcare oversees the effectiveness of program quality management, quality improvement, and preventive health education activities. Quarterly status reports are made available to the plan's management, clients (as required) for review and evaluation of effectiveness.

The Dental Director has overall responsibility for the quality management program. The Dental Director and the Director of Quality Management are responsible for monitoring follow-through when clinical and service opportunities for improvement are identified.

An annual critical evaluation of the QAPI is completed to ascertain that the goals are met and improvement initiatives are effective. Such review focuses on evaluation of defined goals and objectives, review of completed QI activities, program scope and organization. Highlights include trending of key clinical and service indicators, documentation of quantitative improvements in care and service attributable to QI initiatives, evaluation of QI resources, and recommendations for the coming year in the work plan. Any barriers to the QI process are analyzed and identified to create actions to overcome any and all barriers to the improvement process.

Formulation of the annual Quality Improvement Program incorporates findings from the program evaluation, along with identified improvement opportunities, in addition to activities mandated state and federal programs, and client contractual agreements.

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.

We currently conduct performance improvement projects (PIPs), in compliance with Section 3.9.1 that focus on both clinical and non-clinical areas and work closely with our network providers, state and community partners to improve health outcomes and impacted health and social systems, to provide high-quality care for Nevadans.

Our comprehensive quality scorecard, which includes key process and outcome indicators, allows us to identify opportunities for improvement on a continuous basis. For all quality initiatives, we objectively and systematically monitor and evaluate opportunities that may result in PIPs or other formal or informal QI activities. These activities are aimed at improving the quality, timeliness and appropriateness of our care and service delivery.

IDENTIFYING AND DESIGNING PERFORMANCE IMPROVEMENT PROJECTS (PIPS)

Each of our PIPs goes through the following steps:

Identification of potential Projects: Projects are selected based on identified improvement opportunity, clinical need, or State requirement

Baseline Data: Data are collected and analyzed to establish the current health status of the target population and to point to the specific health opportunity

Setting Benchmarks: We establish quantifiable indicators, which clearly and accurately measure the activity being evaluated. Indicators measure changes in health based on the projected intervention. Process and/or outcome measures are established and evaluated as applicable to verify that interventions are being implemented and progressing as planned

Development: After conducting an initial analysis, the Clinical/Quality team develops and implements an intervention(s) known to be effective and suitable to the population selected.

Analysis: A quantitative analysis is conducted to determine if goals/benchmarks have been met. Based upon our review, we perform additional analysis to determine if interventions should continue or if changes need to be instituted. If the PIP was successful, the new processes are standardized and monitored. If the actions were unsuccessful, the Clinical/QA team determines and implements changes that need to be made to the current interventions.

Re-measurement: We conduct re-measurement to determine if improvements are sustained or if new interventions have resulted in improvement. If not, modifications or additional interventions are considered.

Monitoring: Interventions that resulted in improvement are standardized and monitored.

Reporting: Results of PIPs are shared with the Clinical and QA teams in both Dental and where applicable Medical and with outside stakeholders as appropriate, such as network dentists and physicians. Results are also reported to the State as required.

UnitedHealthcare will focus on Performance Improvement Programs (PIPs) designed to meet the following objectives:

- Improve access, particularly for children
- Increase levels of preventive health, focusing on children
- Improve the management of dental disease, primarily dental caries in children
- When possible increase medical-dental integration and encourage the participation of non-dental professionals
- Encourage recipients, especially children, to establish a relationship with a dental home

Specific projects will be designed to improve the HEDIS Annual Dental Visit, help Nevada to meet their target on the CMS Oral Health Initiative, increase affordability and positively impact cost of care (for example by earlier identification of children at risk),, encourage closer cooperation between the medical and dental programs and support Nevada's Dental Home initiative. To the extent that UHC Dental can partner with program medical plans to integrate data and program activities, additional programs, such as Emergency Room Diversion and a physician varnish/early childhood caries initiative would also be considered. UnitedHealthcare has clinical initiatives in each of our client states which support one or more of the objectives noted.

STATE SPECIFIC EXAMPLES

In Rhode Island, where we have a direct contract relationship, we are engaged in two Quality Improvement Activities (QIAs, their term for PIP). The first of these is designed to increase the level of preventive health from baselines as reported on the CMS-416, the second to increase the rate of sealant utilization, also from existing baselines. Regular team meetings are held to discuss proposed interventions focusing on education and outreach, and to measure the impact through semi-annual measurement and follow up. Over time, additional efforts have been put into more community based interventions, for example reaching out to state medical societies to provide oral health education in their newsletters, working with representatives of the state hygiene association and Dept. of Health to define the role of public health hygiene in RI in improving access, and dialoguing with RI's Perinatal and Infant Oral Health Quality Improvement Initiative (PIOHQI) where we successfully linked their efforts with teaching programs initiated by PA HeadStart, to train general dentists to feel more comfortable treating small children in their offices. We did note improvements between our first and second measurement period, of 12.4% for overall preventive health and 4.1% for sealants.

In Pennsylvania, where we perform dental services on behalf of UHC of PA Community Plan, we partner with the Health Plan on a series of interventions focusing on increasing levels of preventive health, improving disease management, and increasing medical-dental integration. Our efforts to increase preventive health resulted in a nearly 14% increase in levels of prevention, and contributed to overall state improvements in dental health prevention as part of the CMS Oral Health Initiative. Current interventions include: working with FQHCs with medical and dental co-located to identify gaps between medical well child and annual dental visits, working with large medical practices to identify recipients who have not had their annual dental visit so that physicians can encourage recipient follow up, encouraging PCPs to apply varnish to small children and refer them for follow up, partner with PA HeadStart on their training programs for general dentists (cited above), provide education to recipients on the importance of early intervention and prevention, and encourage improved maternal health during and immediately following pregnancy. As part of our varnish programs, we are working with the PA AAP, encouraging PCPs to hands on training program which promotes physician oral screenings and varnish application.

SPECIFIC CLINICAL INTERVENTIONS

Our Early Childhood Caries (ECC) programs, (often referred to as physician varnish programs) make use of pediatric and family clinicians (collectively referred to as primary care providers or PCPs), in an effort to identify children at risk, while also satisfying the requirements of the mandatory Early Periodic Screening, Diagnosis and Treatment (EPSDT) visits for Medicaid patients age 1-18. Most very young children see their PCP many times before ever engaging a dentist. By asking PCPs to perform screenings, provide anticipatory guidance to parents, apply fluoride varnish and recommend that that child visit a dentist, we hope to identify children who may be at risk for ECC, while encouraging all children to find a dental home.

To accomplish these objectives, we collaborate closely with our medical plan partners, most commonly local UHC Community and State health plans. When it is feasible, we also engage with academic institutions in the states or cities where we provide services, as we noted in our work with Temple. Much of our collaboration centers on provider education, which is critical to the success of these programs. The education focuses on the etiology of caries, the efficacy of fluoride, the important role PCPs play in detecting caries and how they can incorporate caries screening and fluoride varnish into a well-child visit. Working together, UnitedHealthcare and its partners develop education, follow up to track patient activity at both the PCP and dental office and arrange for appropriate reimbursement.

Our initial ECC programs were implemented in the New York City metropolitan area, in New York and New Jersey, both based on the model described above. The New York program was initiated to meet the requirements of a city program, Take Care New York; a mandate to provide education to parents and pregnant moms, and to encourage physicians to screen children and apply fluoride varnish. UnitedHealthcare Dental undertook planning for its New York ECC program in partnership with the New York Community and State (C & S) Plan and New York University (NYU) College of Dentistry. NYU provided education for PCPs and process expertise, and in return we offered referrals to their program. Results in both states show steady growth for the programs, as demonstrated in the following chart which displays results 2011-15 results.

	Number of Children (Fluoride Varnish)	Number of Children (Primary Dentist Follow – Up)	Number of Children Preventive Care
New York	11,133 (65.7% - age 3 and under)	2,685	2,572
New Jersey	16,100 (61.1% age 2 or under)	3,645	3,510
TOTAL	27,233	6,330	6,082

A more recent ECC program is in Mississippi. To date, 1,506 recipients have received fluoride varnish. The majority of the recipients, nearly two thirds, have received services in the last 12 months. This program continues to grow and we anticipate even more recipients will benefit from the program. We are continuing to develop ECC programs, currently in Pennsylvania, Kansas and Florida.

An additional initiative focuses on emergency room diversion. The objective in Diversion programs is to encourage this population, through close cooperation between the medical and dental plans, to seek care in a dental office, making use of their available benefits. Typically these efforts involve a combination of education on the value of regular dental care and of avoiding unneeded emergency room treatment, outreach consisting of direct communication to those recipients who visit the emergency room, encouraging them to visit a dentist, and referral for appropriate follow up care. These programs are ultimately successful when the medical and dental plans can work closely together, exchanging data, enlisting the help of physicians and dentists in providing patient education, and coordinating outreach and referral. UnitedHealthcare's Health and Dental Plans are currently working with several of our states, including New Jersey, New York, Louisiana, Mississippi, New Mexico and Wisconsin, to better understand the scope of the challenge in those markets and delineate objectives

Our newest efforts focus on the creation of Dental Homes. Medicaid programs are moving toward Dental Home assignments as a way of attacking rates of disease in children and reducing ER use in adults. Dental Home assignments also help UHC enlist the dentist in getting recipients into the office, which can positively impact HEDIS rates as well as other programs we have mentioned already, for instance closing the loop after a PCP varnish application, or driving patients into the office to obtain preventive health. Currently Arizona has an active Dental Home program and we are also piloting an initiative in New Jersey.

In addition to our programs UHC strives to build partnerships with a variety of stakeholders that extend beyond our work with our network dentists, for instance with physicians and community partners.

PHYSICIANS

In order to promote dental health as an integral part of overall health and wellness, we engage physicians in several ways:

- We provide general clinical and service information for physicians, primarily those in primary care (mostly pediatricians and family physicians).
- We provide information to physicians on our individual initiatives as well as oral health educational opportunities, both those online as well as hands on
- We work with medical plans to identify high volume physicians where we can identify specific recipients for follow up.
- Specific focus is placed on Federally Qualified Health Centers (FQHCs) where we emphasize the importance of dental screening and follow up with a dental home. The value of this initiative is that the FQHCs often provide both medical and dental services in the same facility.
- As appropriate, UnitedHealthcare works with the State and the program MCOs to identify children seen in medical settings who may not have received dental follow up. We then provide those families with communication on the importance of dental follow up. Specific to an at-risk condition, such as early childhood caries, parents whose children have been seen by a PCP for screening and varnish application will receive a letter from UnitedHealthcare reminding them of the importance of follow up with a dental home

COMMUNITY ACTIVITY

In addition to maintaining partnerships with advocacy groups, we look for additional opportunities with other community based organizations, (ex. Head Start); initiate or participate in existing health fairs and other community events; and explore opportunities to partner on community initiatives and/or events with hospital groups, FQHCs and other large group practices to provide education, screenings and referrals. UnitedHealthcare has and will continue to support outside efforts to ensure continuity, such as current efforts by Teeth First!, a Rhode Island Grant program, supported by Rhode Island Kids Count, designed to increase awareness of the importance of age one dental care through web-based information, handouts and community events

UnitedHealthcare works with clinicians, both dentists and physicians, and community groups in an effort to engage parents. We will provide information they can share with parents and will discuss potentially including clinicians in an effort to reach out to families who have not visited for regular care. UnitedHealthcare engages community resources, as previously cited, including schools and Head Start programs, as a way of sharing information and potentially as opportunities to conduct fairs and/or screenings.

Specific communication tools include:

- Member manual
- Health fairs and screenings
- Post cards and brochures
- Member news letters
- Appointment reminders
- Importance of an early dental home

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 and will put a process in place to report the status and results of each PIP to DHCFP in a timely manner and in compliance with 42 CFR 438.330. We will fully comply with all time frames and annual PIPs reporting requirements, including the status and results of each project requested by DHCFP and those included in 42 CFR 438.330. We welcome the opportunity to receive DHCFP feedback from the review of our performance improvement projects as well as other aspects of our quality assessment and improvement program. We will also collaborate with the DHCFP and other stakeholders to develop studies, surveys and other analytic activities to improve the quality of care and services provided to our recipients specifically, and Nevadans overall.

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.

We agree to submit the results of performance-improvement measurement data resulting from performance improvement projects (PIPs), performance measures, required standards, and quality assessment and performance improvement requirements, in the annual QI Program document to the DHCFP for evaluation. In addition to the overall evaluation of the internal QI Program, we agree to participate in all PIPs identified by the DHCFP and achieve, through ongoing measurements and intervention, significant improvement, sustained over time.

3.9.3.2 Submit to the DHCFP data specified by the DHCFP which enables the DHCFP to measure the vendor's performance.

Our QI Program provides an integrated, coordinated and continuous quality improvement (CQI) system to comply with contract, state and federal requirements. To maintain compliance with local, state and federal regulatory requirements and accreditation standards, our QI Program relies on the following process:

- Monitoring compliance with regulatory requirements for QI and risk management opportunities and response as required
- Reporting systems that provide appropriate information for meeting the requirements of DHCFP, external regulatory review and accrediting bodies including performance improvement measurement data annually using the standard measure required by DHCFP, including those that incorporate the requirements of 42 CFR 438.340 and 438.330.
- Developing action plans to improve performance consistent with state expectations
- Using the results of our contractual performance in evaluating the QI Program, comparing our metrics to Nevada performance standards, goals and benchmarks, to identify opportunities for continuous improvement
- Submitting data on required performance measures as requested by the DHCFP, to assist DHCFP to measure our performance

We track all submissions to DHCFP in our QI Work Plan, which our QIC oversees. The plan dental director acts as the primary point of contact with DHCFP to manage all quality-related communications.

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 will submit performance improvement measurement data annually using standard measures as required state and federal requirements and the DHCFP. We will submit our annual standardized HEDIS data survey results using standard measures, annual QI Program evaluation (that includes performance improvement measurement data, but is not limited to, access and availability and dental program participation and utilization), quarterly complaints and appeals data, utilization data and any other requested reports as identified by the DHCFP.

We understand the needs of Nevada recipients and have the resources to develop a comprehensive cultural diversity and sensitivity program. We use the state's eligibility files, which include race, ethnicity and primary language data facilitating a comprehensive population health focus. We monitor trends in race, ethnicity and primary language for potential gaps that we can address and interventions that can be developed to improve the dental care and services provided to unique and diverse populations.

We will comply with the requirements stated under RFP Sections 3.9.3.1 and 3.9.3.2, and implement a comprehensive internal QI Program that includes measurement and submission to the DHCFP of performance-improvement measurement data annually using standard measures, and any other data requested by the DHCFP.

We collaborate and partner with the DHCFP to conduct performance measurement and improvement activities according to the most current sources of the internal QI Program guidelines and HEDIS Technical Specifications. We will submit data to the DHCFP as requested to enable the DHCFP to measure the health plan's performance. These data include the HEDIS rates, complaints and grievance data and any other utilization data that DHCFP requests to evaluate our performance.

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:

Our health information systems are compliant with the State's requirements and sufficient to collect, analyze, integrate and report data to achieve the objectives of our QI Program. We use the proprietary Enterprise System to provide, monitor and trend information including, but not limited to, utilization, grievances and appeals, and disenrollment.

The Enterprise System includes several custom-built, integrated application modules which provide the integrated database that edits and collects data on recipients and providers along with the claims and encounters that document the services furnished to recipients. We will meet the requirements of this RFP and 42 CFR 438.242 through the consistent and ongoing use of this comprehensive system.

The information for those reports is extracted from our Enterprise System which maintains encounter and claims data at a single person and aggregate level. Uniform utilization and quality assurance reports will be provided on a quarterly basis, via secure email. Recipient satisfaction and complaint data will be delivered via secure email on an annual basis.

The Enterprise System includes comprehensive, flexible reporting capabilities. Hundreds of standard reports, many of which are customizable through the user interface, are available on demand for immediate online access. Reports display real-time data drawn directly from Enterprise System databases, and most can be exported in a variety of file formats, including PDF and Excel. In addition to the Enterprise System's standard reports and analysis tools, any data stored in the Enterprise System's databases can be easily extracted and repackaged into client-defined report formats without a programming change to the system. The words—real-time, online, anytime—sum up our innovative approach for putting the analytical power of the Enterprise System into the hands of our clients.

DHCFP can log on to our Client Web Portal and instantly monitor financial trends and claim liability; track Call Center activity; generate up-to-the minute provider profiling; review claim and authorization volumes, processing status, and turnaround times; run detailed statistical analysis against paid claim data; and much more.

Analytical tools include Executive Dashboards, Provider Profiling tools, Paid Claim Analysis tools, Quick List reports with linked Profile data, and the Enterprise Business Intelligence System (eBIS). All of these tools are customizable through the user interface, with advanced filtering options that allow flexible, focused analysis without programming. All data exposed through the Client Web Portal is real-time data, drawn directly from Enterprise System databases/data warehouse. On-demand reports generated with these analysis tools can be exported in a variety of file formats, including PDF, CSV, XML, and Excel. DHCFP will have hands-on oversight into program financials and operating metrics—anytime from anywhere—by simply logging on to a website.

DHCFP staff can also receive security access to generate their own reports online, any time, with just a supported web browser and an Internet connection. These on-demand reporting tools offer DHCFP managers and staff oversight 24 hours a day, seven days a week into our management of the dental program.

In addition to Enterprise System analysis and reporting tools available on demand through the user interface, any data stored in the Enterprise System databases can be easily extracted and repackaged into scheduled reports that meet client requirements for data, layout, and file format without a programming change to the system. Scion Dental technical staff has extensive experience working with clients to design, develop, and deliver customized reports to meet specific needs.

Our information management team will work with DHCFP to define requirements to meet changing business needs, and then collaborate with our technical staff to design, develop, and deliver client-defined reports. Because you will continue to have online access to dashboards and other analytical tools, dependence on customized reports is minimized.

UTILIZATION

UnitedHealthcare has integrated clinical, statistical and analytics experience and expertise to create a comprehensive program for identifying and improving outlier performance on key performance measures of utilization, and billing practices. Components of our profiling technology include robust relational databases with real-time, online access to claims data, sophisticated analytical tools, including SAS, data mining and advanced statistical analysis. Our comprehensive data warehouse is available online and in real time to all analysts and clinicians involved in profiling.

Based on the analytic profiling process, UnitedHealthcare may initiate various investigation and remediation efforts. A formal investigation may be triggered. All analytics, including provider profiles, are based on the data in the warehouse.

A clinician will review the profile results of all flagged providers with aberrant claims/utilization patterns and determine if further investigation is warranted. If warranted, the clinician reviews additional detailed reports for flagged providers.

The Claim Audit Report details all services provided to all recipients for a specified time interval and allows the reviewing clinician to view the sequence of treatment, and the type and quantity of services by recipient. The combination of these reports enables the reviewing clinicians to determine whether abusive claims/utilization patterns exist, which would trigger a formal Fraud and Abuse investigation.

GRIEVANCE AND APPEALS

All complaints received, either orally or written, are analyzed, logged, and categorized in our electronic tracking system and automatically routed to the Appeals department for review and resolution. Our appeals specialists log, track, and assign case follow-ups to appropriate staff. When a case requiring follow up is created, the appeals specialist routes the case to the appropriate department, such as credentialing, client services, or claims, or to a specific provider relations representative or dental consultant. Each follow-up record includes due dates and hotlinks back to case details. When a note is entered on a follow-up assignment, the system automatically logs the date, time, and name/user ID of the person who entered the note.

The Appeals department monitors member-initiated complaints about providers, including clinical quality of care complaints. Each month, the appeals department delivers a trending and analysis report to the Clinical Affairs Committee, the Dental Director, and the market's Provider Relations Representative. The report, which summarizes the prior month's grievance activity with a Year-to-Date comparison, is reviewed during Clinical Affairs Committee meetings. If a clinical Quality of Care issue is identified, the local Field Provider Relations Representative personally visits the provider office for further investigation. Correction action may also be taken as required.

DISENROLLMENT

We take advantage of built-in efficiencies in our benefits administration software platform to import, process, and manage data file imports, including eligibility files. Per the RFP, we will accept daily enrollment/disenrollment updates and provide weekly reconciliation of the data. We will also reconcile the monthly file against internal records and notify the State of any inconsistencies within three months of file receipt.

Business rules can be applied against the imported data to ensure it matches the original file data, and customized data edits can be applied to meet specific client requirements. Incoming data files that cannot be loaded can be suspended, corrected, and reprocessed or they can be returned to the client for correction, depending on each client's requirements and preferences.

Data updates can be automatically loaded into the system based on business rules. For example, rules defined for various functional sets of data control how matching records and unmatched (new) records are handled: they can be merged, completely replaced, or ignored. Likewise, rules can also be defined down to the individual field level to control update actions for each field.

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;

Our Enterprise System database will maintains all relevant demographic and health information data for Nevada Dental Medicaid recipients. Diagnosis and treatment are captured as part of claim submission and stored with the claim record, which is automatically linked to the member enrollment record. Historical diagnosis and treatment data is never purged and can be extracted from the system for many different reporting purposes, including paid claim analysis, financial liability reporting, provider profiling, etc. At any time, our member services advocates can access information specifically related to any identified special needs or requirements of our recipients. We can also extract reports that help us identify any significant data related to the utilization or service needs of the recipients enrolled in the program.

As required, the Enterprise System will generate and provide person-level records that describe the care received by that individual during his or her enrollment period.

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);

We have fully HIPAA-compliant editing software in place to validate the integrity of the claims and encounter data we receive from submitting providers. We have staff dedicated to monitoring the volume and quality of encounter data received from contracted providers to verify the completeness and accuracy of this data. We confirm that data received from providers is accurate and complete by verifying the accuracy and timeliness of reported data, screening the data for completeness, logic and consistency, and collecting service information in standardized formats to the extent feasible and appropriate. Claims and utilization management (UM) data are subject to extensive system edits included in the Enterprise System software and we establish and maintain policies and procedures to process claims and encounters that are submitted for payment from any source for services provided to recipients.

We monitor our compliance with internal, regulatory and contractual claims processing requirements through internal claims quality control department audits and random audits.

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

We accept 837D transaction files submitted electronically by individual providers and clearinghouses. Our EDI Analysts work directly with submitters to test files for accuracy and HIPAA compliance, and they resolve any transmission errors before files are loaded into a production environment. Our skilled technical teams offer technical support and business support via telephone and email.

We already have in place systematic rules that ensure medically necessary dental covered services are paid only for eligible recipients, in accordance with dental program regulations.

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 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.

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

We will designate a director of information systems who will be the designated lead to collaborate with the DHCFP related to review and submission of encounter data.

3.9.6 Written IQAP Description

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

We have a written description of our IQAP that meets DHCFP requirements. Our QI Program Description is rooted in principles of continuous quality improvement (CQI) that foster data-driven decision-making and focus on continually leveraging opportunities for improvement.

3.9.6.1 Goals and Objectives.

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.

We maintain an updated QI Work Plan to manage due dates, responsible staff members, timelines for implementation and accomplishments of the specific objectives of the internal QI Program. Overall responsibility for the QI Work Plan lies with the Dr. Donna Nagata, National Dental Director for Quality Assurance, who will be responsible for the oversight of the Quality Assurance Plan for the State.

Each year, quality measures including HEDIS, and access/availability, grievances and appeals, call and claims turnaround data, results of provider audits among others, are evaluated and quantifiable goals are set with staff accountability noted. The QIC reviews and approves the QI Work Plan annually and upon each update as does the board of directors. The Quality Assurance Plan and Protocols will adhere to the following guidelines:

- It is evaluated and implemented by professionals with adequate and appropriate experience in quality assurance
- The plan detects both underutilization and overutilization of services
- The plan assesses the quality and appropriateness of care furnished to enrollees.
- The plan provides for systematic data collection of performance and patient results
- The plan provides for interpretation of collected data to practitioners
- The plan identifies gaps in care and service and provides for needed improvements when problems are found

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.

We maintain an updated QI Work Plan to manage due dates, responsible staff members, timelines for implementation and accomplishments of the specific objectives of the internal QI Program.

THE IQAP WORK PLAN

IQAP Activities will be documented in a work plan and will include the following areas:

Access and Availability: UnitedHealthcare will ensure that all requirements are met relating to the access and availability of our Providers, and has filed the current access and availability standards with the state regulatory agencies as required. The Plan monitors the following appointment availability: initial visits, routine visits, hygiene visits, emergency care and in office waiting times, through access surveys, grievance data, member and provider surveys, on-site audits and provider after hours accessibility.

Member Satisfaction Survey: UnitedHealthcare will have policies and procedures to track and trend member satisfaction.

Recipient Complaint/Grievance Resolution Process: UnitedHealthcare will have a grievance system and mechanism in place to allow for its recipients and/or their representatives to file grievances against both the Providers and the Plan.

Provider Disputes, Grievances and Appeals: Participating UnitedHealthcare dentists or formerly contracted dentists, who believe they have been adversely impacted by the policies, procedures, decisions, or actions of the Plan may have a right to file a dispute with the Plan as provided by state regulation or provider contract.

The Plan will acknowledge receipt of the dispute within fifteen (15) business days and resolve the dispute within forty-five (45) business days of receipt of all information necessary to make a resolution unless otherwise required by individual state requirements. Following notification of the Plan resolution, if unsatisfactory, the provider may appeal this decision as provided in their provider contract.

Guidelines for Quality of Care and Quality of Services: UnitedHealthcare has developed and maintains criteria and guidelines for care and service to ensure that Plan recipients receive all necessary, adequate and appropriate preventive, and restorative dental services which are consistent with generally accepted professionally recognized standards.

Quality of Care Oversight and Monitoring: UnitedHealthcare has various methods for monitoring quality of care to ensure recipients receive the necessary, adequate and appropriate preventive and restorative dental services which are consistent with generally accepted professionally recognized standards and within expected guidelines. These methods include, but are not limited to, On-Site Audits, Potential Quality Issue investigation, analysis of Grievances and Appeals, review of Credentialing issues, Utilization statistics, and Member Satisfaction surveys.

Identification of Clinical and/or High Risk Issues, Disparities: UnitedHealthcare looks to identify and prioritize quality issues, membership data is reviewed periodically to identify and prioritize potential disparities and quality issues using basic demographics, such as age and geographic location (including suburban, urban and rural) and comparing this data to available local and or national benchmark data. The data is reviewed to establish benchmarks for future health care study and quality improvement.

Customer Service: UnitedHealthcare has a customer service center that provides comprehensive service to the Plan's recipients and providers. The Plan addresses the needs of the customers to include accurate recipient benefit and eligibility information in a compassionate and efficient manner. The Quality Improvement Committee reviews the quarterly call resolution times, and accuracy of information provided as part of its quarterly reviews.

Credentialing/Recredentialing: UnitedHealthcare maintains a comprehensive credentialing process to verify the professional credentials of all contracted dentist Providers. The Plan contracts with a NCQA Certified Credentialing Verification Organization (CVO) to assist in the required data collection to complete the credentialing, (and recredentialing) process. Recredentialing of all contracted Providers is done on a three (3) year cycle unless otherwise required by state regulation.

Provider On-Site Reviews: UnitedHealthcare has mechanisms in place for the evaluation of the structural aspects of care at participating dental offices. as well as mechanisms for evaluation regarding the clinical process of care rendered by participating dentists at dental plan offices, including audits of clinical records. The Plan uses valid and reliable data collection and analysis methodologies to evaluate the clinical process of care at dental plan offices, and evaluates participating dentists against current professionally recognized standards of practice as promulgated by national dental professional associations. The clinical evaluations are conducted by qualified licensed dentists and overseen by the National Dental Director where such oversight includes regular training, calibration, and validation of results.

Dental Records: UnitedHealthcare maintains policies regarding Dental Records requirements, such as required and recommended information to be contained in proper dental records. This includes appropriate treatment plans, timeliness of treatment, and continuity and coordination of care. We may perform dental record audits if concerns exist about quality or when the Plan has concerns about dental recordkeeping. In addition, chart review may be involved in anti-fraud investigation.

Provider Satisfaction Survey: UnitedHealthcare periodically conducts Provider Satisfaction Surveys to assess the Provider perception of Plan performance and to identify opportunities for improvement. Areas surveyed include, but are not limited to, the following: Provider Relations (internal and field representatives), Customer Service, specialty referrals, quality management activities, and Provider involvement in grievances and appeals. Survey results are presented to the Quality Improvement Committee for the identification of opportunities for improvement.

Preventive Care Guidelines and Dental Health Education: UnitedHealthcare's preventive dental activities are designed to identify and measure indicators of preventive health and to share feedback to the State, individual Providers, and internally. The goal is increase the utilization of preventive health services, in an effort to promote healthy behaviors and wellness of the recipient.

Additional efforts are offered to educate recipients on the importance of preventive health and the services available in their plan, through communication and outreach, coordinated with the health plan. Primary responsibility is coordinated between QA and the Dental Director, with input from Client Operations, Network Development and Marketing.

Linguistic Access: UnitedHealthcare complies with all federal, state, and client mandated linguistic access requirements. UnitedHealthcare may make materials available in various languages, large print, and also offers hearing-impaired services when required, in accordance with all contractual, state, and federal requirements.

HIPAA Compliance: UnitedHealthcare adheres to all required HIPAA requirements in the processing of recipient's protected health information (PHI). UnitedHealthcare maintains HIPAA Policies and Procedures and performs the required training for all employees. UnitedHealthcare also requires all contracted Providers to handle member health care information with the same sensitivity. Chart audits are reviewed for confidentiality issues.

Emergency Care/Emergency Dental Services: UnitedHealthcare has guidelines and policies regarding the care of Recipients experiencing dental emergencies. Within the scope of dental care benefits under the Recipient's benefit plan, emergency dental services are services required in the event of unforeseen medical conditions such as pain, hemorrhage, infection, or trauma, where immediate attention is necessary. In general, emergency services include relief of pain, swelling, infection, and/or bleeding by procedures to stabilize the emergency condition, and may include issuing prescription medications. Definitive procedures may need to be deferred to a more appropriate time.

Fraud and Abuse Program: A key component of the UnitedHealthcare's management of benefit costs is the identification and investigation of potential fraudulent, abusive, unusual services, or aberrant patterns of care. The program is comprehensive and managed in partnership with our Payment and Integrity Unit, a United Health Group subsidiary and the UnitedHealthcare Special Investigations Unit (SIU). The Fraud and Abuse Program is reviewed periodically as required by specific contract, state, and/or federal requirements. Cases that are verified as being "fraudulent", they are summarized at the appropriate internal committees, and referred to the appropriate authorities for further action. Annual reports of anti-fraud or abuse activity are filed with the state regulatory agencies when required.

Utilization Management: UnitedHealthcare maintains a comprehensive Utilization Management (UM) Program with supporting policies and procedures. Utilization data may be analyzed to ensure that Recipients receive quality oral health services.

UM activities identify aberrant utilization patterns, and provide source data for outcomes studies, allowing analysis of client performance which can suggest targeted QI interventions aimed at improving Recipient oral health outcomes. UM is an additional source of quality indicators, which can be used to evaluate quality in the following four areas: clinical results or treatment choices, over and under-utilization compared to network base lines, accuracy of coding procedures, and cost of care.

ANNUAL QUALITY IMPROVEMENT ACTIVITIES AND WORK PLAN

UnitedHealthcare is committed to quality improvement activities to identify systemic quality of care and quality of service issues, and to create initiatives to improve identified quality parameters and hence to improve care and service.

The IQAP includes mechanisms to evaluate and report trends and patterns with complaints, appeals, and other data sources used to measure quality performance. Such reports are reviewed and acted upon by the Quality Improvement Committee. The IQAP I uses established quality of care indicators relevant to its membership and based on current and sound clinical knowledge and practice, such as national evidence-based guidelines or national consensus guidelines to evaluate the quality of care provided.

The Plan uses valid and reliable data collection and analysis methodologies to identify, track, and trend quality of care and quality of service issues. The Plan establishes performance goals for the quality of care and quality of service indicators to assess performance, identify and set priority areas for improvement, and determine desired level of improvement, as applicable. The Plan tracks and trends performance on quality of care indicators on a Provider-specific basis, as appropriate.

A written evaluation of the IQAP is prepared annually and submitted to the appropriate Clinical Committees for review and approval as well as to the State as appropriate. This evaluation focuses on strengths and weaknesses, trends and patterns, barriers to improvement, and demonstrated accomplishments in improving dental care and services to recipients. Input is obtained from the IQAP, CAC, staff, data sources, satisfaction indicators, and the Plan management.

A Quality Improvement Work Plan is prepared for the upcoming year for submission to the appropriate Committees and to the State for approval as appropriate. The Work Plan incorporates aspects of the IQAP annual evaluation, and revisions, if applicable, indicator requirements, and employer requests for monitoring and reporting. The Quality Improvement Work Plan is prepared and based primarily on the annual IQAP evaluation but may also include client and regulatory requirements or other quality improvement initiatives.

If UnitedHealthcare does not achieve its quality of care or quality of service performance goals, the Plan performs quantitative and qualitative data analysis to identify barriers to the improvement of both clinical and non-clinical aspects of its health service delivery system. In order to improve performance UnitedHealthcare designs and implements interventions to address any identified barriers. UnitedHealthcare also re-measures our performance to determine to determine if we have seen improvement or have met our goals.

MECHANISMS FOR OVERSEEING PROGRAM EFFECTIVENESS

UnitedHealthcare oversees the effectiveness of program quality management, quality improvement, and preventive health education activities. Quarterly status reports are made available and to the Plan's management, clients (as required) for review and evaluation of effectiveness.

The Dental Director has overall responsibility for the quality management program. The Dental Director and the Director of Quality Management are responsible for monitoring follow-through when clinical and service opportunities for improvement are identified.

Formulation of the annual Quality Improvement Program incorporates findings from the program evaluation in addition to activities mandated state and federal programs, and client contractual agreements.

An annual critical evaluation of the IQAP is completed to ascertain that the goals are met and improvement initiatives are effective. Such review focuses on evaluation of defined goals and objectives, review of completed QI activities, program scope and organization. Highlights include trending of key clinical and service indicators, documentation of quantitative improvements in care and service attributable to QI initiatives, evaluation of QI resources, and recommendations for the coming year in the work plan. Any barriers to the QI process are analyzed and identified to create actions to overcome any and all barriers to the improvement process.

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.

The IQAP/QI Program methodology, as described in the Quality Program Description, is used to describe the process for monitoring quality of dental health care throughout the entire range of services we provide. In the QI Program evaluation, all demographic groups, including children experiencing health care disparities, those with special health care needs (CSHCN) and care settings (e.g., including care provided by private providers and FQHC) and types of services are included in the review of the program.

EXAMPLES OF KEY ACTIVITIES

Comprehensive Review: Annually, we conduct a comprehensive review of claims and encounters data for our members across all care settings. This review of private provider, community health center, ER and urgent care data for different age groups, geographic location and by gender helps determine the top diagnoses to determine additional areas for potential intervention.

Quality of Service Monitoring: We monitor quality of service through evaluation of quality of service indicators such as access and availability, claims and call data as well as the review of member and provider satisfaction reports with customer service and data related to ease of access and call response times in our member and provider services center. Member-facing service data are reviewed monthly.

Quality of Care (QOC) Monitoring: QOC monitoring is analyzed through evaluation of quality of care indicators, including utilization patterns, quality measure focusing on preventive health, and quality of care complaints as well by using member feedback from surveys, complaints and appeals, and provider office visits that identify potential issues. We pursue QOC investigations for any type of provider in any setting of care to verify recipients receive appropriate clinical care and services. QOC monitoring is continuous due to the extreme importance of timely response. On a monthly basis, we perform formal reporting of aggregate QOC data that is shared with appropriate quality committees.

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.

The written Quality Improvement Program (QIP) encompasses both clinical care and service activities, involving multiple committees (Quality Improvement Committee (QIC), Clinical Policy and Technology, Clinical Affairs Committee (CAC), Peer Review, and Credentialing) in the improvement process.

The Quality Improvement Committee (QIC) is comprised of the following individuals:	
■ National dental director, Quality Management (Chair)	■ Finance and Underwriting representative
■ Appeals and grievance representative	■ Business Operations
■ Credentialing representative	■ Customer operations representative
■ Growth/marketing representative	■ UMR/UR representative
■ Compliance representative	■ Legal representative
■ Network development representative	■ Government Programs representative

The Clinical Affairs Committee (CAC) is comprised of the following individuals:	
■ National dental director for Quality Assurance/DBP of California dental director (Chair)	■ General counsel
■ Vice president, Utilization Management	■ Dental director, Clinical Coverage Review
■ Vice president, Clinical Government Programs/Rhode Island Dental Director	■ Dental director, Texas
■ OptumInsight director	■ Director of National Clinical Quality Assurance
	■ Director of Clinical Claims Review
	■ Corporate compliance representative
	■ Network dentists

The Credentialing Committee is comprised of the following individuals:	
■ National Dental Director Quality Assurance/DBP of California dental director (Chair)	■ OptumInsight director
■ Vice president, Clinical Government Programs/Dental director, Rhode Island	■ Dental director, Clinical Coverage Review
	■ Dental director, Texas
	■ Dental consultant for Quality Assurance
	■ General counsel
	■ Network dentists (3)

The Peer Review Committee is comprised of the following individuals:	
■ **Dental director, Texas (Chair)** ■ **National Dental Director Quality Assurance/DBP of California dental director (Chair)** ■ **Vice president, Clinical Government Programs/Dental director, Rhode Island**	■ **Dental director, Clinical Coverage Review** ■ **Dental director, Rhode Island** ■ **OptumInsight director** ■ **Director of Clinical Claims Review** ■ **Director, National Quality Assurance** ■ **General counsel** ■ **Network dentists**

Annual quality of care studies and activities such as preparation of the QI Program Evaluation, Description and QI Work Plan as defined by state-specific requirements:

- All data collection and analysis that is due during the year
- Development activities that are new to the internal QI Program are completed during the year, providing performance goals, responsible party, start date, status and completion date
- Key indicators to be reported are also tracked during the year, reviewing performance goals, frequency of reporting, responsible party and responsible committee
- The individuals responsible for the studies and other activities are specified within the QI Work Plan by both name and title
- Additionally, our QI Program description outlines the QI Program structure. This program description clearly outlines:
  - The defined reporting structure, which includes the governing body, the Quality Improvement Committee, Clinical Affairs Committee, Credentialing Committee, Peer Review Committee, Clinical Policy and Technology Committee and any state specific committees as required.
  - Clearly defined roles and responsibilities of the designated senior executive and other clinical staff

The QIC receives regular written reports from Provider Relations, Quality Management and Marketing. It provides information on member and provider satisfaction survey results, recipient complaints, grievances, telephone access, disenrollment, credentialing and preventive health services—all of which are used for developing service improvement projects. The QIC and CAC analyze the information and make recommendations for improvement.

ANNUAL QUALITY IMPROVEMENT EVALUATION AND WORK PLAN

The QIC provides an annual written evaluation of our QIP to the board of directors. This evaluation focuses on strengths and weaknesses, trends/patterns, barriers to improvements and demonstrated accomplishments in improving care and services to recipients.

The committee reviews and revises the QIP for the upcoming year to submit to the board of directors for approval. The work plan incorporates aspects of the annual evaluation, relevant state and federal requirements, indicator requirements and employer requests for monitoring and reporting.

MECHANISMS FOR OVERSEEING PROGRAM EFFECTIVENESS

The national dental director for quality assurance is responsible for monitoring follow-through when clinical and service improvements are identified. We maintain documentation about implementing recommendations of system changes, corrective actions, educational endeavors and overall effectiveness.

We use the QIP to make sure goals are met, gaps in care and service are identified, and improvements are effective. We evaluate the scope, activities, goals and objectives. We trend key clinical and service indicators and note quantitative improvements in care and service, based on the quality improvement initiatives. We evaluate our resources and make recommendations for the coming year.

The annual QIP incorporates findings from the program evaluation; for example, needed improvements, changes in process or structure and follow-up studies, in addition to activities mandated by state and federal regulations and customer expectations. The board of directors reviews and approves the QIP evaluation and annual QIP.

3.9.6.5 Continuous Activity

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

We implement the plan-do-check-act (PDCA) cycle method to conduct and evaluate our QI activities. We use the PDCA cycle to measure and evaluate the continuous performance of our QI activities over time. We use this cycle to:

- PLAN or design baseline or initial QI interventions
- DO or conduct the specific QI interventions
- CHECK or confirm the results of the QI intervention
- ACT or expand on successful QI interventions

We actively use our QIP as the key written description that complements the PDCA process. The QI Work Plan is the foundation document we use to monitor continuous performance of QI activities and to track issues over time.

Our QI staff structure the work plan as a comprehensive listing of ongoing and planned QI activities. We identify the topic for each QI activity, associated performance goals and responsible party (e.g., the director, clinical quality, under the direction of the QIC). Our QI staff members also highlight the start date and completion date for each project and project status (e.g., planning, data collection, data analysis, and barrier analysis, designing actions and implementing actions).

We provide significant detail in the QI Work Plan. Our QI staff, the QIC and task force members review the status of each initiative. We review the QI Work Plan during the year at committee, task force and internal quality-management team meetings. We use our QI Work Plan as the reference document to understand the progress of each initiative and to track issues over time.

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

We require an ongoing review by local, licensed dentists and other health professionals of the process followed in providing dental services. The CAC reviews and approves all clinical practice guidelines, as recommended by the Clinical Policy and Technology Committee, as well as UM decision-making criteria. UnitedHealthcare employed dentists, as well as participating network dentists are part of all meeting committee structures as they are a vital part of our program designs and progress. Dentists and other licensed staff also oversee or have input into all of the health plan's processes and programs including the clinical claims review, disease management and clinical program development, dentist audits, appeals and grievances, quality of care and credentialing/recredentialing, among others.

Clinical policy and procedures are the responsibility of UnitedHealthcare's dental clinical committees. The Clinical Affairs Committee is responsible for:

- Reviewing trends and providing input about network access, dental record documentation, preventive services, credentialing and recredentialing, member complaints and utilization
- Developing criteria and reviewing results of service indicators including annual member satisfaction survey reports and identifying opportunities for improvement
- Reviewing dentist credentialing and recredentialing reports from the Credentialing Committee, appeals from the Peer Review Committee and clinical recommendations on practice guidelines and new technologies from the Clinical Policy and Technology Committee
- Communicating our quality improvement reports, best practices and opportunities for improvement to network dentists
- Reviewing, updating and approving the Quality Improvement Program (QIP) and annual work plan and clinical review criteria annually
- Reviewing and approving revisions to key Quality Management and Utilization Management Policies and Procedures
- Reviewing and endorsing clinical studies/customer reviews, identifying and implementing improvement opportunities

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

Dentists are provided with information through our Provider summary guide, on the dentist web portal, through provider newsletters, letters to providers and through conversations with Network provider representatives and advocates. Information focuses primarily on similar quality processes, as they do for members, provider disputes, appeals, complaints, grievances, and our fraud/waste/abuse program. Additional information is provided on clinical criteria and review requirements, credentialing requirements, information on filing and checking up on claims, record keeping and infectious disease control, access and availability requirements, guidelines for quality of care and service, preventive care guidelines, emergency care requirements and HIPAA. Results of measurements done on Performance Improvement Programs (PIPs) are provided sharing both overall trends and individual provider feedback. We also keep our clinicians informed on pertinent clinical topics (ex. the rise in Emergency Room use for routine dental emergencies, the opportunities in partnering with physicians etc.), new clinical programs and quality improvement projects.

We inform our member services advocates, professional relations directors, regional representatives, network dentists, clinicians and key stake holders. We also may share information with physicians and dental professionals, members, customers and brokers. We provide information on the Web, through newsletters and written materials.

We use a combination of utilization and quality measures in evaluating its dental providers. These measurements are done quarterly in order to track performance over time and provide regular feedback to network dentists. Utilization evaluation looks at dentist performance against their peers in the plan as well as national norms looking for potential overutilization, particularly of restorative and surgical procedures as well as underutilization of preventive procedures. Those found to be over-utilizing receive feedback on their performance which may include a corrective action plan. Not successfully completing the CAP may result in further action which could include termination from the dental network. Cases that are potentially fraudulent are reviewed in partnership with the Payment and Integrity Unit and the UnitedHealthcare Special Investigative Unit (SIU). Results are summarized at the appropriate internal committees, and referred to the appropriate authorities for further action. Annual reports of anti-fraud or abuse activity are filed with the state regulatory agencies as required.

Measures of quality focus on prevention and are based on those developed and implemented by the American Dental Association's Dental Quality Alliance (DQA). DQA Quality Measures are nationally recognized and focus on those preventive procedures that UnitedHealthcare seeks to promote among its dental providers to improve the health of its recipients and to help in meeting Performance Improvement Program (PIP) preventive health targets.

The CAC and other quality-focused committees and subcommittees also provide feedback, review and evaluation of performance and patient health care outcomes to health professionals and health plan clinical staff as related to the care and services provided to recipients.

Our clinical director researches new clinical evidence and existing practice guidelines to initiate development of our own clinical guideline recommendations with input from our clinical staff and our Clinical Policy and Technology and Clinical Affairs Committees (CAC). The Clinical Policy and Technology Committee researches, develops and implements our treatment protocols and new technologies, which are based on principles of evidence-based dentistry. The protocols are endorsed by the Clinical Affairs Committee. Both committees are composed of company leaders, internal clinical staff and network dentists.

New guidelines and recommendations support:

- Clinical claims review
- Claims payment criteria
- Marketing and underwriting
- Benefit addition and modification
- Addition of clinical programs such as those supporting our disease management and wellness programs.

3.9.6.7 Focus on Health Outcomes

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

The IQAP/QI Program methodology addresses health outcomes consistent with existing technology. The methodology used to conduct QI is based upon the development and implementation of interventions to address barriers, re-measurement of data to assess effectiveness of interventions, development and implementation of new interventions, as appropriate and follow-up re-measurement of data to assess effectiveness or sustained impact.

Through this methodology, health outcomes and clinical improvements are monitored and reviewed using the existing the comprehensive data gathered by the Enterprise System. The Enterprise database warehouses gives us access to claims and encounters and demographic information, including race and ethnicity, to create a rich source of data to conduct studies undertaken to measure health outcomes.

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:

We have demonstrated abilities to meet quality assessment and improvement requirements in other Medicaid, Medicare and commercial markets we serve through our IQAP. We have proven processes in place to 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.

3.9.7.1 Specification of Dental Services Delivery Areas 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;

Improved health outcomes for our recipients are the goal of our quality assessment and improvement program. Through continuous monitoring of our recipients using key quality indicators, coupled with the development and refinement of clinical and health service programs, we can address new opportunities to better support quality and appropriateness of care for Nevada recipients and providers. We are certain that we can create a quality framework that embodies DHCFP's vision and objectives and provides a sound basis for assessing the quality and appropriateness of care delivered to our recipients.

To drive clinical and operational performance improvement, our quality management team incorporates ongoing monitoring of critical quality indicators, formal PIPs and compliance with federal and state regulations. Our leaders set short- and long-term performance goals and our quality management team assists them in benchmarking our performance against state and national rates. Our quality management team measures those successes through analysis of industry-standard measures of dental plan quality including, but not limited to, HEDIS measures, EPSDT screening ratios, access and availability data, through clinical evaluations of access and preventive health utilization, and through the feedback we receive as part of compliance audits and provider and member surveys.

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

Nationwide, our health plans fully engage with the annual independent assessments conducted by our state partners and external quality review organizations designated by our regulators. We welcome the feedback we receive because of these independent assessments of the quality of care delivered to our recipients and we appreciate the chance to resolve identified opportunities in the interest of continuously improving our programs. Our goal is always full compliance with all contractual requirements.

We will provide all information required for the external quality review in the time frame and format requested by DHCFP or the EQRO designated by DHCFP. Our goal is to enable verification to maintain fiscally sound contracts, policies and procedures that adequately address quality issues and requirements, provide technical validation of our performance improvement projects (PIPs), and alignment with our adoption, dissemination and adherence to clinical practice guidelines.

We incorporate any findings from the review, including DHCFP's analysis of our grievances and appeals, provider disputes and their independent patient and provider satisfaction surveys into our current QI Work Plan and the annual QI Evaluation, which further informs the development of the QI Program and subsequent year's QI Work Plan. This approach provides the structure to not only address any findings immediately as documented in our current QI Work Plan but also to reflect the findings and monitor for sustained improvement and compliance with DHCFP and EQRO recommendations in upcoming years.

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

As requested, we will provide information regarding projects that were under way during the preceding 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;

We agree to conduct and report on a minimum of one clinical PIP and one non-clinical PIP as directed by DHCFP. We routinely examine the clinical and non-clinical areas where we can most effect change for our recipients, conducting analysis and reporting as often as needed to gauge our performance against industry benchmarks and progress toward our goals. Internal and external processes monitored include:

- Recipient health outcomes or process of care focusing on overall access, preventive health utilization and identification of those at risk for chronic dental disease
- Patterns of utilization focusing on identification of high cost treatments for the management of chronic disease, including hospital based OR and ER services
- Service indicators such as member and provider satisfaction with our dental plan through data from member and provider satisfaction surveys, the grievance and appeals processes, and recipient disenrollment reasons and requests to change providers
- Access, availability and affordability data such as providers' compliance with appointments and networks access
- Other key administrative processes such as call center call volume, abandonment rate, answer timeliness and claims processing turnaround times

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 agree to use the current version of the Conducting Performance Improvement Projects, a Protocol for Use in Conducting Medicaid External Quality Review Activities, Final Protocol as a resource for implementation of the PIPs. This document allows us to confirm the projects are designed effectively to improve processes and, therefore, outcomes.

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;

UnitedHealthcare uses a comprehensive approach to evaluating improvement opportunities, evaluating the effectiveness of interventions and ensuring sustained improvements. Steps include:

- **Baseline Data:** Data are collected and analyzed to establish the current health status of the target population and to point to the specific health opportunity
- **Setting Benchmarks*:*** We establish quantifiable indicators, which clearly and accurately measure the activity being evaluated. Indicators measure changes in health based on the projected intervention. Process and/or outcome measures are established and evaluated as applicable to verify that interventions are being implemented and progressing as planned
- **Development:** After conducting an initial analysis, the Clinical/Quality team develops and implements an intervention(s) known to be effective and suitable to the population selected.
- **Analysis:** A quantitative analysis is conducted to determine if goals/benchmarks have been met. Based upon our review, we perform additional analysis to determine if interventions should continue or if changes need to be instituted. If the PIP was successful, the new processes are standardized and monitored. If the actions were unsuccessful, the Clinical/QA team determines and implements changes that need to be made to the current interventions.
- **Re-measurement:** We conduct re-measurement to determine if improvements are sustained or if new interventions have resulted in improvement. If not, modifications or additional interventions are considered.
- **Monitoring:** Interventions that resulted in improvement are standardized and monitored.
- **Reporting:** Results of PIPs are shared with the Clinical and QA teams in both Dental and where applicable Medical and with outside stakeholders as appropriate, such as network dentists and physicians. Results are also reported to the State as required.

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

We perform an annual evaluation of the Quality Program and QI Work Plan, which subsequently provides recommendations for the upcoming year and to verify that goals have been met and improvements are effective. We focus on the completion of the quality improvement activities and how well we met our goals and succeeded within the scope of our plans. We trend key clinical and service indicators, and document quantitative improvements in care and service that stem from our quality improvement initiatives. We also evaluate our resources and recommendations for the coming year.

The quality improvement program incorporates results from the recent evaluation, including needed improvements, changes in process or structure, or follow-up studies in addition to activities mandated by state and federal requirements and customer expectations.

The written Evaluation includes:

- A description of completed and ongoing quality activities that address the quality and safety of clinical care and the quality of service
- Trending of measures to assess performance in the quality and safety of clinical care and the quality of services
- An analysis of the results of QI initiatives to improve the quality of clinical care and the quality of services to recipients, including barrier analysis
- An evaluation of the overall effectiveness of the QI Program, including progress toward influencing safe clinical practices throughout the network

The Quality Program Evaluation is submitted to the QIC and our board of directors and becomes the basis for the development of the upcoming year's QI Work Plan.

We evaluate our Quality Improvement Program (QIP) in a number of ways, including committee updates and oversight, monitoring by the dental director, evaluating the program annually in an effort to identify gaps in care and/or service and following with improvement opportunities.

The Quality Improvement Committee (QIC) oversees the effectiveness of our quality improvement and preventive health services activities. The Clinical Affairs Committee (CAC) provides quarterly status reports to the QIC and management to evaluate how effectively they were executed. We also share these reports with some customers.

The national dental director monitors follow-through when needed for clinical and service improvements. The director maintains documentation of implementing the recommended changes, corrective actions, educational endeavors and overall effectiveness.

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 continuously monitor and review clinical and service quality utilizing our QI Work Plan as a foundation for program evaluation. The QI Work Plan directs the routine activities under the quality management team and is the basis for our committee activities. Through quarterly updates and subsequent review and approval by the QMC, we verify that the QI Work Plan encompasses all aspects of clinical care, service and operations, and member and provider satisfaction; designates responsible leaders and staff for each identified improvement activity; and includes a time frame for completion and reporting of each activity to the appropriate committee. We assign critical quality indicators, including process and outcomes measures, performance goals and benchmarks to each activity. Each item in the QI Work Plan aligns to a key component of quality as outlined in the Quality Program Description. Our QI Work Plan addresses a broad range of program activities of importance to the health of the populations we serve such as the HEDIS Annual Dental Visit, EPSDT services, preventive health and screening, and member/provider satisfaction. Our QI Work Plan monitors and evaluates important aspects of care and services DHCFP directs including, but not limited to, performance measures and PIPs.

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 are dedicated to the highest standards of integrity and strive to meet and exceed the explicit expectations of DHCFP and the recipients who rely on us for their health care services and agree to cooperate with all state and federal monitoring of our performance.

Overall, we monitor a large number of preventive, outcomes indicators, HEDIS and non-HEDIS alike, for the overall population and for subpopulations within the membership. If we (or DHCFP) identify an area that is not performing as expected in comparison to external and internal benchmarks and performance goals, we perform a barrier analysis to identify ways to improve performance. We use the resulting root cause data to design clinical improvement programs and conduct targeted QI initiatives that can range from informal PDCA cycles and rapid cycle improvement projects through our integrator teams, to more formal focus studies, PIPs or Six Sigma black belt projects. We establish these data-driven programs and interventions to improve performance across identified critical areas, and once implemented, we monitor outcomes and progress toward established clinical performance measures.

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.

We currently implement a comprehensive internal QI Program to collect quality indicators, as described in the Quality Improvement Plan (QIP) and report on the rates based upon these indicators. All of our clinical quality indicators are evidence based from nationally accepted medical specialty organizations, CMS, or state requirements and reviewed by our QIC. Although most mandatory reporting is on an annual basis, the plan has a culture of continuous readiness and part of that process is monthly monitoring of most quality indicators. Quantifiable indicators are reported and discussed at regularly scheduled Clinical Committee meetings. Meeting minutes reflect active discussion and brainstorming on how to increase rates.

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;

We use quality indicators as described in our Quality Improvement Plan (QIP) that are objective, measurable, and consistent with nationally recognized measures supplemented with local knowledge and clinical experience. Key indicators used by us to collect and report on are clinical indicators such as HEDIS Annual Dental Visit rates, preventive health utilization rates as required by the CMS Oral Health Initiative and CAHPS survey results that are standardized and independently audited. All internal quality indicators are consistently measured year-over-year, when possible, to make effective comparisons and maximum impact.

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;

We monitor and evaluate quality of care through studies and PIPs that include:

- Quality indicators specified by CMS with respect to the priority areas selected by the state, intended to focus on overall access and utilization of preventive health services
- Monitoring and evaluating of the quality of care through other internally identified priority areas in addition to the state-required areas
- Continued monitoring of underutilization and overutilization designed to encourage utilization of preventive health services

In addition to mandatory projects and reporting, we initiate internal PIPs to address discovered gaps that if corrected would positively affect our recipients.

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

We regularly monitor the methods we use for data collection and analysis to make certain that any changes needed for intervention strategies and programs can be made quickly and efficiently. We review interim HEDIS data on a monthly basis; for example, to identify any potential gaps that need to be addressed and ensuring data consistency by comparing claims data to alternative sources such as MedMeasures. Internal studies and reviews are subjected to a rigorous data analysis by our internal health care informatics area.

Methodologies are highly scrutinized by QI department staff to confirm that there was a mutual understanding of the data pull and desired output. External auditing vendors are used when required or when needed.

E. 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 have developed systems that identify areas for improvement in health care service utilization and track overutilization, underutilization and inappropriate utilization patterns. We have implemented a multifaceted approach, comprising an oversight structure, policies, processes, data analysis tools and provider outreach programs, which allows us to evaluate member and provider utilization patterns so that we can improve our health plan operations.

Core components of our approach include:

- Monitoring overutilization, underutilization and inappropriate utilization through clinical oversight and integration with quality management. We provide oversight of our program through our clinical leadership team and monitor utilization through integration with our QI department and QI Committee (QIC) structure.
- Identifying overutilization, underutilization and inappropriate utilization through (UM tools and data analysis to identify individuals that may benefit from care coordination, evaluate the effectiveness of care coordination interventions, monitor utilization patterns, identify opportunities for improvement and develop interventions to combat aberrant trends.

Focusing on individual provider performance, we generate and review Provider Report Cards quarterly Provider Report Cards will reveal potential aberrant utilization at the provider level. If significant variation is identified, we can perform a chart audit. We share the results with the dentists with an emphasis on communication and education, although we take corrective action as needed. We also perform clinical assessment and record keeping appropriateness audits as needed. Components of our profiling technology include robust relational databases with real-time, online access to claims data, sophisticated analytical tools, including SAS, data mining and advanced statistical analysis. Our comprehensive data warehouse is available online and in real time to all analysts and clinicians involved in profiling. If fraud, waste and abuse is suspected, the provider is referred to the appropriate internal and State units for follow up.

We can also monitor dentist behavior through the Prior Authorization process. Our dental consultants review flagged procedures and may notice aberrant patterns, which are reported to quality management for follow up.

- Evaluating the efficiency and appropriateness of:
  - Service delivery through the adoption of evidence-based, nationally recognized guidelines and review criteria
  - Our process to determine if a requested procedure, treatment or device meets established medical necessity criteria
  - Ongoing monitoring of utilization metrics that indicate the appropriate use of services
  - Identifying and resolving critical quality of care issues and aberrant practice patterns by tracking, trending and profiling provider-level data using a variety of methods and data sources through our Quality of Care (QOC) Program. Our Peer Review Committee (PRC) monitors these issues and can take a variety of actions to resolve them.
  - Ensuring a high-quality, clinically appropriate, highly efficient and cost-effective delivery system through provider profiling, which identifies opportunities for reducing variation in practice patterns, improves member health outcomes and provides us with a tool to discuss best practices, track practice-level improvements and partner to implement initiatives that improve the quality of care and service provided to recipients.
  - Notifying our Program Integrity Unit and the DHCFP SUR Unit if fraud and abuse is suspected, to determine appropriate action.

Our clinical leadership team continuously monitors our UM Program through our QI department and QIC structure, which includes our UM Committee. The UM Committee, a subcommittee of the larger QIC, collects, monitors, analyzes and evaluates trend and report utilization data to evaluate the ongoing effectiveness of clinical care management interventions, monitor utilization patterns, identify opportunities for improvement and develop interventions to combat aberrant trends that include measurable outcomes so we can determine the intervention's effectiveness. The continuous monitoring of our UM Program includes:

- Collecting quality measures, prior authorizations and claims data and producing reports that provide clinical, QI and UM analyses. This reporting allows us to monitor and evaluate our program related to dental care including identifying overutilization and underutilization of dental care services.
- Clinical leadership team review of UM reporting to verify we provide appropriate, cost effective care and services to our recipients that meet their individual needs.
- Quarterly QIC and UM Committee review and analysis of UM reporting that allows us to detect and correct utilization variances against internal targets and national standards. During these meetings, the committees evaluate and make decisions on UM Program effectiveness and the effectiveness and continuation of programs and interventions.
- Analyzing utilization reporting to make decisions about the effectiveness and continuation of clinical programs and interventions to combat utilization variances. Reports include a description of the utilization variance, the intervention, responsible party, evaluation and recommendations or modifications.
- Our department managers and directors regularly review and analyze reporting, dashboards and scorecards to verify we provide appropriate care and services to our recipients in a cost-effective and cost-efficient manner that meets their individual needs.
- Executive management team review of daily and weekly UM reporting, dashboards and scorecards to evaluate our performance against performance goals.

Our QI department serves as a critical interface between recipients, their representatives, practitioners, providers, the State and other regulators and various health plan departments to identify opportunities for operational improvement and to implement appropriate interventions. UM analysis of quality measures, utilization data, clinical data and claims data helps QI and UM leadership understand trends necessitating further evaluation and identify opportunities for improvement.

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;

A primary objective of our Quality Program is to provide effective monitoring and evaluation of patient care and services provided by contracted providers as compared to the requirements of evidence-based medicine. All strategies are designed to support adherence to delivery standards or practice guidelines specified in the Quality Strategy.

Our four-step process accomplishes this through:

- Review and adoption of national guidelines, confirming applicability to local populations based upon feedback from contracted providers through our Clinical Policy and Technology Committee with endorsement by the Clinical Affairs Committee (CAC).

- Dissemination of clinical and preventive guidelines to all contracted providers and providers whenever we adopt new guidelines or guidelines are updated.
- Monitoring adherence through ongoing measurement of clinical indicators, such as clinical studies and Performance Improvement Projects (PIPs), quality of care issue analysis and focus study findings.
- Review by our Clinical Affairs and Quality Improvement Committees of the results of ongoing monitoring to assess performance and development of improvement programs to address both member and provider barriers.

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

All of UnitedHealthcare's programs are supported by clinical guidelines and evidence based practices. Guideline sources may include the American Dental Association; specialty organizations, such as the American Academy of Periodontology; the American Academy of Pediatric Dentistry and the American Association of Oral and Maxillofacial Surgeons; evidence based clearinghouses, such as the Cochrane Oral Health Group and National Guideline Clearinghouse; American and Federal agencies, such as the National Institutes of Health, the Centers for Disease Control as well as credible international resources such as Britain's National Health Service; evidence based journals, such as the Journal of Evidence Based Dental Practice; and reputable public health benchmarks, such as Healthy People 2020.

The Clinical Policy & Technology Committee, which consists of internal clinicians and participating dentists from a variety of specialties, makes clinical recommendations on practice guidelines and new technologies, based on principles of evidence based dentistry. Much of the Committee's work is in reviewing existing industry guidelines developed and disseminated by organized dentistry and specialty societies such as the American Dental Association. Examples of guidelines adopted include the ADA Evidence Based Guidelines on Topical Fluoride and Pit & Fissure Sealants, the AAPD guidelines on Periodicity and Caries Risk Assessment Tools.

The approved criteria were then reviewed and endorsed by the Clinical Affairs Committee, which oversees the work of the CPTC. Our UM Program description documents the UM guidelines we are using to determine medical necessity and the methods for periodic review and updates.

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

The standards or guidelines we use focus on the process and outcomes of dental care delivery and access to care and address the full spectrum of populations enrolled in our health plan. Guidelines are designed to support our clinical review and claims criteria, our quality management program, clinical disease management and wellness initiatives, underwriting guidelines and both educational and marketing communications to recipients, network clinicians, clients and regulators

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

The CPTC reviews clinical policies developed to support guideline recommendations, the Appropriate Care Criteria and Authorization Guidelines annually, although changes can be made at any time if the state changes the program design, or if other overarching utilization patterns emerge that require a program change. Additionally, the CPTC meets quarterly to consider new developments in evidence-based care, improvements and changes in dental materials and new technology.

Based upon these reviews the CPTC will propose additions or changes to the Appropriate Care Criteria and Authorization Guidelines to the Clinical Affairs Committee. We document the process in written policies and procedures that are reviewed annually by the CPTC and updated as necessary. We will review guidelines and have them accepted in Nevada by our Clinical Affairs Committee or State required Clinical Committee. We will submit any changes to the State for review and approval prior to implementation.

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

The current standards or guidelines from our health plan are included in the Provider summary guide. The Provider summary guide lists each available guideline with a link to the website where the full guidance is displayed. A phone number is also provided for providers who wish to have a hard copy sent to them. Additionally, as each guideline is reviewed or updated, providers are notified in advance of the update via fax blast and again offered the opportunity to call for a hard copy. Recipients and potential recipients are able to view the guidelines on the website or may request a hard copy from our customer service department. Clinical policies are posted on the clinician portal with updates communicated to dentists as they occur.

F. The standard/guidelines must address preventive dental services;

Preventive health standards are based on guidelines recommended by the American Dental Association, American Academy of Pediatric Dentistry and appropriate government agencies such as CMS. These include the AAP's Periodicity recommendations. These standards also support quality measures, Measures of quality focus on prevention and are based on those developed and implemented by the American Dental Association's Dental Quality Alliance (DQA). DQA Quality Measures are nationally recognized and focus on those preventive procedures that UnitedHealthcare seeks to promote among its dental providers to improve the health of its recipients and to help in meeting Performance Improvement Program (PIP) preventive health targets.

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

Our clinical guidelines are applied to all populations managed by our plan. If CMS or the state has specific guidance or coverage positions that guidance is added to our document, either in the form of a National Coverage Determination (NCD), a Local Coverage Determination (LCD) or state language.

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.

Criteria and benchmarks supporting clinical and quality evaluations are based on practice standards/guidelines such as the AAP's Periodicity Recommendations. Through the annual evaluation process, we evaluate the quality of care provided by our health plan's network providers using the clinical practice guideline recommendations. In addition to evaluation of overall plan performance, we use specific provider profiles to evaluate the performance of PDPs on the management of chronic conditions.

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;

UnitedHealthcare has integrated clinical, statistical and analytics experience and expertise to create a comprehensive program for identifying and improving outlier performance on key performance measures of utilization, and billing practices. Components of our profiling technology include robust relational databases with real-time, online access to claims data, sophisticated analytical tools, including SAS, data mining and advanced statistical analysis. Our comprehensive data warehouse is available online and in real time to all analysts and clinicians involved in profiling.

Based on the analytic profiling process, UnitedHealthcare may initiate various investigation and remediation efforts. A formal investigation may be triggered. All analytics, including provider profiles, are based on the data in the warehouse.

A clinician will review the profile results of all flagged Providers with aberrant claims/utilization patterns and determine if further investigation is warranted. If warranted, the clinician reviews additional detailed reports for flagged providers.

The Claim Audit Report details all services provided to all recipients for a specified time interval and allows the reviewing clinician to view the sequence of treatment, and the type and quantity of services by recipient. The combination of these reports enables the reviewing clinicians to determine whether abusive claims/utilization patterns exist, which would trigger a formal Fraud and Abuse investigation.

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;

Quality-of-care investigations are tracked to identify trends or patterns of issues that may be provider-specific or system wide. The designated Peer Review Committee (PRC), which includes a multidisciplinary team of providers representing a range of dental specialties, reviews the trends or identified patterns. Based upon the identified patterns, we may take action to correct individual problems and patterns of problems in the system. We monitor the effectiveness of the corrective action plans to verify the issues have been corrected. This process for investigating quality of care issues also includes the assessment of quality and appropriateness of care furnished to any recipient.

C. Clinical and related service areas requiring improvement are identified;

From the quality-of-care investigation process and the QI process previously identified, we identify clinical and related service areas requiring improvement. We create action plans to address the improvement area, including the performance of a detailed barrier analysis, review of literature and best practices and recommended actions from the QIC or task forces.

We allow access to the DHCFP of any of the dental plan's clinical analyses, when available and appropriate.

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

We will work collaboratively with the DHCFP to determine recipient race and ethnicity. We understand that the state may issue routine reports that identify the recipient race and ethnicity, and we are fully prepared to use that data to determine disparities among various clinical areas in addition to designing interventions to then reduce or eliminate those identified disparities.

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

We agree to allow DHCFP access to clinical studies upon request.

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.

We maintain the quality assurance structure and processes that support the retrospective monitoring and problem-solving associated with the quality of care delivered to plan recipients, including investigation, peer review and implementation of corrective action, as needed, up to and including termination of their contract with the dental health plan. All processes and procedures are documented in formal policies approved by the PRC and other appropriate plan representatives.

3.9.8.5 These written corrective action procedures must include:

A. Specification of the types of problems requiring corrective action;

We take action to correct both provider specific and system wide patterns of quality of care issues in the delivery system. We have a process in place that defines both the types of issues requiring corrective action and the suggested corrective actions.

UnitedHealthcare uses a combination of utilization and quality measures in evaluating its dental providers. These measurements are done quarterly in order to track performance over time and provide regular feedback to network dentists.

UnitedHealthcare has integrated clinical, statistical and analytics experience and expertise to create a comprehensive program for identifying and improving outlier performance on key performance measures of utilization, and billing practices. Components of our profiling technology include robust relational databases with real-time, online access to claims data, sophisticated analytical tools, including SAS, data mining and advanced statistical analysis. Our comprehensive data warehouse is available online and in real time to all analysts and clinicians involved in profiling.

Based on the analytic profiling process, UnitedHealthcare may initiate various investigation and remediation efforts. A formal investigation may be triggered. All analytics, including provider profiles, are based on the data in the warehouse.

Utilization evaluation looks at dentist performance against their peers in the plan as well as national norms looking for potential overutilization, particularly of restorative and surgical procedures as well as underutilization of preventive procedures. Those found to be over-utilizing receive feedback on their performance which may include a corrective action plan. Not successfully completing the CAP may result in further action which could include termination from the dental network. Cases that are potentially fraudulent are reviewed in partnership with the Payment and Integrity Unit and the UnitedHealthcare Special Investigative Unit (SIU). Results are summarized at the appropriate internal committees, and referred to the appropriate authorities for further action. Annual reports of anti-fraud or abuse activity are filed with the state regulatory agencies as required.

Measures of quality focus on prevention and are based on those developed and implemented by the American Dental Association's Dental Quality Alliance (DQA). DQA Quality Measures are nationally recognized and focus on those preventive procedures that UnitedHealthcare seeks to promote among its dental providers to improve the health of its recipients and to help in meeting Performance Improvement Program (PIP) preventive health targets.

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

The final decision concerning appropriate corrective actions for specialty care such as dental related quality of care is made by the dental director (as applicable) or our PRC, as appropriate.

Dental corrective actions are monitored on a quarterly basis by the provider services department to verify implementation and completion of actions within the established time frames.

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

In cases where the PRC has determined it is necessary to take adverse professional review action against a practitioner, we afford the affected practitioner the termination review process described in the Practitioner Appeal Process policy. (For purposes of such termination review process, an "adverse professional review action" is an action or recommendation that is based upon the competence or professional conduct of the affected practitioner and that has the effect of suspending, limiting or terminating the affected practitioner's participation in our network.)

To promote coordination with our credentialing process, a report is forwarded to the Credentialing Committee chair for review and determination if the Credentialing Committee needs to considers a provider.

We flag provider files for special review and refer them to the credentialing committee if they exceed the following thresholds:

- Five complaints per re-credentialing period in this contract
- Three complaints in favor of member per re-credentialing period
- Three or more quarters of outlier utilization patterns as documented by the Provider Profile report

The credentialing committee will review the files and make a determination on whether to keep the provider in the network. We use the same process for notifying the provider of a determination decision as we use for the initial credentialing.

The credentialing department also performs ongoing monitoring of bi-monthly reports from the Office of Inspector General (OIG) and the Nevada State Board of Dental Examiners website to identify expired licenses and sanctions imposed against providers. In addition, we continue to monitor providers for issues of substandard professional conduct and competence. The credentialing committee reviews the data and determines whether providers should be terminated from the network.

We will report to the credentialing department when a provider is denied network provider status. Such denial can include when a provider is denied admission to the contractor's provider panel, is removed from the contractor's panel, or voluntarily withdraws from the panel when the denial, removal, or withdrawal is due to a substantive issue. Substantive issues include violations of the Department of Occupational and Professional Licensing's regulations, and allegations of fraud, waste or abuse.

We will electronically submit information relating to the non-inclusion of providers to the credentialing department within 30 calendar days of the non-inclusion action using the department-specified form. We will not report non-inclusion of providers when due to non-substantive issues.

D. The schedule and accountability for implementing corrective actions;

Our PRC and/or the dental director with quality oversight or dental director are accountable for implementing the schedule for the corrective actions of individual providers. Our dental director validates that the provider implements a corrective action plan (CAP) according to the committee's recommendations and completes the needed actions on time. The schedule for completion of the corrective action plan is dependent upon the action assigned and the severity of the offense. We present the results of the corrective action plan to the PRC for additional review and action, which may include escalation of the CAP or termination of the physician's participation in the network.

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

Upon completion of corrective action, our provider services department continues to monitor quality of care complaints filed against the identified provider. We may also conduct a focused audit to determine the effectiveness of corrective action. This information is forwarded to the dental director for his/her determination of decline or cessation of the related issue.

In cases where the established corrective action does not appear to have been effective, the dental director presents the issue(s) to our PRC for recommendations for further action. Such action may include, but not be limited to counseling, focused review or restriction/suspension/termination.

For system wide policy and procedure changes, our quality of care department assesses the effectiveness of system modifications through monitoring of quality of care complaints.

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

We review and may terminate dentists who do not meet our standards, do not follow our policies and procedures, have consistent aberrant practice patterns, or consistently receive validated complaints. If we find evidence of fraud, we notify the appropriate state dental board or, if the dentist treats Medicare or Medicaid patients, the office of the inspector general or the state attorney general.

We immediately send the dentist a letter outlining the issues that must be addressed. We provide a corrective action plan based on the audit findings, which may include recovery of overpayments and other disciplinary actions. We explain to the dentist what procedures must be implemented to comply with our standards.

The dentist must respond within 30 days. The response must include a description of the action taken in response to the corrective action plan, including the date implemented and the dentist's signature. The response is reviewed to ensure appropriate compliance. If a dentist has not appropriately responded, additional steps will be taken up to and including termination.

The Peer Review Committee reviews all cases that meet one or more of the grounds for termination. The committee reviews the dentist narrative and evaluates each case on its own merits. The committee has the right to accept, suspend, un-publish, place a dentist on probation, require a corrective action in lieu of termination or terminate the dentist. We notify dentists prior to a final decision by the Peer Review Committee. Dentists may appeal decisions in writing within 30 days of notice.

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.

We implement and submit a Plan of Correction (POC) to provide feedback and realign providers to generally accepted medical practice. Depending on the POC issued, multiple avenues of monitoring and evaluation occur.

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

Once the initial activity is complete, our PRC and supporting quality of care staff continue to monitor for a length of time, again, depending on offense and severity. Last, there is a final verification of practice patterns to confirm actions for improvement have been effective and permanent. If improvement is not in evidence, additional interventions are considered by the PRC up to and including termination from the network.

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;

We conduct an Annual Evaluation of the content and scope of our internal QI Program to address all required services and to ensure that we are meeting our required metrics. The program evaluation documents and tracks the completion of QI studies, trending of quality and service indicators and other performance data, demonstrated improvements and any areas in need of improvement. We perform a formal evaluation of the overall effectiveness of the internal QI Program annually that includes a review of all types of services, in all settings, inclusive of all recipients. The appropriate clinical committees and the board of directors reviews the Evaluation and upon approval, it is submitted to the DHCFP for review.

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

As required by DHCFP, our annual QI Evaluation includes quality assurance studies and other completed activities; 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. These State requirements are manifested in the collection, review and written analysis of performance indicated by the following data elements:

- A thorough population analysis based upon validated claims and encounter data
- Detailed HEDIS Annual Dental Visit rates, with trending over at least three years, including age and geographic analysis for the Medicaid population
- Barriers, interventions and goals for selected clinical indicators and measures, including those focusing on overall access as well as preventive health utilization
- Overutilization and underutilization analysis
- Prior authorization metrics
- Member appeals and grievance data

- Cultural and linguistic information used to analyze the needs of our recipients' diversity
- Member services department statistics including hold times, abandonment rates and first call resolution, as well as claims turnaround times.
- Detailed appointment and access availability data

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

We will provide an executive summary at the beginning of the QI Evaluation, summarizing the effectiveness, continuity, consistency and acceptability of the internal QI Program for the board of directors. We highlight significant improvements to the care delivered to our recipients, focusing on improvements in overall access and preventive health utilization. Quality improvement leadership evaluates any areas of deficiency and presents them to the QIC or appropriate subcommittee. The appropriate committee approves recommendations for corrective action plans, either internal or external, and follow-up is scheduled to ensure CAP compliance is completed in subsequent meetings.

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:

The ultimate accountability for the QI Program rests with our board of directors. The board of directors is our governing body and is responsible for formulating the vision and strategic goals, promoting effective and efficient executive management performance and promoting quality of the health care and services provided to recipients. The board's functions as they relate to the QI Program include:

- Review, evaluate and approve our QI Program description, annual Evaluation and QI Work Plan
- Review and evaluate periodic reports from the QI Program delineating actions taken and improvements made
- Review and evaluate summary key indicator reports, study updates, results of member surveys and clinical initiatives to include an analysis of significant trends, variations and action plans
- Direct the operational QI Program and take action as appropriate based upon the review of reports and updates

3.9.9.1 Oversight of IQAP

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

Our board of directors meets at least quarterly and has ultimate responsibility for the QI Program and related processes and activities.

Each quarter, our board of directors reviews and approves internal QI status reports. Minutes from board meetings document the approval of the three annual QI reports and quarterly status updates. Documentation is maintained in the office of the CEO, who is a member of the board of directors.

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.

Our board of directors is responsible for the quality of care and services provided to our members. The board delegates oversight of the operational components of the Quality Improvement Program (QIP) to the Quality Improvement Committee (QIC). The board receives quarterly reports at their meetings.

Each year, the board of directors reviews the quality improvement plan written report for the concluding year and approves it for the coming year.

COMMITTEE STRUCTURE

QUALITY IMPROVEMENT COMMITTEE (QIC)

The QIC has overall responsibility for both clinical and operational quality and oversees quality improvement, utilization management, credentialing, members' rights, dental records and preventive health services. The QIC meets at least quarterly to plan, monitor and evaluate the quality and appropriateness of health care services provided to our members.

Their responsibilities include the following:

- Peer review committee results
- Utilization review activities
- Endorse performance benchmarks and goals
- Review and evaluate results of quality assessment indicators, performance measures and studies
- Receive reports from quality improvement project teams, approve action plans and follow up to ensure action plans are effective
- Review and make recommendations from member satisfaction surveys
- Receive Clinical Affairs Committee (CAC) minutes
- Design and implement corrective actions to achieve resolution of identified deficiencies
- Establish the QIP based on corrective actions, performance improvement goals and follow-up studies
- Systematically monitor the indicators and important aspects of care

CLINICAL AFFAIRS COMMITTEE (CAC)

The CAC has overall responsibility for clinical quality and consists of plan dentists and contracted network dentists who provide input on clinical issues to the national dental director and to the Quality Improvement Committee.

Their responsibilities include the following:

- Provide input to the QIC on network access, dental record documentation, preventive services and other clinical initiatives, credentialing and recredentialing, member grievances and appeals, member and provider satisfaction and utilization monitoring
- Review and identify opportunities for improvement, based on the results of network quality measurements, including annual member satisfaction survey reports, appeals and grievance statistics
- Communicate with network dentists about our quality improvement reports, best practices and improvement opportunities
- Review and accept the adoption of new technologies and dental procedures, including recommendations for new or modified benefits and services

Credentialing Committee

The Credentialing Committee consists of plan and network dentists.

Their responsibilities include the following:

- Review to accept or deny new providers, and recredential existing providers
- Review individual dentists who meet special review criteria, including, but not limited to: malpractice reports, state board actions and sanctions, Federal sanctions
- Provide oversight of delegated credentialing

Peer Review Committee

Their responsibilities include the following:

- Make determinations for providers who appeal a Credentialing Committee decision
- Make determinations on quality of care grievances and cases suspected of potential fraud and abuse
- Review and make recommendations of dentists that require peer review based on utilization management, quality management or other quality indicators

Clinical Policy and Technology Committee

The Clinical Policy and Technology Committee researches, develops and implements recommendations on clinical guidelines and new technologies based on principles of evidence based dentistry.

Their responsibilities include the following:

- Make evidence-based recommendations on practice guidelines and new technologies based on scientific research meeting the highest levels of evidence available, as well as the recommendations of recognized experts such as organized dentistry, specialty societies and government organizations
- Ensure recommendations are available to dentists online as well as through our provider newsletter and the Provider summary guide
- Use recommendations as the foundation for clinical policy and coverage determinations as well as for the basis of new benefits and programs(including our condition management and wellness initiatives), utilization review and claims criteria, underwriting and marketing materials

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.

Each quarter, the board of directors receives written reports from the internal QI Program. The National Dental Director for Quality Assurance attends the board of directors meetings and presents updates to ongoing activities and measures and results of completed initiatives. In addition, a description of new projects including resources needed to complete the project, anticipated results and resources needed, if any. When new initiatives are approved, feedback from the board is considered and amended to the project if appropriate.

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:

Each year, our board of directors and our QIC formally review the annual QI Program Evaluation which is submitted to the DHCFP in the second calendar quarter of each year.

A. Studies undertaken;

A written report summarizing the activities of the health plan over the past calendar year, including studies and clinical initiatives will be submitted on a yearly basis.

B. Results;

The results will be submitted at requested by DHCFP.

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

The studies will include results of any subsequent actions and aggregate date on the results of specific clinical initiatives, patterns of utilization and quality of services.

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

The annual Evaluation is an assessment of the QI Work Plan activities to determine the continuity, effectiveness and current acceptability for continued use.

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.

The board of directors and QIC minutes are recorded at each meeting and reflect key discussion topics, discussion, recommendations, decisions, scheduled actions, responsible party, due date and status. All action items are addressed and the status is reported back to the board of directors and QIC during subsequent meetings. Direction and feedback are considered and adopted from both groups, particularly when presented with project updates or new projects and additional information is needed. Ineffective pilot or limited projects are altered or discontinued at the direction of the board of directors or QIC when indicated.

3.9.10 Active QA Committee

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

Our Quality Improvement Committee (QIC) has overall responsibility for clinical and operational quality and oversees the effectiveness of our quality improvement activities and health management programs nationally. The committee plans and coordinates network-wide improvements in quality of care and services in order to meet customer expectations, as well as to enhance and improve the health of our members.

This committee:

- Designs, oversees and evaluates quality improvement activities and health management programs
- Endorses performance benchmarks and goals
- Receives reports from quality improvement project teams, approves action plans and follows up to ensure actions are effective
- Reviews reports on patient care indicators
- Annually reviews quality improvement effectiveness
- Provides member and provider satisfaction surveys for improvement opportunities
- Reviews provider network trends
- Reviews minutes and activities of the Clinical Affairs Committee (CAC)

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.

At least quarterly, the QIC meets to oversee the internal QI Program activities. The occurrence of committee meetings increases in frequency as needed to conduct follow-up and review of findings and actions.

3.9.10.2 Established Parameters for Operating

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

The role, structure and functions of the QIC and related task forces and subcommittees are specified. They include:

- A clearly defined reporting structure, which includes the governing body, the QIC, Clinical Affairs Committee, Credentialing Committee, Peer Review Committee, Clinical Policy and Technology Committee and any state mandated committees (updated as necessary)
- Clearly defined roles and responsibilities of the designated senior executive, dental director
- Active participation of plan providers
- Dedicated resources
- Documentation of committee actions and QI activities, including meetings, monitoring and analysis of quality indicators and QI study results, and communications with providers and members about program policies
- The implementation of QI and quality of care programs and associated methodologies

3.9.10.3 Documentation

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

Documentation of quality activities is essential to the improvement process. Committee minutes, whether from the larger QIC or the subcommittees, are carefully crafted to include important discussion points, next steps, due date and accountable person. Each subcommittee reports to our QIC at least twice a year and projects are referred to the larger body, if needed.

Once a year, the annual Evaluation is crafted to include the previous year's activities in detail including quality of care and quality of service monitoring and clinical outcomes. The QI Program description describes the structure of the plan quality functions and is carefully reviewed, updated and approved by the QIC and the board of directors annually.

Meeting minutes and previous versions of annual documents are carefully stored for easy access and are available to the State upon request.

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.

Internal QI Program subcommittees are accountable to the Governing Board via semiannual reports to the larger QIC. QIC activities are reported to the board each quarter along with QI 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.

Active participation by providers who represent the network of providers in a variety of specialties is integral and vital to our dental health plan's Internal QI Program. Providers are invited to participate to provide insight and guidance into the services and needs of the recipients.

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 national dental director for quality assurance is the quality management chair and is the designated senior executive responsible for IQAP implementation. Our chief dental officer will have responsibility for overall clinical strategy, including clinical programs for our commercial customers, clinical policy and managing customer clinical relationships. This includes clients, clinicians, regulators and our internal clinical and operational teams. The chief dental officer will provide clinical leadership for our clinical directors.

In addition, we have various director positions that will provide support, data and resources for IQAP implementation.

Utilization management director: Our utilization management director oversees our clinical cost management program, including utilization review (professional claims review), health care affordability, fraud and abuse and our profiling program.

Quality management director: Our quality management director oversees our quality assurance program, clinical regulatory and compliance, and the majority of our committees including Quality Improvement, Clinical Affairs, Credentialing and Peer Review.

Clinical Government Programs director: Our government programs manages all customer clinical aspects of government dental programs and serve as the clinical liaison with Community and State market leadership, state dental directors, government officials, regulators and our internal clinical and operational teams.

Our clinical directors are supported by clinical consultants who provide clinical support to our internal departments, and offer clinical input in their areas of expertise.

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.

Our internal QI Program has a full time director and staff members designed to support all quality improvement activities. The QI team is supported by other functional areas at UHC including Utilization Management, Government Programs, Networks, Member Services and Claims.

3.9.13 Provider Participation in IQAP

We include internal providers as well as participating network providers in a variety of specialties as part of our key stakeholders who participate in developing, implementing and evaluating our dental quality improvement program.

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 summary guide.

To keep our participating providers well informed about our QI Program and our quality activities, we communicate with them through multiple avenues:

- We post on our provider portal our annual Provider summary guide, including a dedicated QI Program summary to all participating physicians and other providers. We also publish the Provider summary guide on the provider section of our website so that providers have easy access to this information at all times. Additionally, dentists are immediately informed of changes to policies and guidelines, which are posted on the UHC clinician portal.

- We ask and receive input and feedback from our network providers during all QIC and task force meetings. We also provide the QI contact telephone number for feedback in all provider newsletters, and on the website.

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.

Our contract specifically includes language that states that hospitals, physicians and other providers shall cooperate with administrative, claims, quality management and managed care programs as may be published in policy statements, newsletters and other communications.

We also state that our providers should deliver quality customer service and cooperate in UM, clinical quality assessments, administrative services, access to health care services, and information systems. We also include in its contracts that our providers cooperate with credentialing and recredentialing.

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

Our contract includes language that providers must allow access to records of our recipients. We require that providers and other vendors provide medical records in relation to a quality-of-care related complaint within a defined period, usually 72 hours. We also require that providers provide us access to their medical records for other IQAP activities such as HEDIS data collection and other clinical quality improvement projects and initiatives.

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:

We currently do not delegate any IQAP activities; however, we do have a process in place if we should ever delegate for IQAP activities in compliance with Section 3.9.14.1 (A.-C.). We have a written procedure for monitoring and evaluating the implementation of the delegated functions, verifying the actual quality of care and providing evidence that there is continuous and ongoing evaluation of delegated activities through specified and routine reports. We remain accountable for our internal QI Program functions even if certain functions are delegated to other entities. In the case that activities are delegated, we have a policy and procedure in place to make certain there is a written description of delegated activities and the crosswalk of accountability for the dental plan and the delegate.

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

We currently do not delegate any IQAP activities; however, we do have a process in place if we should ever delegate for IQAP activities in compliance with Section 3.9.14.1 (A.-C.).

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

We currently do not delegate any IQAP activities; however, we do have a process in place if we should ever delegate for IQAP activities in compliance with Section 3.9.14.1 (A.-C.).

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.

We currently do not delegate any IQAP activities; however, we do have a process in place if we should ever delegate for IQAP activities in compliance with Section 3.9.14.1 (A.-C.).

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:

We maintain a comprehensive credentialing process to verify the professional credentials of all contracted dental providers. The plan contracts with a NCQA Certified Credentialing Verification Organization (CVO) to assist in the required data collection to complete the credentialing, (and recredentialing) process. Recredentialing of all contracted providers is done on a three year cycle unless otherwise required by state regulation.

All participating providers undergo a careful review of their qualifications including, but not limited to, license status, education, training (including specialty training), work history, malpractice history, health status and state or federal sanctions. Providers must successfully complete the credentialing review process and be approved by our Credentialing Committee prior to being offered network participation or to continue participation in our provider network. This rigorous credentialing process ensures that qualified health care professionals provide recipients with quality services and coordinated care.

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.

We have a uniform documented process of written policies and procedures, which outline the credentialing process as well as the subsequent recredentialing process in detail. The credentialing and recredentialing policy is extensive and is compliant with Nevada Administrative Code 679B.0405, which requires use of Form NDOI–901 when credentialing providers. We will maintain this policy, thereby complying with the standards set forth in this section.

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.

We will allow DHCFP and/or its contracted EQRO to inspect our 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.

Our board of directors delegates all operational aspects of the credentialing and recredentialing of providers to our Credentialing Committee with oversight by the Clinical Affairs Committee. Our Credentialing Committee reviews and approves all changes to the credentialing and recredentialing policy as needed throughout the year to ensure continued compliance with processes, policies and requirements mandated by state, federal and accrediting agencies. Policy changes are reviewed and adopted during the monthly credentialing committee meetings. Additionally, UnitedHealthcare's Professional Networks Department provides quarterly reporting which outlines the volume and processing time frames of credentialing and recredentialing files processed for the previous quarter.

3.9.15.3 Credentialing Entity

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

Our credentialing and recredentialing processes fall under the purview of our Credentialing Committee, and supervised by the Clinical Affairs Committee. The Credentialing Committee is a multidisciplinary committee with representation from various types of providers, including general dentists and specialists. The Credentialing Committee is responsible for development, review, approval and implementation of all credentialing policies and procedures. The Credentialing Committee also conducts the review of individual credentialing files and has the full authority to make credentialing and recredentialing decisions regarding the approval or disapproval of providers.

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.

Our Credentialing Committee has defined standards outlined in our policies and procedures identifying the specific providers that require credentialing/recredentialing review. Our policies delineate practitioners as licensed independent health care professionals who diagnose, treat, prescribe and provide dental services to our recipients.

Providers are initially credentialed and then recredentialed every three years.

We typically handle initial credentialing internally according to NCQA guidelines, Centers for Medicaid and Medicare Services (CMS), and any state-specific credentialing standards.

We collect the appropriate documentation, verify the practitioner's credentials, and the Credentialing Committee makes the decision. Our leased networks and some individual offices conduct their own credentialing verification in accordance with our standards. We perform oversight to ensure this delegated process matches our own.

A complete credentialing application package includes:

Completed application: Can be the Council for Affordable Quality Healthcare (CAQH) application, a state-mandated application, or our standard company application.

Education & Work history: Work history/Curriculum vitae (CV) for the last five years; dental school and graduation year; specialty program and graduation year and board certification (if applicable).

Malpractice information: A copy of the dentist's malpractice fact sheet and any malpractice or adverse actions explanations (if applicable).

Attestation and State licenses: The attestation must be signed and dated and we must receive copies of all state licenses.

DEA / CDS information: Federal Drug Enforcement Administration (DEA) certificate or Controlled Dangerous Substance (CDS) certificate or registration, if applicable.

Our credentialing department (or an NCQA-accredited credentials verification organization [CVO]) conducts primary source verification (PSV). All items must be verified except any static historical elements. Verifications may not be older than 180 calendar days when given to the Credentialing Committee for a decision. We use the following sources:

- The National Practitioner Data Bank
- Office of the Inspector General (OIG)
- State professional licensing board
- State specific Medicare/Medicaid Opt Out Reports
- Dental schools; and specialty programs/boards

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.

Confirmed.

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

Confirmed.

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

Confirmed.

D. Work history.

Confirmed.

E. Professional liability claims history.

Confirmed.

E. The practitioner holds current, adequate malpractice insurance according to the vendor's policy.

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

J. 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.

Confirmed.

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;**

   Confirmed.

2. **Any history of chemical dependency/ substance abuse;**

   Confirmed.

3. **History of loss of license and/or felony convictions;**

   Confirmed.

4. **History of loss or limitation of privileges or disciplinary activity; and**

   Confirmed.

5. **An attestation to correctness/ completeness of the application.**

   Confirmed.

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

M. 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.

We may require an initial facility site review before the credentialing file can be approved by the dental director or sent for review by the committee (one visit for each facility). The site visit tool includes a site's accessibility, appearance, space, languages spoken, special needs availability, adherence to infection control, medical or dental recordkeeping practices, availability of appointments, and confidentiality procedures.

N. 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.

Our policies are compliant with the DHCFP requirement that we notify our offices within 15 calendar days of the determination to deny a Medicaid provider credentialing or recredentialing due to concerns about provider fraud, integrity or quality. Similarly, we must notify within 15 calendar days if the Credentialing Committee de-credentialed, terminated or disenrolled a provider due to suspected criminal actions, or disciplinary actions related to fraud or abuse.

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:

Network dentists are recredentialed every three years according to NCQA standards, or according to state and federal requirements. We begin the recredentialing process six months prior to the three year target date to ensure that the providers meet the three year cycle. Aperture, a NCQA-certified credentials verification organization, reviews and conducts primary source verification. We maintain recredentialing information in each provider's file.

We incorporate appraisal of professional performance, judgment and clinical competence into the recredentialing process for all dentists irrespective of their specialty.

We review the following at recredentialing: member complaints; results from provider site reviews, utilization management profiles, and information from other licensing and accreditation agencies.

The credentialing department reviews data from its internal inquiry system regarding member complaints and quality of care reviews. Provider files will be flagged for special review and referred to the Credentialing Committee if they exceed the following thresholds:

- Five grievances per recredentialing period
- Three grievances in favor of member per recredentialing period

We have an ongoing monitoring process between recredentialing cycles to ensure continued compliance with credentialing standards. We track expired dental licenses, Medicare/Medicaid sanctions, and issues of substandard professional conduct and competence. The credentials verification organization (CVO) provides twice per month reports from the OIG website and state licensing websites for lists of sanctions imposed against providers, or for expired licenses, when it is required by the state. The Credentialing Committee reviews the data and decides whether providers should be terminated from the network.

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

Confirmed. Our credentialing cycle is completed every three years.

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.

Confirmed.

C. The recredentialing, recertification or reappointment process also includes review of data from:

1. **Recipient grievances and appeals;**

   Confirmed.

2. **Results of quality reviews;**

   Confirmed.

3. **Utilization management;**

   Confirmed.

4. **Recipient satisfaction surveys; and**

   Confirmed.

5. **Re-verification of current licensure, if applicable.**

   Confirmed.

D. If the vendor de-credentials, terminates or dis-enrolls a provider the vendor must inform the State within 15 calendar days. If the de-credentialing, 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.

Our policies are compliant with the DHCFP requirement that we notify their offices within 15 calendar days of the determination to deny a Medicaid provider credentialing or recredentialing due to concerns about provider fraud, integrity or quality. We also comply with the requirement that will notify them if the credentialing committee de-credentialed, terminated or disenrolled a provider due to suspected criminal actions, or disciplinary actions related to fraud or abuse.

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.

Our policies and procedures related to delegation certify that the delegated credentialing activities are conducted in a manner that complies with our standards, NCQA standards and any other related state or federal requirements. Our policies include written descriptions regarding:

- Performing pre-delegation assessment activities (reviewing prospective delegate materials, reviewing on-site review of prospective delegates' credentialing operations)
- Determining the delegation by the Credentialing Committee
- Executing a delegation agreement, which includes our responsibilities of and those of the delegated entity, scope of delegated activities, type and frequency of reporting
- Our monitoring and performing oversight activities
- Performing Corrective Action Process and Procedures (as appropriate)

We do not delegate credentialing and recredentialing processes.

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.

We have extensive experience in credentialing and recredentialing services. Our credentialing policies outline the processes and procedures for the suspension, reduction or termination of practitioners and/or facilities. The established policy has written criteria by which the credentialing committee may disapprove a provider. Further, the policies clarify the avenues of appeal that are afforded to the affected provider(s).

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.

Our policies are compliant with the DHCFP requirement that we notify the provider's office within 15 calendar days of the determination to deny a Medicaid provider credentialing or recredentialing due to concerns about provider fraud, integrity or quality. Similarly, if the Credentialing Committee de-credentials, terminates or dis-enrolls a provider due to suspected criminal actions, or disciplinary actions related to fraud or abuse, we would follow the same DHCFP-approved process.

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.

We currently maintain policies and procedures that establish the process and requirements for provider disputes and appeal rights pertaining to denying, suspending or terminating a provider's credentialing privileges by the Credentialing Committee. The policy specifically includes written processes regarding the following:

- Notice to the provider of adverse professional review action
- Pre-hearing process
- Hearing panel
- Presiding officer
- Conduct of hearing, burden of proof and failure to appear at hearing
- Post hearing process

If the hearing panel upholds an adverse decision, our policies also include processes regarding the timely notification to the Peer Review Committee, the Network Development and Contract department, the appropriate licensure board, the National Practitioner Databank, the DHCFP and other appropriate state or federal entities.

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.

Our recipients' rights and responsibilities policy includes at a minimum those enumerated in 3.9.16.1., A through I below. Upon enrollment, each recipient receives a member handbook that contains detailed information about being an active partner in their health care by understanding their rights and responsibilities.

Specific patient rights language informs patients that they have a right to:

- Get information regarding your rights and responsibilities
- Be treated with respect and dignity by UnitedHealthcare—DHCFP personnel and network dentists and providers without regard to your race, national origin, and gender, age, and sexual orientation or religious affiliation.
- Privacy and confidentiality for treatments, tests or procedures you receive and all records and communications to the extent required by law.
- Voice concerns about the service and care you receive.
- Register complaints and appeals concerning your dental plan or the care provided to you.
- Receive timely responses to your concerns.

- Participate in candid discussions with your dentist about appropriate and medically necessary treatment options for your child's conditions, regardless of cost or benefit coverage.
- Be provided with access to dental care.
- Obtain a second medical opinion for dental and surgical procedures.
- Participate with your child's dentist and other caregivers in decisions about their care.
- Refuse treatment and not have it affect your child's future treatment.
- Make recommendations regarding the organizations recipient's rights and responsibilities policies.
- Receive information about UnitedHealthcare—our services and network dentists and providers.
- Be informed of, and refuse to participate in any experimental treatment.
- Have coverage decisions and claims processed according to regulatory standards.

Further, to help foster engagement among recipients, we present the same information on the member website and distribute in our newsletter. We mail newsletters the first month of every quarter and send supplementary postcards during the following two months, on a three-year rotational basis.

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;

Confirmed.

B. To be provided with information about the vendor, its services, the practitioners providing care, and recipients' rights and responsibilities;

Confirmed.

C. To be able to choose their primary Dental care practitioner;

Confirmed.

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

Confirmed.

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

Confirmed.

F. To formulate advance directives;

Confirmed.

F. 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;

Confirmed.

G. 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

Confirmed.

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

Confirmed.

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:

Our plan has added responsibilities to encourage the recipient to fully participate in his/her plan and to benefit the community including:

- Know and confirm your dental benefits prior to receiving treatment.
- Contact an appropriate health care professional when you have a dental need or concern.
- Show your dental ID card before receiving dental services for your child(ren).
- Keep scheduled appointments or call the dentist 24 to 48 hours before the scheduled appointment to cancel.
- Provide information needed for your child's care.
- Follow agreed-upon instructions and guidelines of dental and health care professionals.
- Participate in understanding your child's dental problems and developing mutually agreed upon treatment goals.
- Use emergency room services only for an injury or illness that, in the judgment of a reasonable person, requires immediate treatment to avoid jeopardy to life or death.
- Notify your local Medicaid office of changes in name, address, telephone number, family status or if you have other insurance coverage.
- Know what benefits and which providers are covered by UnitedHealthcare and which are not.

- Call Member Services when you have questions about your child's eligibility, benefits, claims, and more.
- Call Member Services to verify that your child's dentist is participating in the Nevada Dental Medicaid network before receiving services for your child.

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

Confirmed.

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

Confirmed.

C. Recipient obligation to participate in their health care decisions; and

Confirmed.

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 hours ahead of scheduled appointment, report provider fraud/abuse, provide feedback on recipient needs and expectations, etc.

Confirmed.

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.

As part of our ongoing network management activities, we maintain a provider summary guide, which contains important information for our contracted network providers. This tool is used to communicate and share policies and process such as provisions pertaining to recipients' rights and responsibilities.

Our provider summary guide is available to all providers on our website. We update the provider annually and throughout the year to confirm the most current and up-to-date information is available to our provider network.

When providers join our network, they receive an introductory letter, instructions on where to access the provider summary guide and an executed contract.

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.

We focus on communicating clearly. Upon enrollment, each recipient receives a copy of our member handbook, which contains a written statement that includes information on recipients' 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:

Our grievances, appeals and State Fair Hearing processes are included in our internal quality assurance program (IQAP) through which our trending results are reported and analyzed. We monitor grievances and appeals reports twice daily to attain compliance with DHCFP requirements and report results monthly to the Medicaid Compliance Committee, annually to IQAP and quarterly to our board of directors. Through these reported results, we identify causes for trends for which we can generate action plans or initiate task forces to implement solutions to improve trending in a specific category. Our broad grievances and appeals procedures include steps for documenting and tracking disputes to resolution within the established time requirements.

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

We understand that the grievance and appeals process must be performed in a timely manner. Our grievances and appeals processing procedures, policies and processes comply with RFP Section 3.9.16.5 and 42 CFR 438.402.

B. Documentation of the substance of grievances, appeals, and actions taken;

All complaints received, either orally or written, are analyzed, logged, and categorized in our electronic tracking system and automatically routed to the appeals department for review and resolution. Appeals specialists log, track, and assign case follow-ups to appropriate staff. When a case requiring follow up is created, the appeals specialist routes the case to the appropriate department, such as credentialing, client services, or claims, or to a specific provider relations representative or dental consultant. Each follow-up record includes due dates and hotlinks back to case details. When a note is entered on a follow-up assignment, the system automatically logs the date, time, and name/user ID of the person who entered the note.

The appeals department monitors member-initiated complaints about providers, including clinical quality of care complaints. Each month, the appeals department delivers a trending and analysis report. If a clinical quality of care issue is identified, the local field provider relations representative personally visits the provider office for further investigation.

The appeals department coordinates all clinical and non-clinical review of complaints. The entity with decision-making authority depends on whether the complaint is related to a non-clinical issue or a clinical issue.

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

Our extensive experience in the resolution of grievances and providing access to the State Fair Hearing process in the states we serve demonstrates our compliance with RFP Section 3.9.16.5. We send a written Notice of Disposition within 30 calendar days for grievance resolution. We also make every effort to contact the member and provide prompt verbal notice of our decision related to an expedited grievance. The Notice of Disposition includes, at a minimum, the following:

- The actions we took to investigate and resolve the grievance

- The final outcome of the investigation of the grievance
- The reason for the action
- The recipient's right to file an appeal with us and the procedures for exercising appeal rights
- When the appeal is unfavorable, we send a written Notice of Appeal Resolution that provides the right to State Fair Hearing

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

Our appeals team routinely generates and delivers customized reports for our clients. Our system can accommodate any number of customer-defined categories for grievances and appeals. Any data stored in our integrated benefits management system, including data from the customer service and authorization determination systems, can be easily extracted and repackaged into client-defined report formats without a programming change to the system.

Our standard practice is to generate monthly reports of all grievances and appeals received from recipients and providers. As referenced in Section IV.J of this RFP, we will submit a monthly report to the contract monitor that includes the following information for each grievance and appeal:

- Recipient name
- Medicaid ID number
- Subject of complaint
- Provider name
- Date received
- Date resolved
- Classification of complaint: 1) Emergency clinical, 2) Non-emergency clinical, or 3) Non-clinical.

We will also generate and submit separate reports of grievance and appeal data aggregated for the month by complaint type.

The appeals department monitors recipient-initiated grievances about providers, including clinical quality of care grievances. Each month, the appeals department delivers a trending and analysis report to the credentialing committee, the dental director, and the market's provider relations representative. The report, which summarizes the prior month's grievance activity with a year-to-date comparison, is reviewed during credentialing committee meetings. If a clinical quality of care issue is identified, the local field provider relations representative personally visits the provider office for further investigation.

In addition, each month the quality improvement committee analyzes the grievance and appeals volume and turnaround times from the month prior to identify trends. Each quarter, the committee gathers to determine the best approach to improve any negative trends identified.

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

We comply with DHCFP due process and fair hearing policies and procedures specific to Nevada Medicaid and Nevada Check Up recipients.

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

We also comply with regulations outlined in 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.

Recipients are encouraged to offer their suggestions for changes in policies and procedures, including their rights and responsibilities policy, through multiple sources. For example, recipients are encouraged in the member handbook, the member website and the newsletter to offer their ideas to member services at the number provided. Further, recipients are asked to offer recommendations and comments on the health plan's quality program through the QI contact located on the member website and included in the member newsletters.

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:

Understanding that improved health outcomes and reduced medical costs are closely linked to increased recipient participation and education, we deliver prompt recipient engagement and learning opportunities to help Nevada Medicaid and Nevada Check Up recipients understand how to access the services they need. Our written materials and personal interactions with recipients comply with the requirements in RFP Statement of Work Section 3.9.16.7 and promote accessibility of the services offered in the State. The following table summarizes our methods of delivering the important steps to assure accessibility of services:

Assuring Accessibility of Services for Members	
Information provided	***Methods we use to provide the information***
Identification of points of access to primary care, specialty care	■ Provider directory delivered with the new member welcome kit ■ Member website ■ Welcome call ■ Personalized assistance through member services—including telephonic and concierge services, and care advocates
How to obtain services during regular hours of operation	■ Member handbook—hard copy provided with the new member welcome kit and a downloadable version available on the member website ■ Provider directory available on the member website ■ Member website ■ Welcome call

	■ Personalized assistance through member services, care and care advocates
How to obtain emergency and after hours care	■ Member handbook—hard copy provided with the new member welcome kit and a downloadable version available on the member website ■ Provider directory available on the member website ■ Member website ■ Welcome call ■ Personalized assistance through member services, care and care advocates
How to obtain emergency out-of-service care	■ Member handbook—hard copy provided with the new member welcome kit and a downloadable version available on the member website ■ Provider directory available on the member website ■ Member website ■ Welcome call ■ Personalized assistance through member services, care and care advocates
How to obtain names, qualifications and titles of the professionals who provide and are accepting medical patients and/or responsible for their care	■ Provider directory available on the member website ■ Member website ■ Personalized assistance through member services, care and care advocates
How to access concierge services	■ Welcome letter ■ Member ID card ■ Welcome call ■ Member handbook—hard copy provided with the new member welcome kit and a downloadable version available on the member website ■ Member website

WELCOME PACKET

Our Recipient Welcome Packet is an introduction for recipients to understand how to access dental services, learn about their benefits, and become educated about the importance of dental health. All new recipients will receive this welcome packet within 10 days of enrollment. The Recipient Welcome Packet provides essential education, instruction, and tools recipients need to get started in and make the most of the Medical Assistance Program.

The welcome packet will include:

- A welcome letter
- Durable recipient ID card
- Recipient Handbook
- Provider Directory

- Recipient's right to file grievances and appeals and how to file
- Introduction to personal services available from the call center, including our toll-free telephone number, assistance in finding a provider, obtaining translations or materials in alternative formats, and obtaining information about continuation of dental services during the transition to UnitedHealthcare as the new dental benefits administrator
- Educational information promoting oral health
- Introduction to our self-servicing Member Web Portal, including how to register and a description of the online tools available

WELCOME LETTER

Our welcome letter will highlight major program features and encourages the establishment of a Dental Home. If the recipient has selected a Primary Care Dentist (PCD), we will confirm that selection and provide the PCD's name, location, and telephone number. If a recipient has not selected a PCD during the enrollment process, the welcome packet will include the PCD selection form with clear instructions on how to select a PCD.

RECIPIENT ID CARDS

All welcome packets will include the recipient's identification card. The ID card will be durable and will contain 800 telephone number, website address, and the toll free 800 number for the State Enrollee's Action Line. If a PCD has been selected during enrollment, the ID card will also include the PCD's name and telephone number. Identification card templates will be submitted to the State of Nevada for the Department's approval 15 days before the go-live date.

MEMBER HANDBOOK

In addition to being mailed to recipients during orientation, the member handbook will also be posted online and accessible 24 hours a day, 7 days a week via the member Web portal. The member handbook will address all issues related to accessibility, recipient responsibility, and how to get assistance with any issue. The handbook will contain all required content and begin with a table of contents to provide readers with a quick method for finding content.

We will organize the handbook content with the information used most frequently by recipients first. We will add more specialized information later in the book. Our toll-free member Services and TDD/TTY numbers will be prominent at the bottom of each page. The member handbook will open with a reminder that a recipient may request the handbook translated into another language or alternative format.

We will submit the member Handbook template to the State of Nevada for the Department's approval 15 days before the go-live date and will make any required changes. Any revisions made to the Recipient Handbook will be submitted to the State for re-review and approval.

We will ensure that our member handbook aligns with Department goals and meets the unique needs of Nevada residents.

Our member handbook topics include, but are not limited to:

- Explanation of the relationship between UnitedHealthcare and you as a recipient

- How UnitedHealthcare dental member services can help you access a dentist, or to obtain appointment assistance
- Summary of benefits that are at no cost to you as a recipient and description of all covered services including: diagnostic and preventive services; basic services; major services; orthodontic services; alternative courses of treatment; benefit limitations
- Description of services not covered
- Information on the importance of oral healthcare and establishing a dental Home
- A guide to dental visits and appropriate scheduling for routine care
- What to do in an emergency, including definitions of urgent and emergent care
- How to access transportation services
- Your Child's Oral Health (EPSDT)
- How to use the member Web portal
- Key telephone numbers, including the State's Enrollee Action Line, and how to obtain assistance for recipients with special needs, non-English speakers
- Oral health and hygiene tips, emphasizing preventive care (such as visiting the dentist regularly and proper brushing and flossing)
- Explanation of utilization management and how to detect abusive services
- What is Fraud, Waste, and Abuse and how to report it
- Confidentiality and protecting healthcare information
- Recipient Bill of Rights and responsibilities
- How to file grievances and appeals
- Handy form for writing in your PCD/specialists phone numbers and location

MEMBER WEB PORTAL

We will offer a customizable, self-service Web portal that provides recipients with an intuitive information hub surrounding the dental services offered by the Nevada Medicaid dental program. Our member Web portal offers a communication vehicle beyond traditional telephone and mailed communications, providing recipients faster, easier access to education and services. After registering online, recipients can log onto the portal for direct access to a host of features, including relevant benefit information, educational links, online documents and education materials, links to online videos, as well as our provider search function and claims history.

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

Confirmed.

C. At a minimum, recipients are given information about:

Confirmed.

1. **How to obtain services during regular hours of operations;**

   Confirmed.

2. **How to obtain urgent, emergency and after-hour care;**

   Confirmed.

3. **How to obtain emergency out-of-service area care;**

   Confirmed.

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**

   Confirmed.

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

   Confirmed.

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.

We understand the importance of providing recipients with easily understood materials so they can use the information to take appropriate action and improve their health status. To make sure our recipient materials are easy to understand, we develop them using a glossary created as part of an internal initiative to improve health literacy through simplification of our communications. Our glossary includes health care and health insurance terms prepared in English and Spanish that are simple to comprehend. Our goal is to make educational messaging understandable, accessible and actionable.

Nevada Medicaid and Nevada Check Up recipient materials are written at no higher than an eighth-grade reading level where terminology permits (e.g., certain medical terms may be higher than an eighth-grade reading level). To confirm that recipient materials do not exceed the eighth-grade reading level, we use our proprietary readability tool, based upon the Flesch-Kincaid grade level formula. This tool rates the content and confirms that the materials we produce are easy to read, understand and act upon, and that they present information in a manner that most recipients can easily comprehend.

We regularly review and update our recipient materials to comply with any required reading level changes in the programs. We consider recipient feedback on our written materials when we make revisions, while also maintaining Nevada-specific program requirements.

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

To facilitate understanding of recipient materials for Nevada Medicaid and Nevada Check Up recipients, we provide written materials in both English and Spanish, and can accommodate any recipient request for translation. As needed, we will provide materials in other prevalent languages within the State.

We solicit, verify and document our recipients' needs for interpreter and translation services during welcome calls and other recipient interactions with our staff. Collecting and evaluating this information enables us to prepare culturally appropriate materials and other resources for our recipients.

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:

We comply with all requirements in Section 3.9.16.9 (A through E) and have a process in place to assure patient record confidentiality. We have written policies and procedures in place to comply with the HIPAA Privacy Rule, provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act and Nevada law.

We require our affiliates and business partners, including our providers, to protect the privacy and confidentiality of recipient information as required by HIPAA and Nevada law. Providers as Covered Entities under HIPAA are required to apply appropriate administrative, technical and physical safeguards to protect the privacy and security of recipients' medical information and protect against unauthorized acquisition, access, use or disclosure of PHI.

Our business associate Addendum included in each provider and subcontractor service contract mandates adherence to our security and privacy requirements. Our requirements for contracted providers include designating a person or persons responsible to maintain safekeeping of medical records and appropriate system backup for electronic medical records.

In addition, the Provider summary guide lists the medical record review standards assessed during on-site visits at provider offices to attain compliance with confidentiality standards. We have specific policies and procedures on Identification and Authentication, Minimum Necessary and Disclosures to Third Parties, which prohibit disclosure of PHI without an authorization, or as otherwise permitted under HIPAA. Disclosures of PHI required by law, to coordinate treatment, payment and health care operations and to protect the health or safety of an individual are all permissible disclosures under HIPAA.

It is our policy to notify a recipient of any release of the recipient's information in response to a court order. The recipient will be notified within 30 days of release of the information. Our HIPAA privacy policies detail the circumstances under which we may disclose recipient information without the recipient's authorization. Permissible disclosures under HIPAA are outlined in our Disclosures to Third Parties policy, which includes reporting certain information to agencies when required. For example, we may use or disclose PHI to the Secretary of HHS when required under the Privacy Rule to investigate or determine our compliance with the Privacy rule or we may use or disclose restricted PHI for any public purpose disclosure under 45 CFR § 164.512 of the Privacy Rule.

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

Confirmed.

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;

Confirmed.

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:

Confirmed.

1. **It is required by law, or pursuant to a hearing request on the recipient's behalf;**

   Confirmed..

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**

   Confirmed.

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

   Confirmed.

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

Confirmed.

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.

Confirmed.

3.9.16.10 Treatment of Minors

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

Our Identification and Authentication policy contains guidelines regarding disclosure of PHI to a parent or other individual acting as the personal representative of a minor recipient. We also have department-specific procedures for handling of minors' PHI. Generally, after verification of an individual's identity (as parent or personal representative of a minor), our member services department releases eligibility and claim information and answer questions pertaining to the minor child's coverage. Member services scan applicable documentation (i.e., court papers on guardianship, custody, etc.) into a minor recipient's record for reference as to who is his/her personal representative. A parent may make changes to the minor's account only if he or she is on the insurance policy (PDP change, order ID cards, change address). In accordance with Nevada law, we do not release any information related to a minor's mental health, substance abuse, reproductive health or sexually transmitted diseases to a parent or personal representative without the minor's authorization. In addition, we do not release a minor's PHI without his/her authorization to a parent or personal representative if the minor is emancipated under Nevada Revised Statutes (N.R.S.) 129.080, or meets one or more of the following conditions under N.R.S. 129.030:

- Is or was married
- Is pregnant or has a child
- Has been living on his/her own for at least four (4) months (must provide proof, such as a documented address change)

Any records containing PHI pertaining to situations where the minor can consent to and receive treatment on his/her own are not released to the parent or personal representative without the minor's authorization.

3.9.16.11 Assessment of Recipient Satisfaction

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

As a key component to providing high quality health care to the Medicaid populations, we are keenly aware of how important it is to gain our members' trust and improve their health status by providing health care services that meet their needs and expectations. To understand the issues our recipients face and how we can best help them, we conduct yearly surveys that focus on perceived member satisfaction with access to care, quality of care, our staff and network provider attitudes, satisfaction with their dental office, communication and overall satisfaction with their benefit plan. Designed to measure and monitor member satisfaction with the health plan's services, our surveys comply with all of the State's requirements as described below, including sampling requirements.

We will use sampling methodology agreed to with the State. Our surveys are done by phone, due to a better completion rate, as well as costs. The survey script is submitted and approved by the State as is done with all member communications. Surveys are typically completed during 4th quarter and results are completed during 1st quarter by our marketing team. Results, findings and corrective action as required, are shared with the appropriate clinical committee.

Results are used to:

- Identify and investigate causes for dissatisfaction
- Create action plans implemented to address identified issues
- Communicate with providers regarding areas for improvement

The primary improvement opportunity that has come out of past surveys focuses on access, particularly for certain specialties. Member feedback has been important to our network strategy and helps us to identify gaps in access as well as specialty coverage. A secondary opportunity is improving the survey itself. Based on our experience, UnitedHealthcare will continue to look for opportunities to educate recipients on the survey prior to initiating member contact and will look for ways to craft survey questions to elicit the most meaningful information.

As a specific example, a 2015 Member Satisfaction survey identified an overall satisfaction rate of 95 percent (65 percent very satisfied, 30 percent somewhat satisfied). Highest satisfaction was expressed with Overall Dentist and Staff Care Quality, Overall Customer Service Experience, Level of Coverage for Preventive Services and Level of Coverage for Restorative Services. Lower levels of satisfaction were noted for Level of Coverage for Major Procedures and Access to Network Dentists (more on Access below). In addition to survey outcomes, opportunities were noted in survey processes designed to improve the level of member responses: providing additional education and communication on the survey, re-evaluating the wording of survey questions, and including different survey delivery options, mail as well as telephonic.

In addition to monitoring by the QI Committee (QIC), we re-examine the year over year progress and trends achieved in member satisfaction at least annually. Formal presentations are made to the QIC with the oversight of member satisfaction. All QI related committees provide oversight to initiate action on the data received because of satisfaction surveys and committee members work with individual departments to improve their results if below the goal of 90 percent.

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

Please see response to Question 3.9.16.11.

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

1. All recipients;

Please see response to Question 3.9.16.11.

2. Recipient requests to change practitioners and/or facilities; and

Please see response to Question 3.9.16.11.

3. Disenrollment by recipients.

Please see response to Question 3.9.16.11.

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

1. Identify and investigate sources of dissatisfaction;

Please see response to Question 3.9.16.11.

2. **Outline action steps to follow up on the findings; and**

   Please see response to Question 3.9.16.11.

3. **Inform practitioners and providers of assessment results.**

   Please see response to Question 3.9.16.11.

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

Please see response to Question 3.9.16.11.

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.

We agree to comply with the State's requirements for access to care.

ACCESS TO ROUTINE, URGENT AND EMERGENCY CARE

We expect our network dentists to provide initial, follow-up and hygiene appointments within 14 business days. Dentists must provide emergency appointments within 24 hours. Network dentists must follow these access standards and we monitor their compliance.

The professional networks team will ensure that UnitedHealthcare maintains a dental network sufficient to provide all recipients with access to the full range of covered services, as well as choice of provider. We monitor the network build by utilizing GeoAccess reports which demonstrate the strength of our network based on State access requirements. Our robust network will have sufficient coverage for recipients with the appropriate access requirements by the go-live date. If deficiencies are identified, we will make arrangements to provide services with an out-of-network provider for a recipient until we recruit an additional provider.

We monitor access standards through the analysis of annual member satisfaction survey results, grievance and appeal trends, and after hours telephone audits performed by our provider services staff. Additional site visits to provider offices may also be performed to show compliance with standards. Our provider advocate team also monitors access to care through secret shopper surveys.

UnitedHealthcare continually strives to achieve 100 percent compliance with access requirements. If despite the best efforts by UnitedHealthcare there are no providers or specialists available within the required access standards, we will contract the nearest provider in a contiguous county.

MEMBER SERVICES ACCESS

We have a robust quality assurance program that strives to deliver world-class customer service to all callers. We record 100 percent of the calls received in the customer service center, capturing both audio and video recordings for all inbound and outbound calls. Quality monitoring specialists monitor both live and recorded calls to evaluate member services advocate performance based on courtesy and professionalism, caller interaction, rapport building, providing complete and accurate information, problem resolution, HIPAA and PHI compliance, and appropriate call log documentation.

We expect our member services advocates to ensure each caller is satisfied with the outcome whenever possible. We have the capacity and capabilities to perform customer surveys to measure the caller's satisfaction.

Our dedicated quality assurance specialists conduct regular quality reviews for each member services advocate using a combination of live and recorded calls. Both English and non-English speaking calls are monitored to evaluate member services advocates performance based on courtesy and professionalism, caller interaction, rapport building, providing complete and accurate information, problem resolution, HIPAA and PHI compliance, and appropriate call log documentation.

Our interactive voice response system (IVR) notifies all callers that their call may be monitored for quality purposes, before callers speak with a Customer Service Representative.

We acknowledge and accept the customer service performance standards required by the State. We will adjust our customer service staffing levels as necessary to meet all of the State's performance standards.

3.9.18 Dental Record Standards

We transact and maintain eligibility information per HIPAA regulations. We maintain the standard member benefit plan information including the identification number, address, plan name, coverage information, effective dates and the subscriber's employer group.

The minimum information needed to verify employee eligibility includes the following:

- Employee's first and last name
- Unique employee identifier
- Effective dates of coverage
- Coverage tier (personal or family)
- Date of birth
- Necessary experience separation fields
- Gender
- Address
- Cancellation dates
- Relationship code

DEPENDENT PROCESSING

The dependent automated certification process validates each dependent name and other required data items. Our system identifies dependents and matches them with their claims history during claim payment. It is much more difficult to identify an individual dependent because there is not one field that makes a dependent unique, as opposed to identifying an individual employee.

Our customers need to properly identify dependents on the eligibility file. We expect to receive:

- Dependent relationship to employee
- Dependent first name
- Dependent date of birth
- Dependent gender code

Each dependent has an individual record that contains all required fields. We use the dependent's first name, date of birth, gender and relationship to the employee to identify a unique dependent. We use special processing logic to determine if a dependent is unique. This logic, along with the four required fields, is part of our Suspect Duplicate Processing, which prevents us from loading duplicate dependent information to our transaction payment system.

During the implementation of your account, we will provide a copy of our electronic eligibility guide, which contains the list of information needed in the eligibility file.

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.

Our network provider contracts include provisions for HIPAA compliance with regard to access to medical records for quality review. Our network contracts and the Provider summary guide require all contracted network providers to:

- Treat medical records as strictly confidential
- Grant access to medical records only through written authorization by the recipient or when release is required by law
- Provide applicable state and federal government agencies and us with reasonable access to records relating to the health care services provided recipients, including quality reviews conducted by the Secretary of the U.S. Department of Health and Human Services

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

In full compliance with the requirements of this RFP, we require all contracted network providers to maintain current, detailed and organized dental records using a medical recordkeeping system. The system can be either hard copy or electronic and allows for the collection, processing, maintenance, storage, retrieval and distribution of patient records. Our requirement that dental records be available to health care practitioners at each encounter is founded in our belief that these records should facilitate communication, coordination and continuity of care, and promote efficiency and effectiveness of treatment. We conduct periodic medical record reviews to ensure conformity with good professional medical practice and appropriate health management. Our provider advocates confirm all providers are educated on the importance of delivering consult notes back to the referring provider in an effort to keep clear lines of communication regarding the recipient's treatment 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:

We have an existing policy and procedure, which states that practitioners must maintain medical records in a current, detailed and organized manner. Practitioners must have a medical record-keeping system, in a hard copy or electronic format that allows for the collection, processing, maintenance, storage, retrieval and distribution of patient records.

The medical records should facilitate communication, coordination and continuity of care, and promote efficiency and effectiveness of treatment. These standards reflect all aspects of patient care. Part of our safety activities include regular auditing of our recipients' medical records to ensure compliance with the minimum standards set by our plan, the state and federal laws as they related to medical records and privacy.

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;**

   Each page of the medical record contains the recipient's name or 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;**

   Personal biographical data to include date of birth and age, race, sex, ethnicity, language preference if other than English, any disability including limited English proficiency (LEP), address, home telephone number, marital status and emergency contact information. Guardian information, if applicable is also documented (Medicaid also requires age, race and sex). If applicable, we also include employer's name and work telephone number.

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;**

   Medication allergies and adverse reactions, or absence thereof, are consistently and prominently noted in the medical record. Placement of allergy information must be consistent across all records.

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;**

   For patients 18 and older, past medical history is easily identified and includes serious accidents, operations and illnesses. For children and adolescents under 18 years, past medical history relates to prenatal care, and birth and preventive services.

5. **Diagnostic information;**

   Treatment plans are consistent with diagnoses.

6. **Medication information;**

   Medication information is present, including prescribed medications, dosages, dates of initial prescriptions and refill prescriptions.

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

   Significant illnesses and health conditions are indicated on the problem list, including current updates.

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;**

   For patients 12 and older there is appropriate notation assessing the use of cigarettes, alcohol or other substances; if affirmative, there is also evidence of education.

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;**

   Reports presented electronically, or by some other method, also require representation of review by the ordering practitioner. Consultation, laboratory and imaging reports filed in the chart are initialed by the practitioner to signify review. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.

10. **Emergency care; and**

    Documentation evidencing continuity and coordination of care is present for all aspects of care including emergency care documentation.

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

    All patient visit data includes at a minimum adequate evidence of all parameters listed in a-g.

    - Encounter forms or notes have a notation regarding follow-up care, calls or visits
    - Unresolved problems from previous office visits are addressed in subsequent visits
    - The history and physical examination identifies appropriate subjective and objective information pertinent to a patient's presenting complaints

- There is evidence preventive screening and services are offered in accordance with our preventive health guidelines
- There is evidence of appropriate referral to consultants, as indicated
- Laboratory and other studies are ordered, as appropriate
- Working diagnoses are consistent with findings
- Documentation of patient education regarding diagnoses, treatment and medications, including risk factors
- There is no evidence the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure (e.g., unnecessary procedures, inappropriate procedures)
- The specific time of return is noted in weeks, months or as needed

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

   Confirmed.

b. **Plan of treatment;**

   Confirmed.

c. **Diagnostic tests;**

   Confirmed.

d. **Therapies and other prescribed regimens;**

   Confirmed.

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;**

   Confirmed.

f. **Referrals and results thereof;**

   Confirmed.

g. **All other aspects of patient care, including ancillary services;**

   Confirmed.

12. **Entry Date – All entries must have date and time noted;**

    All entries are dated.

13. **Provider Identification – All entries are identified as to author; and**

    All entries in the dental record contain author identification, which may be a legible handwritten signature, unique electronic identifier or initials.

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.**

    The record is legible to someone other than the writer; if the dental record is illegible, the medical director reviews a copy of the record for determination. A second physician reviewer will be engaged to further judge records, as necessary.

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

UnitedHealthcare maintains policies regarding Dental Records requirements, such as required and recommended information to be contained in proper dental records. This includes appropriate treatment plans, timeliness of treatment, and continuity and coordination of care. We may perform dental record audits if concerns exist about quality or if the State has concerns about dental recordkeeping. In addition, chart review may be involved in anti-fraud investigation.

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

Our documented record assessment system assess the conformity with good professional medical practice and appropriate health management. As part of our record review process, a clinical professional conducts the dental record reviews in regards to legibility, organization, completion, conformance and documentation of the items listed in the Medical Records requirements above. This reviewer works closely with our vice president of health care quality and education to make recommendations to the Credentialing Committee and to oversee corrective action plans of individual practitioners.

3.9.19 Utilization Review

UnitedHealthcare maintains a comprehensive Utilization Management (UM) Program with supporting policies and procedures. Utilization data may be analyzed to ensure that recipients receive quality oral health services. UM activities identify aberrant utilization patterns, and provide source data for outcomes studies, allowing analysis of client performance which can suggest targeted QI interventions aimed at improving member oral health outcomes. UM is an additional source of quality indicators, which can be used to evaluate quality in the following four areas: clinical results or treatment choices, over and under-utilization compared to network base lines, accuracy of coding procedures, and cost of care.

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.

We have been providing medically necessary dental services Medicaid and CHIP recipients for over 20 years, resulting in significant improvements in utilization, while promoting recipient oral health and ensuring that providers deliver services that are appropriate to recipients' needs. We will use the same utilization management (UM) guidelines and processes for the Nevada Medicaid Dental Program.

UM Guidelines & Process to Develop and Revise Criteria

UnitedHealthcare uses our proprietary Appropriate Care Criteria to ensure appropriate utilization and quality of services for recipients participating in the Nevada Medicaid Dental Program. Our guidelines are consistent with the requirements in the Nevada Dental Practice Act's requirements, Nevada State Board of Dental Examiners rules, and national guidelines from the American Dental Association (ADA) and the American Academy of Pediatric Dentistry (AAPD).

Our authorization guidelines are algorithms programmed into the Enterprise System our software platform, which ensures consistent medical necessity authorization determinations and can be customized for different providers as an incentive for good utilization patterns. The algorithms present the clinical criteria in a decision tree format that is clear, easy to understand and transparent to the providers and review staff.

To ensure that providers understand our determinations, we make the Appropriate Care Criteria and Authorization Guidelines available to providers online through the UnitedHealthcare Provider Web portal and in hard copy, upon request.

The Appropriate Care Criteria and Authorization Guidelines were developed using principles of evidence based dentistry and our extensive experience in managing dental services for Medicaid and CHIP programs.

Guideline sources include the ADA; specialty organizations, such as the American Academy of Periodontology; the American Academy of Pediatric Dentistry and the American Association of Oral and Maxillofacial Surgeons; evidence based clearinghouses, such as the Cochrane Oral Health Group and National Guideline Clearinghouse; American and international governmental agencies, such as the National Institutes of Health, the Centers for Disease Control and Britain's National Health Service; evidence based journals, such as the Journal of Evidence Based Dental Practice; and reputable public health recommendations, such as Healthy People 2020.

The initial criteria were reviewed and accepted by the corporate Clinical Policy and Technology Committee (CPTC), which includes clinical staff, dental consultants and participating providers. The approved criteria were then reviewed and endorsed by the corporate Clinical Affairs Committee, which oversees the work of the CPTC. Our UM Program description documents the UM guidelines we are using to determine medical necessity and the methods for periodic review and updates.

The CPTC reviews the Appropriate Care Criteria and Authorization Guidelines annually, although changes can be made at any time if the state changes the program design, or if other overarching utilization patterns emerge that require a program change. Additionally, the CPTC meets quarterly to consider new developments in evidence-based care, improvements and changes in dental materials and new technology.

Based upon these reviews the CPTC will propose additions or changes to the Appropriate Care Criteria and Authorization Guidelines to the clinical affairs committee. We document the process in written policies and procedures that are reviewed annually by the CPTC and updated as necessary. We will review guidelines and have them accepted at the Nevada level by our peer review committee. We will submit any changes to Nevada's Department of Health for review and approval prior to implementation.

APPLICATION OF UM GUIDELINES TO AUTHORIZE MEDICALLY NECESSARY COVERED DENTAL SERVICES

UnitedHealthcare maintains a written utilization management (UM) program description that documents the program's objectives, the UM organizational structure and qualifications of review staff, procedures to review medical necessity and notification procedures, UM guidelines used and the methods for reviewing and updating as needed.

The manager of the utilization management program supervises the day-to-day operation of the authorization program. Providers are instructed to submit a standard ADA claim form and supporting documentation, either by hard-copy, electronic claim submission or via the Web portal, to request authorization for procedures requiring medical necessity review. Dental review specialists are available 8 a.m. to 5 p.m. CT Monday through Friday to assist with any authorization requests. Callers may also leave a message, which will be responded to within one business day.

To facilitate the review, all documents and radiographs are converted to electronic images, if not already in electronic form, and the pertinent information is entered into the authorization module of the Enterprise System.

The authorization request is available to the reviewers either through the internal computer network or over a secure internet connection, protecting the privacy of the recipient and enabling a rapid review to be performed. We maintain the electronic radiographs indefinitely in the event that any future follow-up is required. In the event that additional information is required, UnitedHealthcare will request such information in written correspondence within three business days of receipt of the authorization request, or contact the provider by phone. The Authorization System is completely automated and the reviewers have access to all submitted documentation in electronic form.

UnitedHealthcare uses the following three levels of authorization review:

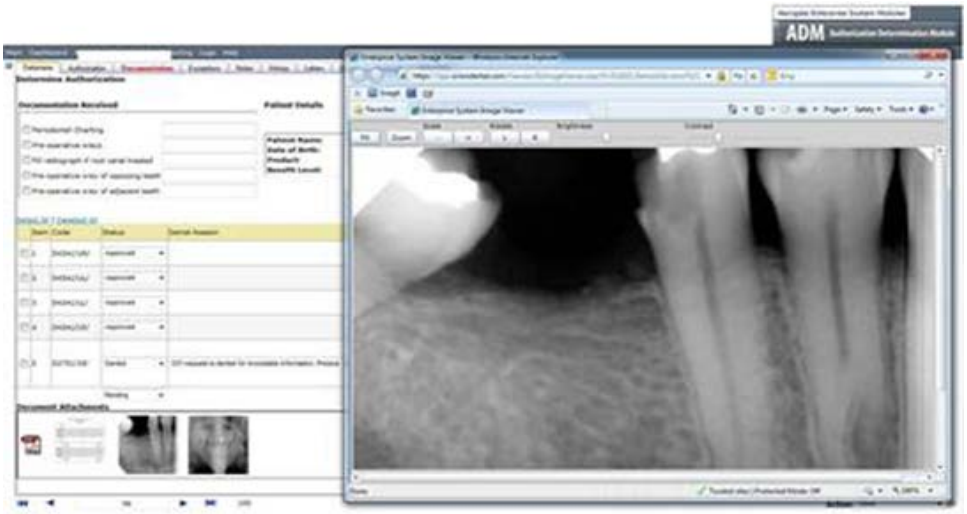
- **Level 1** - Automatic system reviews
- **Level 2** - Dental review specialist reviews
- **Level 3** - Dental consultant reviews

The Level 1 review is performed automatically by the Enterprise System by applying hundreds of business rules via coded algorithms against the services to be authorized. The system rules automatically deny services for administrative reasons where appropriate, such as "member ineligible" or "service not covered."

The Level 2 review is performed by dental review specialists, who have extensive clinical backgrounds, and a minimum of 3 years' experience as a dental assistant. The dental review specialist reviews each authorization request that has passed the Level 1 review to determine whether it meets criteria for medical necessity.

The reviewer has a number of system tools available to ensure consistent and sound clinical determinations including: scanned documentation available for electronic review, complete tooth, authorization and claim history for each recipient, all Level 1 results - including authorizations with business rule edits flagged for further consideration and over 100 proprietary dental clinical algorithms.

Please see the screen shot below from our clinical review module:



The dental review specialist approves requests that meet criteria.

If the request does not meet criteria, the dental review specialist flags it for dental consultant clinical review and determination. The dental review specialist may also deny the authorization request for administrative reasons.

The Level 3 reviews of authorization requests that could not be determined appropriate during Level 2 reviews are completed by consultants or internal dentist staff that are appropriately licensed and credentialed and report to the Nevada dental director. The Level 3 reviewer will make a final determination of either “approved” or “denied.”

The Level 3 reviewers call the requesting provider to resolve any questions on the request and use the Enterprise System to make automated requests for additional documentation. The dental review specialists and dental consultants each have separate, defined work queues in the Enterprise System to direct them only to those authorizations that require their attention.

UnitedHealthcare maintains written policies and procedures to govern all aspects of our UM program, including, but not limited to, policies and procedures to:

- Ensure operations refrains from any activities to influence clinical decision-making by any kind of financial or other incentives and that medical necessity determination decisions are based solely upon each recipient’s specific needs, the Appropriate Care Criteria and the Authorization Guidelines

- Monitor the efficiency and results of each dental reviewer by review of the turnaround times, number of approvals, number of denials and reviews by code

- Ensure consistency of decisions through semi-annual inter-rater reliability reviews of authorizations determinations made by our dental review specialists and dental consultants. The goal is to maintain a score of 80 percent. In 2016, UnitedHealthcare's 20 consultants achieved inter-rater scores of 100 percent.
- Refer suspected cases of provider or member fraud, abuse, or waste to the Office of Inspector General
- Monitor the effectiveness of our UM program by assessing over and underutilization and compliance with all requirements, generating provider profiles that monitor provider utilization patterns, and comparing outcomes to benchmarks for comparable populations
- Target areas of inappropriate service utilization for medical necessity review.

It is always our intent to ensure that we provide quality services while controlling costs. Based on ongoing data analysis, we have determined these services are the most likely to be subject to inappropriate utilization. Our analysis is substantiated by requirements to review the same codes in most Medicaid and CHIP programs. The review and authorization of these codes prior to service delivery ensures that recipients are receiving care appropriate to their needs and minimize overtreatment and unnecessary services. We can also modify those codes based upon your specific needs, upon request.

Authorization Notification - The Enterprise System generates determination letters daily to recipients and providers and includes the specific clinical reason and/or contractual basis for the determination, and information on submitting an appeal. If necessary, a verbal notification can be made to the provider.

Reconsideration - UnitedHealthcare makes authorization determinations based on medical necessity and appropriateness, the recipient's presenting oral condition and individual needs and applicable benefits and exclusions. We will reconsider denials of authorization when the network provider submits additional information including, but not limited to: dental records from the treating dentist, orthodontic records and treatment plan, radiographs, or photographs of study models and/or photographs of intraoral tissue lacerations, hospital readiness form and/or orthodontic readiness form, and medical records from the primary care physician.

We require pediatrics growth data for orthodontic appeals related to nutritional deficiency and speech/language records are required for orthodontic appeals related to speech pathology. If the denial is upheld after reconsideration, we notify the provider of the appeal procedures.

Urgent Care – We define urgent or emergent authorizations as those requests for services to treat situations that involve pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury. We immediately grant emergent and urgent requests for authorization and the dental provider is encouraged to treat the recipient, then send the completed claim and any necessary documentation on a claim form marked "Retrospective Review."

The chief dental officer or one of the dental consultants evaluates all retrospective reviews to determine coverage and also certify the services were emergent or urgent in nature.

If we note a pattern of abuse for any one practice, UnitedHealthcare will create a corrective action plan (CAP) and counsel the provider, which will include a discussion of the definition for urgent and emergent care.

The Quality Improvement Manager will be focused on the clinical aspects of Nevada's dental program. This role will include providing support for clinical initiatives and best practice guidelines. Our company, through its Clinical Policy and Technology Committee is committed to researching and developing practice guidelines in a broad spectrum of clinical areas, including caries prevention and oral health. These guidelines and algorithms, based on principles of evidence-based dentistry, include areas such as caries management; recall interval, patient selection for dental x-rays and caries risk assessment. Guidelines are shared with dentists through Newsflash, and incorporated into the Provider summary guide that is distributed to dentists.

All of UnitedHealthcare's programs are supported by clinical guidelines and evidence based practices. The Clinical Policy & Technology Committee, which consists of internal clinicians and participating dentists, makes clinical recommendations on practice guidelines and new technologies, based on principles of evidence based dentistry. Much of the Committee's work is in reviewing existing industry guidelines developed and disseminated by organized dentistry and specialty societies such as the American Academy of Pediatric Dentistry. Examples of guidelines adopted include the ADA Evidence Based Guidelines on Topical Fluoride and Pit & Fissure Sealants, the AAPD guidelines on Periodicity and Caries Risk Assessment Tools.

Clinical guidelines are available to network dentists and are shared in our dentist newsletter and Provider summary guide. They are also shared internally and form the basis of our claims criteria, UM/UR review criteria, underwriting guidelines (including adoption of new CDT codes), marketing materials and new products.

3.9.19.2 Scope

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

Our quality management program includes assessing dental procedures per claimant. This measure is an indicator of recipient access and appropriateness of treatment. We will use the results to monitor appropriate treatment, specifically over- and underutilization. This measure is the number of procedures received by a recipient who received at least one procedure. By utilizing industry leading data technology, innovative clinical models, enhanced provider recruitment and education and creative outreach and case management UnitedHealthcare is committed to increasing the number of children who have access to dental services before the age of 21.

3.9.19.3 Pre-Authorization Review Requirements

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

All Level 2 reviews are performed by dental review specialists, who have extensive clinical backgrounds, and a minimum of 3 years' experience as a dental assistant. The dental review specialist reviews each authorization request that has passed the Level 1 review to determine whether it meets criteria for medical necessity.

The Level 3 reviews of authorization requests that could not be determined appropriate during Level 2 reviews are completed by consultants or internal dentist staff that are appropriately licensed and credentialed and report to the Nevada dental director. The Level 3 reviewer will make a final determination of either "approved" or "denied."

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

We have written procedures to address the failure or inability of a provider or recipient to provide all of the necessary information for review. If the provider or recipient did not submit the necessary clinical information for review, our intake staff makes, at a minimum, one phone and one fax attempt to contact the provider or recipient and obtain the clinical information. If we receive the clinical information, we conduct a prior authorization review.

UnitedHealthcare makes authorization determinations based on medical necessity and appropriateness, the recipient's presenting oral condition and individual needs and applicable benefits and exclusions. We will reconsider denials of authorization when the network provider submits additional information including, but not limited to: dental records from the treating dentist, orthodontic records and treatment plan, radiographs, or photographs of study models and/or photographs of intraoral tissue lacerations, hospital readiness form and/or orthodontic readiness form, and medical records from the primary care physician.

We require pediatrics growth data for orthodontic appeals related to nutritional deficiency and speech/language records are required for orthodontic appeals related to speech pathology. If the denial is upheld after reconsideration, we notify the provider of the appeal procedures.

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

We maintain written policies and procedures for the filing, receipt, prompt resolution, and documentation of any and all prior authorization requests. We routinely create customized versions of policies and procedures to meet specific State requirements. Our software platform generates customized determination letters that include state-defined determination reasons for both recipients and providers.

When we deny a service authorization request, we make every effort to document the reasons for UM decisions in a clear and understandable way for the recipient. The Enterprise System generates determination letters daily to recipients and providers and includes the specific clinical reason and/or contractual basis for the determination, and information on submitting an appeal. If necessary, a verbal notification can be made to the provider.

The reasons for decisions clearly describe why the recipient's condition fails to meet criteria for approval and includes references to the benefit provision, guideline, protocol or other criterion on which the denial was based. Making sure each recipient has enough information about the reason for the denial allows the recipient to make an informed decision about whether to appeal the denial.

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;

Our prior authorization policies and procedures are consistent with the provision of covered medically necessary medical, dental and behavioral care according to community standards of practice. We follow a UM decision-making hierarchy when making UM decisions based upon clinical criteria. This hierarchy outlines the criteria consistent with evidence-based medicine, community standards of practice and state Medicaid benefits.

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;

Upon enrollment, recipients receive oral and written information regarding our grievance and appeal system, including pertinent policies and procedures, and details on filing grievances, appeals and state fair hearings. This includes the right to file grievances, appeals and claim disputes, the requirements and time frames for filing them, the toll-free number to file oral grievances and appeals, and the time frames for filing. In addition, we send our recipients an annual reminder about grievance and appeal system processes and their right to use these processes.

We provide this information in our member's welcome packet, in our member handbook and our secure member website. For detailed instructions for filing a grievance or appeal, the recipient may call our toll-free number for access to member services. In compliance with the RFP guidelines, we communicate the information regarding member grievance, appeal and State Fair Hearing procedures and time frames to our recipients at enrollment.

PROVIDERS APPEALS

We do 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 in compliance with 42 CFR 438.102. Any recipient, his/her authorized representative or a provider acting on behalf of the recipient, with written permission from the recipient, may file an appeal with us. Providers who represent recipients do so free of any retribution. We do not take punitive action against a provider who requests or supports an expedited appeal on behalf of a recipient.

We communicate this information to providers in our provider summary guide at the time they enter into a contract with us and annually through our biannual newsletter, and on our website.

We strive to avoid grievances and appeals by delivering high quality, responsive and culturally competent services and communications to our recipients. We know it is important for recipients to have a process to express dissatisfaction and for us to receive information toward continuous improvement. We have significant experience processing a member grievance, appeals and State Fair Hearing program that assures the appropriate and timely processing and resolution of member grievances or appeals when a recipient does not agree with a decision we have made. We give this information to subcontractors at the time they enter into a contract with us.

NOTICE OF ACTION

Recipient authorization notices include recipient and provider information, authorization number, services requested, the disposition and date of the decision, reason for an adverse decision if applicable, and all recipient appeal rights including how to file an appeal using the State-approved appeal process. Using recipient eligibility information, the benefits management software can distinguish those recipients not eligible for appeal rights at the time of an adverse notice and exclude appeal rights from any and all notices to the recipient.

We notify recipients via mail with State-approved letter templates and/or telephone calls, if applicable.

Both recipient and provider notices are permanently attached to the authorization record. Designated State staff will have 24 hours a day, seven days a week online secure access to all authorization records and related documentation through the client web portal.

Recipient authorization notices include all recipient appeal rights including how to file an appeal using the MLTC appeal process.

Confirmation of receipt of a prior authorization request can be received by the provider in one of three ways: 1) EDI requests have built-in response files that indicate what was accepted; 2) web portal requests give the providers a screen message with the ability to print the document; 3) paper requests will have an automated written response. All acknowledgment of receipt occurs within one business day of receipt.

If a dental covered service that a recipient is already receiving is denied, modified, or terminated, we will information the recipient of the availability of an intervention specialist who can help coordinate any necessary aid during the appeal process.

As described above, our benefits management software uses recipient eligibility data to identify recipients not eligible for appeal rights at the time of an adverse notice and exclude appeal rights from any and all notices to the recipient.

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

If the recipient's life or health is at risk, the recipient may file an expedited appeal. To handle emergency clinical situations, the appeals specialist follows department protocol to expedite the resolution, which includes immediately notifying an on-call dental consultant. For expedited appeals, the Nevada Dental Director or Dental Consultant will make the expedited appeal determination within one business day from the receipt of the appeal and the complaints and appeals specialist will verbally notify the recipient. Written notification will follow verbal notification within two business days of the decision. All other steps are the same as the standard appeal process. For all inquiries that are clinical in nature, the appeals specialist gathers clinical documentation and routes it to a licensed dental consultant for review and determination.

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

The Quality Improvement Committee (QIC) receives regular written reports from Provider Relations, Quality Management and Marketing. It provides information on member and provider satisfaction survey results, member complaints, grievances, telephone access, disenrollment, credentialing and preventive health services—all of which are used for developing service improvement projects. The QIC and CAC analyze the information and make recommendations for improvement.

The Quality Improvement Program (QIP) encompasses both clinical care and service activities, involving multiple committees (Quality Improvement Committee (QIC), Clinical Policy and Technology, Clinical Affairs Committee (CAC), Peer Review, and Credentialing) in the improvement process.

The annual QIP incorporates findings from the program evaluation; for example, needed improvements, changes in process or structure and follow-up studies, in addition to activities mandated by state and federal regulations and customer expectations. The board of directors reviews and approves the QIP evaluation and annual QIP.

The national dental director for quality management and chief dental officer are responsible for monitoring follow-through when clinical and service improvements are identified. We maintain documentation about implementing recommendations of system changes, corrective actions, educational endeavors and overall effectiveness.

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

We are compliant with compliant with 42 CFR 438.210 to make sure compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any recipient.

We distribute a statement on an annual basis to recipients and to practitioners, providers and employees that make UM decisions affirming:

- Utilization Management decision making is based only on appropriateness of care and service and existence of coverage
- We do not reward practitioners or other individuals for issuing denials of coverage or services
- Financial incentives for UM decision makers do not encourage decisions resulting in underutilization
- We do not use incentives to encourage barriers to care and services

The affirmative statement is found in the following areas:

- Included in member materials (e.g., Member handbook)
- Posted on our website

- Distributed annually through email to UM staff including:
- Medical directors dental care decisions
- Licensed UM clinical directors, managers, supervisors; licensed clinical reviewers and non-clinical reviewers
- Delegated entities that make UM decisions on our behalf
- Included within the Provider summary guide for our network providers
- Published as an annual member newsletter article

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

We have mechanisms in place to ensure delegated entities that support our utilization management program meets all state and federal requirements. Before we agree to delegate any UM functions to a delegated entity, we clearly define the delegate's scope of responsibility (e.g., the delegated entity does not have the authority to issue service denials) and conduct an on-site audit of the delegate's UM policies, programs, procedures and oversight mechanisms. Through this pre-delegation audit, we determine that the delegate has implemented a UM Program that complies to plan UM standards as well as those authorized by the State, federal authorities and NCQA.

In addition to the pre-delegation audit, we provide continuous oversight of the delegate's UM Program through mechanisms such as periodic, routine, on-site chart audits or monthly audits of pertinent UM tasks. We conduct a full annual audit that reviews the entire scope of the delegate's UM Program, including reviewing its UM policies, programs, procedures and oversight mechanisms.

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.

UnitedHealthcare will work to improve access by ensuring continuity of care between primary health care physicians and dentists – we have touched on some of these strategies elsewhere:

- UnitedHealthcare will provide information on various dental health topics to physicians including information on the importance of following up at a dental home. This will include specific focus on FQHC's and hospital programs

- As appropriate, UnitedHealthcare will work with the State and the program MCOs to identify children seen in medical settings who may not have received dental follow up. We will then provide those families with communication on the importance of dental follow up. Those families will also be selected to receive appropriate outreach in the form of postcards and similar communications in an effort to further encourage dental engagement

- Specific to an at-risk condition, such as early childhood caries, parents whose children have been seen by a PDP for screening and varnish application will receive a letter from UnitedHealthcare reminding them of the importance of follow up with a dental home

- UnitedHealthcare will engage with community based efforts key provider groups that provide health services to the children of Nevada

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.

We will be utilizing the industry leading Enterprise System platform to administer the Nevada dental Medicaid program. Using the integrated Enterprise System platform maximizes the opportunity for communication between us, the PDP, the recipient, other service providers and care managers. The system integrates recipient assessments, case management notes and person-centered care treatment plans with the basic administrative data, claims, encounters, service authorizations and call center communications with our recipients. The Enterprise System tracks information about recipient health in the Enrollment Module. Diagnosis and treatment are captured as part of claim submission and stored with the claim record, which is automatically linked to the recipient enrollment record. Historical diagnosis and treatment data is never purged and can be extracted from the system for many different reporting purposes, including paid claim analysis, financial liability reporting, provider profiling, etc. Our technology is web-based, fully integrated 3-tier architecture. Data sources for populating the system include EDI data loads, electronic submission through Provider Web Portal, and data entry through the Enterprise System user interface.

The Enterprise System includes several custom-built, integrated application modules which provides the integrated database where all information on recipients is maintained and accessible to all authorized staff, including recipient case-management data and all utilization data. The system includes all required database information, such as:

- Administrative and demographic data

- Claim and encounter data

- Prior authorization and provider referral data

- Communication history (e.g., correspondence and explanations of benefits)
- Member services call center contact data
- Grievances and appeals

This member-related information is available to our service staff that interacts with recipients and with the providers serving our recipients.

3.9.21 IQAP Documentation

UnitedHealthcare oversees the effectiveness of program quality management, quality improvement, and preventive health education activities. Quarterly status reports are made available to the Plan's management, clients (as required) for review and evaluation of effectiveness.

The Dental Director has overall responsibility for the quality management program. The Dental Director and the Director of Quality Management are responsible for monitoring follow-through when clinical and service opportunities for improvement are identified.

An annual critical evaluation of the QAPI is completed to ascertain that the goals are met and improvement initiatives are effective. Such review focuses on evaluation of defined goals and objectives, review of completed QI activities, program scope and organization. Highlights include trending of key clinical and service indicators, documentation of quantitative improvements in care and service attributable to QI initiatives, evaluation of QI resources, and recommendations for the coming year in the work plan. Any barriers to the QI process are analyzed and identified to create actions to overcome any and all barriers to the improvement process.

Formulation of the annual Quality Improvement Program incorporates findings from the program evaluation in addition to activities mandated state and federal programs, and client contractual agreements.

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.

UnitedHealthcare has developed and maintains criteria and guidelines for care and service to ensure that Plan recipients receive all necessary, adequate and appropriate preventive, and restorative dental services which are consistent with generally accepted professionally recognized standards. We have various methods for monitoring quality of care to ensure recipients receive the necessary, adequate and appropriate preventive and restorative dental services which are consistent with generally accepted professionally recognized standards and within expected guidelines. These methods include, but are not limited to, On-Site Audits, Potential Quality Issue investigation, analysis of Grievances and Appeals, review of Credentialing issues, Utilization statistics, and Member Satisfaction surveys.

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.

Nationwide, our Dental Medicaid plans fully engage with our state partners, Federal Secretary of Health and Human Services or any federal or state regulatory entities. We maintain and make available all studies, reports, protocols, standards, worksheets, minutes or other documentation as requested and establish proactive and efficient ways for the state to receive and access requested information such as electronically with look-up functions. Our goal is always full compliance with all contractual requirements.

3.9.22 Coordination of Quality Assurance (QA) Activity with Other Management Activity

The QIC structure supports the QAPI Program through routine reporting, analysis, and identification of opportunities for improvement and implementation of interventions to improve the quality of care and service to recipients. Information from the Dental Clinical Policy & Technology Committee (DCPTC), the Credentialing Committee and the Peer Review Committee (PRC) report to the QIC, through the Clinical Affairs Committee (CAC) at least quarterly. The QIC presents reports to the Board of Directors.

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.

Annually, we formally document our quality assurance program through a trilogy of documents that help us establish goals and objectives to drive continuous quality improvement (CQI). These documents include the Quality Program Description, the QI Work Plan and the Quality Program Evaluation. Annually, we conduct a comprehensive evaluation of the effectiveness of our Quality Program, and the evaluation from the prior year informs the development of the Quality Program Description and QI Work Plan for the upcoming year. Our board of directors and QIC approves all three documents as documented in the meeting minutes and submits them to applicable regulators as required. The QIC is the decision-making body that is accountable for the implementation, coordination and integration of all QI and management activities specific to quality improvement in Nevada. Our QIC includes dental clinical staff, operational leaders and network providers. The QIC analyzes and evaluates the result of quality management and improvement activities, recommend policy decisions, confirm that providers are involved in the quality program, institute needed action and verify that appropriate follow-up occurs.

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

We conduct ongoing monitoring of providers, which includes collection and review of sanctions; limitations on licensure; member complaints; and quality issues. If an issue or violation of our credentialing requirements is uncovered during this time, appropriate action is taken in accordance with our provider participation agreements, the credentialing plan, and regulatory and accreditation requirements.

While provider utilization is continuously tracked and promptly acted upon if an issue arises, we also provide our Credentialing Committee with provider utilization data at the time of recredentialing. These committees review the reported list of providers and their data to identify providers with utilization issues and factor their performance into our network recredentialing decision and processes.

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.

Nationwide, we coordinate quality assurance activities with UM, risk management, our members' grievances and appeals through our staffing models, committees and our robust and systematic performance monitoring that links these dimensions and the routine sets of reports and dashboards, which are part of the suite of performance monitoring tools.

Our QIC monitors UM, risk management and our members' grievance and appeals processes and outcomes for continuous quality improvement, with the intent of promoting overall quality in the delivery of services to our recipients.

Ultimately, the UM Program, annual Evaluation and QI Work Plan are reviewed by the board of directors, independently from the Quality Program key documents.

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

Quality assurance (QA) is a large part of all other management functions and our dedicated on-site quality staff helps to facilitate this coordination. Network changes or updates, benefits redesign, medical management systems, feedback to practitioners, patient education and recipient services are all supplemented by QA activities including feedback about the quality of services delivered by our contracted practitioners.

1. Network changes;

As provider network changes are made, we analyze the impact of these changes on the provider network. Access and availability reports are also routinely reviewed to verify that the standards for geographic access for PDPs and high-volume specialists, open panels, and appointment access, among others, are maintained during any changes and transitions. In addition, as new providers are needed in certain specialties or geographic areas, Provider Services outreaches to new providers to create letters of agreement or new contracts to bring those providers into our network. Changes in network or access and availability are discussed routinely during the QIC or related task force meetings to evaluate the impact of any changes on the membership. Any actions and potential barriers in health care are reviewed to confirm limited effect.

2. Benefits redesign;

As benefits are redesigned, we complete an evaluation to determine how the benefit redesign impacts recipients and providers. Senior management at the health plan review available utilization and other related information to make consistent and educated decisions on the best way to redesign benefits. As appropriate, benefits redesigns are discussed throughout the QIC structure. Any discussions focus on how benefit redesigns may affect recipients or providers through any changes to related UM processes or any impact that could be seen on services and member satisfaction.

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

Minimizing the disruptions for recipients and providers is vital to maintaining a cohesive and collaborative relationship at all points of care. Our UM Committee is responsible for reviewing ongoing reports to determine utilization trends and the impact on pre-service determinations, amongst others. In addition, the QIC and related task forces evaluate reports related to grievances and appeals to review trends. If trends for appeals are noted, consideration is given to that decision making protocol to see if it needs to be updated or staff need retraining on their interpretation. All dental management protocols are reviewed by the CAC (that includes quality leadership) to verify that the protocols are evaluated and approved before final adoption. Our UM Committee reviews reports such as the prior authorization turnaround times to determine if there are potential opportunities for improvement or challenges to address.

4. Practice feedback to practitioners;

We have developed an innovative, proprietary provider report card that profiles each provider's utilization, compares them to their peers and identifies outliers in terms of utilization and quality metrics. The provider report card was developed with MicroStrategy, which provides online, interactive access to individual provider report cards, provides lists of recipients who received treatment from each provider, and displays the chronological treatment history for each recipient. The report card reports each provider's utilization in each clinical treatment category (amount paid, number of services, recipient count), showing the statistical variation from his/her peers by state. The provider's percentile ranking in each category is reported, in addition to the ratio of that provider's performance to the peer average. For example, if a provider ranks at the 15th percentile for preventive services that means that 85 percent of the peer group score higher than this provider in terms of preventive services per recipient. A ratio of 4.5 in surgical extractions indicates that this provider submits surgical extraction codes at a rate per recipient 4.5 times the network average. In addition each provider's overall costliness is reported and compares him/her to their peers. A provider with a cost index of 300 percent generates a claims cost per recipient three times the network average.

Several Dental Quality Alliance (DQA) preventive measures are included in the report card:

- Percentage of children who accessed care who received an periodic evaluation
- Percentage of children who accessed care who received topical fluoride
- Percentage of children who accessed care who received sealants
- Percentage of children aged 6-9 who received a sealant on a first permanent molar tooth
- Percentage of children aged 10-14 who received a sealant on a permanent second molar tooth

Each provider's metric for each DQA measure is reported and compared to the state average.

The report card enables us to identify providers who demonstrate unwarranted variation. Generally we are concerned with providers who under-deliver preventive and diagnostic services or over-deliver other services. We can examine recipient treatment histories, visit by visit, to assess the sequencing and types/quantity of services rendered. If aberrant patterns are suspected we can retrieve recipient radiographs from the prior authorization module. Armed with detailed treatment histories, supporting radiographs and the report card, a UnitedHealthcare dentist can make a preliminary determination of whether there are potential quality of care and/or claim submission concerns.

The report card is supported by our comprehensive data warehouse, which is available online and in real time to all analysts and clinicians involved in profiling. The Nevada Dental Director, a licensed Nevada dentist, will review the profile results of all flagged Providers with aberrant claims/utilization patterns and determine if further investigation and/or remedial action is warranted.

5. Patient education; and

We use several methods and communication channels to educate members and families about the preventive care linked to our HEDIS measures and our quality activities including, but not limited to:

Welcome Kit and Member handbook: The Member handbook is a valuable resource providing information on EPSDT, well-child checkups, emergency and urgent care, covered/non-covered services, and a summary of benefits, language and cultural help and information about our quality activities. New recipients also receive welcome calls within 30 days of enrollment to enable our staff to personally provide information and education to recipients on how to access services, and allow recipients to ask any questions they may have about obtaining services. The Provider Directory, also included in the new member welcome kit, encourages regular checkups, screenings and to provides recipients and their families with a list of participating network providers.

Educational Mailings: We provide education through routine educational mailings using a set of targeted, age and gender-appropriate member health education and prevention reminder mailers.

Member Website: Our website is an additional resource for recipients and their families, providing assistance in accessing services by providing benefits information, online provider directories, our member handbook and information on quality assurance. All of our member materials, including those posted online are designed to meet the unique needs and challenges of our recipients, including appropriate reading levels, multiple language offerings and culturally appropriate materials.

6. **Recipient services.**

Member advocates: Our knowledgeable, experienced member advocates are also key recipients in our member outreach and education about EPSDT screenings as they answer our members' non-clinical questions efficiently and accurately. Our member advocates are trained on Nevada benefits and priorities for the unique population they serve, and our frequent reinforcement of that training keeps those objectives top of mind for every member advocate. For example, since our member advocates know that achieving compliance in EPSDT screenings is a primary goal, in each interaction with the recipient, member advocates verify that the recipient has a PDP, and that the recipient has seen his/her PDP to receive all preventive care, including EPSDT screenings. Our member advocates can schedule recipient appointments with the PDP, while the parent or guardian is on the phone.

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.

We provide our state partners with complete and accurate reporting related to uniform utilization, cost, quality assurance and recipient satisfaction/complaint data; in addition to quality of care internal monitoring, evaluation and action planning activities including the provision of all required reporting in the format, frequency and timing specified. Our reporting and analytics staff is responsible for the state agency's reporting deliverables and facilitate any data validation activities requested by the state agency.

We also will provide all ad hoc, management and standard reporting, and automated tracking and processing systems necessary to perform the responsibilities of the Nevada contract. Our customer web portal will provide the State with access to real-time data that can be organized in several easy-to-use formats including: executive dashboards, provider profiling reports, and Enterprise Business Intelligence System (eBIS) reports. The portal also will provide your staff with full oversight of our authorization processing and call center performance.

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

We monitor and track grievances and appeals information on an annual basis. Those reports will be submitted to the State at least annually.

3.9.24 Dispute Resolution

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

We maintain a provider services unit to handle provider questions and disputes. The provider services unit includes employees dedicated to contract management, development of the provider directory, provider advocates, provider credentialing and network contract management. While the appeals and grievances department handles provider disputes for us, the provider services department is available to monitor and help facilitate resolution to provider disputes when necessary.

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.

Participating UnitedHealthcare Dentists or formerly contracted Dentists, who believe they have been adversely impacted by the policies, procedures, decisions, or actions of the Plan may have a right to file a dispute with the Plan as provided by state regulation or provider contract. The Plan will acknowledge receipt of the dispute within fifteen (15) business days and resolve the dispute within forty-five (45) business days of receipt of all information necessary to make a resolution unless otherwise required by individual state requirements. Following notification of the Plan resolution, if unsatisfactory, the Provider may appeal this decision as provided in their Provider Contract.

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.

Our appeals and grievances department received and processes grievances and appeals. It tracks all grievances and appeals to resolution, including the nature of the dispute, the date received and the final resolution. We submit quarterly reports and provide monthly reports as requested that document the grievance and appeals activity, including member and provider inquiries and disputes.

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:

In compliance with Section 3.10.1, we agree to collaborate with the State to support the Strategy and perform in alignment with all federal and state statutory and regulatory quality requirements. As an organization, we are committed to continuous quality improvement. UnitedHealthcare is committed to quality improvement activities to identify systemic quality of care and quality of service issues, and to create initiatives to improve identified quality parameters and hence to improve care and service.

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

Our approach to each state's local and state public health needs is based upon our ability to leverage the support and resources of the larger organization, including identifying and expanding health promotion programs and "best practices" to address local priorities, such as those identified by the Nevada Strategy. Our belief is that quality strategy must begin locally, taking into account each state's unique patterns of care, provider community and patient populations. Through our quality management program, we address the regulatory requirements of the State and federal requirements as outlined in 42 CFR §438, and strive to achieve the highest standards of care.

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.

The Nevada Medicaid and Nevada Check Up quality management program is structured and staffed to enable us to systematically monitor and evaluate the quality and appropriateness of care and continually improve health outcomes for recipients in Nevada.

We use a comprehensive array of monitoring approaches and mechanisms as components of our quality management program infrastructure to identify and prioritize areas for improvement, set quantifiable goals and metrics, and communicate clear expectations. We accomplish this through the formal structure of our Quality Improvement Committee (QIC).

The QIC is an integrated and cross-functional committee that provides Strategy oversight—incorporating clinical and non-clinical program review to holistically address member care and service rendered in Nevada. Our QIC structure delineates clear accountability and inclusive participation by leaders from all functional areas that are empowered to act to address opportunities to improve care and service.

Our monitoring and evaluation strategies for our quality management program include the following activities:

- Implementation of interventions as indicated for continued quality improvement
- Measurement of various indicators regarding our performance on preventive health, including, but not limited to, HEDIS measures for children and adults
- Leveraging our nationwide data and experience to internally benchmark our performance and to expand best practices for the benefit of Nevada recipients

We agree to submit all state required documentation and fully engage with the annual independent assessment conducted by the external quality review organization as designated by our regulators. We welcome the feedback we receive because of these submissions and independent assessments on the quality of care delivered to our recipients and we appreciate the chance to resolve identified opportunities in the interest of continuously improving our programs. Our goal is always full compliance with all contractual requirements while working innovatively to exceed the expectations of DHCFP.

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);

We have a written strategy for assessing and improving the quality of services we provide. On an annual basis, we formally document our quality management and improvement processes through a trilogy of documents: the Quality Management Program Evaluation for the prior year, which in turn informs the development of the Quality Management Program Description and the QI Work Plan for the upcoming year, which we review and submit to DHCFP.

A WRITTEN STRATEGY FOR QUALITY MANAGEMENT AND IMPROVEMENT

The trilogy documents serve as the cornerstone for our quality management program, including methods, timelines and individuals responsible for completing each task. The QIC and board of directors approve all three documents. They are then submitted to DHCFP for review and are available for review by the DHCFP designated external quality review organization (EQRO) as requested.

QUALITY MANAGEMENT PROGRAM DESCRIPTION

The Quality Management Program Description provides details regarding the goals, objectives, structure, oversight, leadership participation, resources, methodologies used and key components of the quality management program. Goals and objectives are set based upon the findings of the previous year's evaluation and through direction from the board and our executive team to confirm alignment with the strategic plan.

Both the board and the QIC approve the Quality Management Program Description annually and direct its revision as appropriate to the changing needs or strategy. Both the board and QIC also confirm that the Quality Management Program Description includes monitoring and evaluation of both care and service and subsequently all critical components for a comprehensive quality management program. The Quality Management Program Description also describes the subcommittees of the QIC, including their scope, membership and frequency of meetings.

QUALITY IMPROVEMENT WORK PLAN

The QI Work Plan is a living document, updated annually or as needed. The Work Plan directs the routine activities under the quality management program and is the basis for our committee activities. Through updates and subsequent review and approval by the QIC, we verify that the Work Plan encompasses all aspects of clinical care, service and operations, and member and provider satisfaction; designates responsible leaders and staff for each identified improvement activity; and includes a time frame for completion and reporting of each activity to the appropriate committee. We assign critical quality indicators, including process and outcomes measures, performance goals and benchmarks to each activity. Each item in the Work Plan aligns to a key component of the quality management program as outlined in the Quality Management Program Description. We not only focus on those measures identified by our state partners, our Work Plan also addresses a broad range of program activities of importance to the health of the populations we serve, to include EPSDT services, preventive health and screening, and member/provider satisfaction.

QUALITY PROGRAM EVALUATION

The Quality Program Evaluation is the annual assessment of the effectiveness of our quality management program. The quality management team reviews in detail the effectiveness of each activity on the Work Plan for the prior year, as they align with the critical components in the Quality Management Program Description and evaluates our performance on our critical quality indicators against the established, approved performance goals and benchmarks.

Incorporating qualitative and quantitative data; clinical service and satisfaction data; and committee actions, the Evaluation assesses whether we have met our goals and objectives as set forth in the Quality Program Description. The QI Work Plan for the next year includes the barriers, opportunities and interventions identified in the Evaluation, providing the mechanism by which the established, documented quality management program drives ongoing quality improvement for QI Program Evaluation This evaluation includes:

- Monitoring and reviewing all QI Program activities performed
- Reviewing successes and program effectiveness
- Addressing barriers and challenges
- Identifying potential opportunities for improvement
- Responding to additional actions based upon the program review
- Demonstrating key successes in QI

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;

We agree to participate in and assist with collecting input from Nevada recipients and other stakeholders in the development of the Strategy. As we partner with states, our ultimate accountability is to demonstrate that we are an effective steward of state and federal Medicaid dollars. The effective use of these health care resources helps to change health behaviors and improve the health of the individuals who make up the populations we serve. We welcome the opportunity to collaborate with recipients, providers, other State agencies and other MCOs to support the state agency in achieving their managed care quality improvement goals. We also collect and share recipient feedback with DHCFP as described in the following paragraphs.

To assess our QI Program from our recipients' perspective, we conduct ongoing activities to monitor recipient satisfaction. On an annual basis, we collaborate with an external survey conduct the member satisfaction survey. We review the results of this survey with the QIC for identification of additional actions to improve the recipient experience and eliminate barriers that may affect their experience.

In addition to survey results, on an ongoing basis, we monitor complaints and grievances received from our recipients and providers. We have well-defined policies and processes for responding to issues and tracking and trending the types of issues we receive and their outcomes. We track and trend complaints and grievances data from recipients and providers on a monthly, quarterly and annual basis as an additional mechanism to assess and improve customer satisfaction with our dental plan.

We identify, document, and immediately respond to our recipients' problems and issues including, but not limited to service gaps and complaints or grievances regarding the quality of care rendered by our providers.

On a quarterly basis, the QIC reviews complaints and grievances inventories to enable monitoring for trends and analysis of opportunities for improvement. In addition, the trended data are further analyzed in the annual program evaluation, which drives quality improvement recommendations made to various operational areas based upon the year-over-year data.

C. Ensure that the vendors comply with standards established by the DHCFP;

We have an ongoing quality assessment and performance program in place to monitor our execution of the services we provide to DHCFP. Our internal quality assurance program—referred to as the quality improvement (QI) program—consists of systematic activities to monitor the health care and services delivered to recipients using predetermined and objective standards such as number/types of grievances, number of providers and member satisfaction.

We identify opportunities for improvement, quality barriers for each standard and we design initiatives to address specific areas of focus. Our annual QI Program evaluation is another opportunity to review and assess effective improvement with input from DHCFP.

COMPLIANCE WITH DHCFP STANDARDS

To make sure we comply with DHCFP standards, we provide access to all information required for the external quality review. We provide all materials in the time frame and format requested, for the designated EQRO. This provides verification that we:

- Maintain fiscally sound contracts
- Have policies and procedures that adequately address quality issues and requirements
- Provide technical validation of our performance improvement projects
- Provide technical validation of our HEDIS data collection and measures
- Review our adoption, dissemination and adherence to standards and clinical practice guidelines
- Comply with various quality assessment/improvement standards such as:
- Internal Quality Assurance Program (IQAP)
- Credentialing and Recredentialing
- Recipient Rights and Responsibilities
- Recipient Information
- Availability and Accessibility of Services
- Continuity and Coordination of Care
- Grievance and Appeals
- Subcontracts and Delegation
- Cultural Competency Program
- Coverage and Authorization of Services
- Provider Dispute Resolution
- Confidentiality and Recordkeeping
- Provider Information
- Enrollment and Disenrollment

We provide access to documentation, medical records, premises and staff as deemed necessary by the state agency or its evaluators. We immediately respond to and implement any recommendations made by the EQR within the time frame established by the EQRO, state agency or its designee.

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

Our quality improvement program strategy relies upon consistent, evidence-based practices that positively affect the health care status of Nevada recipients. Our goal is to be responsive to the overarching health care needs of recipients and our approach to quality management is designed to be flexible, innovative and ever-changing, based upon recipient and provider feedback, community assessment and performance measures related to gaps in care.

Our QIC, as a formal committee, comprises senior leaders empowered to make policy decisions and to leverage resources in support of quality improvement, conduct oversight to verify adherence to regulatory and NCQA standards and to monitor key quality indicators, and supervising the ongoing continuous quality improvement process. Quality adherence activities include approving the Quality Program Description and Quality Program Evaluation, reporting biannually to the board of directors and monitoring of EQRO and NCQA review progress and findings. From a quality improvement perspective, based upon the QI Work Plan, the QIC monitors the key quality indicators for outcomes, satisfaction and operations and further evaluates the impact and effectiveness of continuous quality improvement projects, including PIPs.

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

We agree to submit one copy of the initial strategy (e.g., Quality Management Program Description) and a copy of the revised strategy when significant changes are made. This includes two regular reports on the implementation and effectiveness of the quality strategy (e.g., Quality Program Evaluation).

The quality-management program documents, which include the Quality Program Description, the QI Work Plan and the Quality Program Evaluation, establish the basis for CQI in improving recipient health outcomes and continuously evaluating program effectiveness. The evaluation of the effectiveness of our quality management program, and the Quality Program Evaluation from the prior year informs the development of the Quality Program Description and QI Work Plan for the upcoming year.

The QIC, the decision-making body that is ultimately responsible for the implementation, coordination and integration of quality management activities, policies and procedures, periodically analyzes and evaluates the impact, effectiveness and the degree to which they support our goals of CQI every quarter through the QIC meeting.

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.

We work with DHCFP to align the Quality Program Description with the State's Strategy and to create exceptional opportunities for integrated, coordinated and continuous quality improvement (CQI) in compliance with state and federal requirements. We employ a knowledgeable, multidisciplinary quality management team and proven processes that emulate national benchmarks, standards and best practices. We compare these performance metrics to the State's minimum performance standards, goals and benchmarks and to national and regional data, with the objective of achieving sustained improvement year after year and meeting benchmarks as quickly as possible.

The formal, documented, quality management program that we design in collaboration with the DHCFP addresses the particular focus areas identified by DHCFP and the Strategy. It stresses health outcomes and provides for the collection, analysis and reporting of data that support outcome measurement and other indices of quality health care.

As part of CQI, we incorporate all DHCFP standards and any EQR findings into our current QI Work Plan and the annual evaluation, which further informs the development of the quality management program and subsequent year's Quality Work Plan. This approach provides the structure to not only address any findings immediately as documented in our current Work Plan but also to reflect the findings and monitor for sustained improvement and compliance with EQR recommendations in upcoming years.

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.

Quality of care activities are monitored through information obtained in a quarterly MCO 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 MCO 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;

We assess the quality and appropriateness of care and services furnished to recipients through the strength and scope of our quality management program. Through the quality management program, we objectively and systematically monitor and evaluate the quality and appropriateness of care and services rendered by providers using encounter data, process measures and other administrative activities that lead to favorable recipient outcomes. Our quality management program promotes quality of care and service across our health plan clinical programs and operations, and results in improved patient outcomes using the following approach:

Data-Driven Continuous Quality Improvement: At the core of our quality management program is the use and analysis of data to monitor and improve the quality of care delivered over a wide range of clinical and health service-delivery areas, including subcontractors, health services, operations, network management, credentialing, compliance, member services, appeals and grievances and claims. For our recipients, we place emphasis on the clinical areas related to management of disease, recipients with special needs and access to services for recipients. By routinely analyzing key indicators that measure the processes and outcomes of care rendered to our recipients, we are able to identify where we should focus improvement efforts.

A High-Quality Member Experience: We design the quality management program to improve the recipient's experience of care including measurement of consumer satisfaction with the services he/she receives through formal and informal (e.g., member surveys, appeals and grievances, community feedback) initiatives. To improve the health of populations and to reduce the per capita costs of health care, we objectively monitor, systematically evaluate and effectively improve the quality and safety of clinical care and quality of services provided to our recipients.

An Integrated, Coordinated Person-centered Approach: Our quality management program provides an integrated, coordinated and continuous approach to improving the quality of health care and support services across the continuum of care. By improving quality, we strive to affect the health outcomes of our recipients in a positive way. The quality management program is the foundation of our consumer promise to recipients, simplifying, personalizing and leading the way to better care for them and their families.

Driving Program and Cost Efficiencies: Comprising efforts designed to drive program and cost efficiencies across our health plan operations, our quality management program serves as the roadmap for achieving measurable and sustainable improvements by delivering the right care, at the right time, in the right setting. Throughout the quality management process, we seek input from recipients, providers, state partners and key community stakeholders to help us develop programs designed to address the specific needs of recipients in Nevada. We leverage our assets, capabilities and employees to provide our recipients, providers and state agency with cost-effective, high-value and high-quality services.

SUPPORT FOR RECIPIENTS WITH SPECIAL HEALTH CARE NEEDS

For individuals with special health care needs, we have developed a strategic approach that incorporates system of care values to provide integrated delivery of care and interventions that are relevant to all populations including special needs populations. Our approach stresses the importance of assessing the behavioral, emotional, social, educational and physical needs of the recipient, including considerations for nuances that are important to the recipient, such as incorporating traditional and nontraditional services. Care coordination should be recipient driven and holistic in nature, using the assessment process and incorporation of care team activities to enhance the capabilities of the recipient and his/her support system.

Grounded in and guided by person-centered care principles, we embrace each recipient's unique and holistic needs, preferences, goals, background and culture and, through the coordination of services and supports, enhance the recipient's well-being, independence and integration in the community. We incorporate data, operations and services to coordinate a full range of services to meet each recipient's needs through a seamless, holistic experience of care that improves recipient outcomes and enhances quality of life.

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;**

We understand the value the importance of having a cultural competency plan in place. We incorporate cultural awareness into the delivery of care to recipients in many ways, using personal high-touch care and appropriate technological supports, understanding the impact culturally competent care has on improving health outcomes. We integrate recipient age, gender, address, race/ethnicity and language data with clinical data to identify and address any disparities in care that are associated with the aforementioned recipient demographics. We provide clinical and non-clinical cultural competency training to staff to create an awareness of the unique needs of recipients from various cultures, resulting in the delivery of more personalized service.

We believe that cultural competency provides the foundation for our ability to meet our recipients' specific health needs, while honoring each individual's unique circumstances, values and beliefs. Therefore, we actively 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 (LEP) and diverse cultural and ethnic backgrounds. We currently comply with all State and federal regulations pursuant to MSM Chapter 100, Section 103.6 and 42 CFR 438.206(b) (2).

CULTURAL COMPETENCY PLAN

Our Cultural Competency Plan (CCP) is one of the most important elements in our ability to incorporate cultural awareness into the delivery of care to our Nevada recipients.

We have prepared an extensive CCP to comply with the State's requirements related to promoting the delivery of culturally competent services to its recipients. We maintain a comprehensive, written cultural competency plan customized for the State, maintained by the local health plan leadership and is available for State review.

Our CCP includes recommendations and 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 CCP facilitates the provision of timely and appropriate health care and services for plan recipients that continues to be a critical priority for our diverse population. Our plan also includes methods for collecting data that identify race, ethnicity and primary language. We evaluate these data metrics to determine if a health disparity is present. Using common HEDIS measures, we compare the state defined racial groups using statistical significance testing and focused interventions are designed when necessary. We track and document primary language in our Enterprise system so that our internal recipient communications remain sensitive to recipients' preferences. The plan is able to receive a monthly data file and evaluate the accuracy of the data, reconciling discrepancies with the state as needed.

Every year, our CCP and associated monitoring and evaluations remains essential to understanding the needs of different populations who are enrolled in the health plan. Since these needs may change over time, we update the CCP throughout the year with results of recipient and provider feedback, quality improvement initiatives (e.g., PIPs) and other population profile information that provides a timely foundation for culturally competent care of our recipients.

ENCOURAGING CULTURAL COMPETENCY FOR MEMBERS

MEMBER COMMUNICATION AND TRANSLATION RESOURCES

To provide the best service for our recipients with whom we may have communication challenges, we determine the need for changes or additions to verbal and written recipient tools by collecting data on race, ethnicity and preferred written and spoken languages and conduct analyses of this data to perform a cultural and linguistic assessment. We track the number of incoming calls to the member services center requesting the use of an interpreter via our interpretation services, and the number of requests for materials written in languages other than English or in alternative formats, to meet the needs of recipients.

HELPING OUR NON-ENGLISH-SPEAKING MEMBERS

Delivering a consistent member experience as part of our "one-stop" service model includes focusing on the quality of the interaction with our recipients and providing personalized service, including speaking to the recipient in his/her first language. Accessible and appropriate linguistic services are the foundation of culturally proficient health care and upon enrollment into our health plans, the recipient's need for linguistic and translation services is determined and noted in the recipient's record. Our interpretation services are always available to provide our recipients with access to more than 200 languages to meet their communication needs.

Helping Our Hearing-Impaired Members

We use the 711 TTY line to facilitate communication with hearing-impaired recipients, and print the telephone contact information on all recipient mailings and marketing materials. Member advocates are trained on handling calls from TTY operators who are assisting our hearing-impaired recipients.

Assistance for Members with Cognitive Impairment

For our members with cognitive deficits related to either disease states (e.g., Alzheimer's) or mental illness (e.g., depression, schizophrenia), our member advocates are trained to assist the member using empathetic listening and if necessary, engage the assistance of a care coordinator, as necessary, for in-person member assistance.

Provider Cultural Competency

The provider network manager will ensure that we maintain a network sufficient to provide all recipients with access to the full range of covered services, as well a choice of dentist or specialist as required under the contract. The provider network will be responsive to the medical, linguistic, cultural, and other unique needs of any minority or disabled individuals, or other special population in the Nevada Medicaid program. We will also ensure that providers meet all current and future state and federal eligibility criteria, reporting requirements, and any other applicable rules and/or regulations related to the contract through our comprehensive provider training program, ongoing provider outreach, and the use of social media outlets to connect with providers. Our network will also be developed in accordance with the geographic requirements of the Medicaid enrollees in order to adequately address the distance and travel time to appointments as well as the physical access and means of transportation.

Our network management practices ensure that our contracted provider network includes culturally competent practitioners of diverse backgrounds who speak the threshold languages and who can readily access needed interpreter services for all languages spoken by their recipients. We will monitor the demographics of our member population and actively attempt to recruit providers of specific ethnicity in areas, where membership is reflective of a specific cultural group to allow ease of communication and comfort on behalf of the recipient.

We will require all of our providers to complete at least one web-based or live training session in cultural competence. We track compliance in our web-based training sessions through automated webinar attendance logs. Our contracts include a sensitivity provision and require our providers to follow the Americans with Disabilities Act for translation for speech, hearing, or visually impaired recipients. Additionally, a copy of our cultural competency guidelines will be included in the Provider summary guide, and we will publish articles on cultural sensitivity in our provider newsletters.

We place a priority on the recruitment of culturally and linguistically appropriate providers. We will ensure that our provider recruitment process includes the collection of provider demographic data to facilitate the matching of recipients to appropriate providers whenever possible. We recognize that the lack of sufficient numbers of bilingual, culturally diverse professionals is a global challenge in the larger delivery system. On an ongoing basis, our manager of provider outreach will work closely with providers to reinforce the importance of reducing disparities in the delivery of dental services to diverse populations. Both our complaints and appeals analyst and our recipient advocates will be instructed to immediately notify the provider network development manager if they receive a complaint related to a provider's lack of cultural sensitivity. The provider network development manager will contact the provider to discuss the complaint and will discuss with the provider the premise of culturally competent service delivery. Repeated complaints of insensitivity may cause a provider to be terminated from the network.

As part of broader initiatives relating to integrated health care, there are concerted efforts to collaborate with medical and other ancillary specialty benefit functional areas in the development and implementation of various cultural awareness programs. Such programs include the development of cultural coursework and access to the coursework via a web portal, expanded partnership with the U.S. Department of Health & Human Services' Office of Minority Health to disseminate cultural competency educational information for health care professionals, inclusion of web portal links to the Office of Minority Health which provides self-directed education modules, and establishment of tip sheets referencing cultural norms of some ethnic groups who may have a propensity for certain conditions and increased receptivity to certain treatment plans. There are also plans to develop and offer accredited online coursework for continuing education credit and supplementary tools to cultivate respectful, effective interactions with an increasingly diverse patient base to promote healthier lifestyles.

STAFF TRAINING

Cultural sensitivity training for our staff includes topics such as types of disabilities and myths and misconceptions of people with disabilities; stresses the importance of using people-first language to emphasize abilities not disabilities; and provides general etiquette tips in interacting with people with disabilities to promote understanding, respect, dignity and positive outlooks.

MEMBER COMMUNICATION AND WRITTEN MATERIALS

As we communicate with recipients, one thing is clear—we must provide information that is easy to understand:

Assistance for Non-English-Speaking Members: For those recipients who speak a language other than English, Spanish or other language prevalent in Nevada, we offer free interpretation services for more than 200 languages.

Alternative Printed Formats and Services: Language translation services are available for those recipients who are blind or deaf, hard-of-hearing or speech-impaired. To accommodate recipients with different communication needs, we offer interpretive services and can provide information in Braille, large print and voice-recorded CD formats. If a recipient has any questions, he/she can call the member services number (listed in the member handbook under “Important Phone Numbers”) for assistance.

Assistance for Members with Cognitive Impairment: For those recipients with cognitive deficits related to either disease states (e.g., Alzheimer’s) or mental illness (e.g., depression, schizophrenia), our member advocates are trained to assist the member using empathetic listening and if necessary, engage the assistance of a care coordinator (for in-person member assistance).

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;

We monitor and evaluate our internal performance using the program data from a variety of established sources to inform our QI Work Plan. This includes current performance goals and prospective goals, exclusive to Nevada, continuously monitored and updated no less than quarterly, to reflect new priorities and needs. The process includes the creation of critical quality indicators to measure the structure, process and outcomes of care and service rendered. Monitoring of this data is outlined in our Work Plan, which dictates frequency and responsible party, and performance goals and benchmarks to support analysis of our performance. Our QI Work Plan, expanded to reflect the population, addresses the following:

- Quality improvement program scope
- Specific annual objectives and progress toward goals
- Quality of clinical care and associated measures, to include wellness, prevention, chronic conditions, the needs of specialty populations
- Quality of service and associated measures
- Safety of clinical care and associated measures
- Member and provider satisfaction
- Outlines time frames, responsible leaders and staff, and identification of previously identified issues for each activity

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;

We provide all information required for the external quality review in the time frame and format requested by the EQRO designated by the DHCFP. We incorporate any findings from the review into our current Work Plan and the annual evaluation, which further informs the development of the quality management program and subsequent year's Work Plan and any DHCFP approved PIPs. This approach provides the structure to not only address any findings immediately as documented in our current Work Plan, but also to reflect the finding and monitor for sustained improvement and compliance with EQRO recommendations in upcoming years.

We eagerly anticipate the opportunity to collaborate with the EQRO and other stakeholders to develop studies, surveys and other analytic activities to improve the quality of care and services provided to our recipients specifically and Nevadans overall. Our collaboration continues to encompass partnership with the DHCFP and the EQRO to annually measure identified performance measures to assure quality and accessibility of health care in the appropriate setting to our recipients. This includes validation of our PIPs and corresponding measures. We immediately respond to and implement any recommendations made by the EQRO within the time frame established by the EQRO, the Agency or its designee.

We welcome the feedback we receive because of the independent assessment of the quality of care delivered to our recipients and appreciate the chance to resolve identified opportunities in the interest of continuously improving our programs.

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

We have extensive national experience tracking, reporting and improving HEDIS measures. We report to DHCFP and/or the EQRO all HEDIS measures identified in Nevada's Quality Strategy on an annual basis, using the most current version of HEDIS specifications.

HEDIS serves as our standard set of indicators to continuously measure plan performance.

Results are used to identify current gaps in care or service and are integrated into our QI projects. HEDIS measures allow us to track and benchmark performance across the following areas:

HEDIS* Measure: Annual dental visit: This measure is a basic indicator of members' access to care. Results will be used to identify opportunities to increase member access. The measure is the percentage of enrolled recipients who had at least one dental visit during the measurement year and were eligible for coverage in each month of the measurement year.

Dental Utilization by Service Category Role-up: This measure is an indicator of our company's overall performance. We will use the results to identify opportunities to focus on provider and member oral health education, dependent on the percentage of service categories. This measure is the percentage of members enrolled for 11 or 12 months of the measurement year who received a covered dental service that is captured by one or more of the Service Category Role-up buckets during the measurement year. Service Category Role-up Buckets include: (a) Preventive; (b) Diagnostic; (c) Restorative; and (d) Other. We will break out utilization by age bracket and compare results to those of the previous measurement period to determine improvement.

Dental Procedures per 1,000 Member Months: This measure is an indicator of recipient access and delivery of services. We will use the results to identify over- and under-utilization of services. The measure will be calculated for each period within our examination period, which we define as the months captured by two full calendar years and any months in the current year that fall within the last 36 months of the measurement month. If the measurement month is December, the examination period would be all 36 months. The period can by a month, quarter, calendar year or year-to-date. We will break the results out by age bracket and service category role-up.

Dental Procedures per Claimant: This measure is an indicator of recipient access and appropriateness of treatment. We will use the results to monitor appropriate treatment, specifically over- and underutilization. This measure is the number of procedures received by a recipient who received at least one procedure. By utilizing industry leading data technology, innovative clinical models, enhanced provider recruitment and education and creative outreach and case management UnitedHealthcare is committed to increasing the number of children who have access to dental services before the age of 21.

Average Wait times for Appointments: This measure is an indicator of recipient access. The Nevada Medicaid program has an accessibility standard which requires that a recipient must have an appointment scheduled within 24 hours for treatment of an urgent dental condition, or an appointment within six weeks for a non-urgent dental visit. We are currently exceeding the State's requirements.We expect our network dentists to provide initial, follow-up and hygiene appointments within 14 business days. Dentists must provide emergency appointments within 24 hours. Network dentists must follow these access standards and we monitor their compliance.

6. Designates an information system that supports the initial and ongoing operation and review of the DHCFP's quality strategy;

We use powerful analytic systems to design, collect, document and implement data to evaluate the effectiveness of the programs that serves our recipients. Our experience and knowledge of the program enables us to leverage the existing system configurations, including exchanges and interfaces already in place and provide efficiencies, expend fewer resources, and avoid interruptions to the continuum of care for our recipients.

USE OF DATA IN THE DESIGN OF QUALITY IMPROVEMENT PROGRAMS

When we identify a situation in which we are not meeting our performance goals, we use data to design our quality improvement initiatives. With consultative support from our local quality improvement team, this process takes place anywhere in the health plan. This includes from our integrated teams who receive scorecards and consultative support from our national quality management team to interpret the data specific to their areas of focus, to our Quality Improvement Committee (QIC), which is charged with monitoring of all critical aspects of care and service delivery. We primarily use data through two mechanisms: benchmarking and root cause analysis.

To understand our performance in the context of the health care systems in-state, regionally or nationally, we obtain data that allows us to determine if our performance is indicative of an opportunity unique to our health plan or our performance reflects a larger scale pattern. For example, when benchmarking against other health plans' results, we may discover that all health plans in a state declined in performance, indicating external causal factors. Conversely, if our performance is well below other similar health plans, we look internally for causes of that performance and we seek best practices to enable improvement in our metrics. Benchmarking data helps us understand the context of our performance and focus our quality improvement efforts.

Once we have a general focus, we convene a team of internal staff from quality management, dental management, customer service and provider relations and conduct an in-depth root cause analysis, with the objective of understanding the barriers and opportunities to improve performance. Data incorporated into a root cause analysis can be qualitative or quantitative, and might include:

- Feedback from member or provider surveys
- Utilization management data such as authorizations
- Claims and encounters data
- Member and provider satisfaction survey data
- Complaints grievances and appeals data
- Access and availability results
- Published literature
- Staff feedback, often from our clinical practice consultants and member advocates

Once we have this data, we establish causal factors to identify the areas where we can best implement actions to remove barriers to achieving our performance goals. The result of this process is a set of recommendations for member-focused, provider-focused and system focused actions that we can implement through a formal Performance Improvement Project. Because these action steps were identified based upon data analysis, we are able to make the best use of our resources to implement the 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**

We are dedicated to the highest standards of integrity and strive to meet and exceed the explicit expectations of DHCFP and the recipients who rely on us for their health care services and agree to cooperate with all state and federal monitoring of our performance.

Regarding the quality penalty fee outlined in this RFP, overall, we monitor a process and outcomes indicators, HEDIS and non-HEDIS alike, for the overall population and for sub-populations within the membership. If DHCFP or we identify an area that is not performing as expected in comparison to external and internal benchmarks and performance goals, we perform a barrier analysis to identify ways to improve performance.

We use the resulting root cause data to design clinical improvement programs and conduct targeted quality improvement initiatives. We establish these data driven programs and interventions to improve performance across identified critical areas, and once implemented, we monitor outcomes and progress toward established clinical performance measures.

Related to sanctions for non-compliance with the provision of covered medically necessary benefits and services, the benefits package provided to our recipients is no less in amount, duration and scope than those covered services specified in the Nevada Medicaid Service Manual.

We have numerous controls and processes to validate benefit plans are configured correctly and reflect the same benefit package as outlined in this RFP. Our workflows provide for accurate automation of benefit plans and verify all medically necessary services are in the same amount, duration and scope as services furnished to recipients under FFS programs.

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.**

As an organization, we are committed to market leadership in quality and regulatory compliance and we have made this commitment to the recipients we serve in our Medicaid, Medicare and commercial plans. We adhere to 42 CFR Part 438 standards set by CMS. However, should there be a conflict in standards or requirements, we will apply whichever guidelines are more stringent.

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.

We comply with all DOI fiscal standards in addition to the managed care program standards described in Section 3.11.

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.

We will provide a performance security deposit in the form of a bond furnished by a surety company that is authorized to do business in the State of Nevada to the DHCFP that will guarantee payment of the vendor's obligations under the contract.

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.

We will meet the requirements of Section 3.12.2, including the initial deposit of $4,000,000 within 10 days of the award of the contract. We also will review the deposit at the end of the first quarter of the contract period to ascertain whether the deposit needs to be increased or decreased.

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.

The security deposit shall be equal to 110 percent of the highest month's total capitation amount in the first quarter or $4,000,000, whichever is greater. It will be deposited with the State Treasurer within 15 calendar days after the end of the first quarter of the contract.

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.

After the initial year of the contract, we will increase our security deposit amount to reflect an amount equal to 110 percent of the preceding year's highest month's total capitation or $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:

When submitting performance security to the State of Nevada in the form of a surety bond, we will use a company that meets the following listed requirements:

- A.M. Best A-VII rated insurance company
- Certified by the Department of Treasury, Financial Management Services for Nevada
- Licensed by the Nevada Department of Business and Industry, Division of Insurance

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

Please see Question Response 3.11.2.3.

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

Please see Question Response 3.11.2.3.

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

Please see Question Response 3.11.2.3.

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 agree to maintain the performance security deposit after the contract term for the length of time to be determined by DHCFP to cover all outstanding liabilities.

3.11.3 Vendor Liability

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

All requirements set forth below in 3.11.3 A-D are included in our provider contracts.

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;

Our subcontractor contracts include language to ensure that our recipients are not held liable for our debts, in the event of our insolvency.

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

We ensure that our recipients are not held liable for any services provided to recipients in the event we fail to receive payment from the state. We also ensure that recipients continue to receive services without disruption.

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

We ensure that our recipients are not held liable for services provided to recipients in the event a health care provider fails to receive payment from the state or the organization. We honor our financial responsibilities and continue to pay claims for these recipients despite the delay in capitation payment from State agencies.

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.

We ensure our recipients are not held liable for payments to a provider who furnishes covered services under an agreement with us through language in our provider agreements. We also communicate this provision to recipients via the member handbook.

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.

We ensure our recipients are not held liable for continuation of services to recipients during insolvency pursuant to State Medicaid Manual 2086.6.B. Recipients will continue to receive services should we become insolvent.

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.

We meet state and federal requirements for processing claims for eligible recipients for eligible services in a timely manner. We have robust IT systems that will allow claim processors to evaluate recipient and benefit eligibility in a timely manner.

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.

We are a committed partner to confirming that Medicaid is the payer of last resort and has strong electronic screening for third party liability (TPL). We have established comprehensive TPL procedures in place to comply with this requirement. We have sophisticated IT systems that allow us to stop payment of a claim prospectively based upon known TPL. Once claims with TPL are identified and verified directly with the other payer, we coordinate activities to ensure costs for services are either avoided or recovered from the liable party.

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.

Information technology is a key factor in our ability to effectively manage health benefit programs for DHCFP and deliver quality, cost-effective health care to its recipients. Our integrated platform is able to process electronic enrollment and premium processing, provider network management, electronic claims processing, automated utilization management, person-centered case management, sophisticated electronic encounter reporting, auditing and management processes.

The Enterprise platform integrates recipient demographics, eligibility, benefits, case management, prior authorization, provider demographics and automated contractual rates for accurate claims processing. As a claims management tool, it provides a high degree of automation and data capture. During the various stages of the adjudication process, it provides accurate and highly automated adjudication of claim submissions through interaction with membership eligibility, product benefit parameters, provider pricing agreements, medical management requirements and the clinical editing system comprising CMS-developed edits under the National Correct Coding Initiative (NCCI).

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.

We accept claims from both network and non-network providers for covered services in accordance with the current contractual time frames:

- Network providers will be able to submit claims for up to 180 days
- Non-network providers will be able to submit up to 365 days from the last date of service

To confirm compliance, we programmed our industry-leading and award-winning claims processing platform, with edits that allow provider submission according to DHCFP-mandated timelines.

3.11.4.5 The vendor must meet the requirements for timely claims payment in 42 CFR 447.45d (2) and (d) (3) and abide by the specifications of 447.45(d) (5) and (d) (6). The vendor must pay ninety-five percent (95%) of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within thirty (30) calendar days of the date of receipt. The vendor must pay ninety-nine percent (99%) of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within ninety (90) calendar days of the date of receipt.

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

We fully comply with 42 CFR 447.45d (2) and (d) (3) and the specifications of 447.45(d) (5) and (d) (6). We further agree for valuable consideration that NRS §695C.185 and NRS§695C.128 will apply to the terms of any contract we may enter into because of this RFP. We work collaboratively with our provider network on many issues, including establishing and documenting in our network contracts an alternative payment schedule. We have consistent practices if 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. We have passed audits to confirm that we use these dates consistently.

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.

We maintain policies and procedures to receive and process claims and encounters that are submitted for payment from any source for services provided to recipients.

RECEIPT OF CLAIMS

We accept claims electronically and on DHCFP-mandated paper claim forms from both network and non-network providers.

- Paper claims are received through the mail.
- Providers submit claims and encounters directly to clearinghouses, which then transmit the claims and encounters to us in an HIPAA-compliant format. Files are received via a secure file transfer protocol (SFTP) directory. Submitting via EDI is the preferred method for claims submission, as it allows for much faster entry of claims into our system for providers and less risk of claims getting lost in the mail.

All claims and attachments—whether on paper or electronic—are processed by our leading edge claims platform, with the same system edits being applied concurrently to both paper and electronic claims.

Our software platform was originally designed and built to be a web-based dental benefits management system. Our system design and electronic capabilities are unique to driving what we do best: giving our clients, government agencies, and dental providers unmatched claims processing services, including claims adjudication, service limitations, and accurate pricing, as well as transparency into program operations.

Our technology tools allow us to automate and customize claims processing tasks, ensure accurate and timely payments, and lessen administrative burdens for high-quality providers—leaving our professional staff free to focus their attention on those providers and members who need it most.

Because of the many benefits associated with the submission of electronic claims, we prefer to receive claims electronically. Our dedicated Electronic Outreach team and on-site Field Provider Relations Representatives work closely with providers to encourage and support electronic claim submission (whether through a claims clearinghouse, a secure direct claim data file submission from the provider, or claim data entered via the provider web portal). For those providers who have not yet adopted technology, we also accept and process paper claims submitted on the current approved ADA Dental claim forms.

Our advanced reimbursement features built into our benefits management software give complete flexibility to set up any payment methodology, fee schedule, or reimbursement schedule required by the State.

Our benefits administration software system verifies recipient eligibility based on the recipient's unique Member Identification number (MID) and recipient matching attributes at numerous points during both the data entry/file import process as well as during claims processing. During the claim processing edit cycle, the system checks each recipient's eligibility information to verify that the patient has coverage under the appropriate benefit package as of the specified date of service.

Our benefits administration software automatically determines whether a service is submitted within the 90-day timely filing from date of service limit. The system determines if a claim should be paid or denied based on both the benefit plan rules and the patient's service history. For timely filed claims that were originally denied and subsequently resubmitted, we will meet the State's requirement. We have an established and effective corrected claims process to support reprocessing of previously denied claims as timely and reevaluating for payment reconsideration.

Our benefits management software has the capacity for fully automated, continuous, real-time claims processing. In 2014, we implemented a continuous claim processing initiative to improve our overall speed of processing claims payments and to improve the efficiency of the check run process by reducing human intervention.

Successful implementation of this initiative has had impressive results—some providers are finding their claims are moving from electronic submission to electronic payment in a single day. With client approval, we have implemented daily provider electronic fund transfer (EFT) claims payments for those providers who transact 100percent of their claims through electronic submission and receive electronic payment and remittance advices. We will work with the State to determine the feasibility and timing of implementing a real-time dental claims adjudication and daily payment process for the plan's providers.

We agree to provide the State with testing and approval processes as part of any update or replacement to our benefits management software system that could impact claim payment or interface with the State's systems, at least as it affects the State. A cornerstone of our benefit administration platform is to provide our clients with seamless technology services without interruption. This includes, but is not limited to appropriately loading your member eligibility information, adjudicating claims according to State rules and policies, forwarding claims and claim reversals accurately to MMIS, accepting MMIS data loads into our system, and sending prior authorization data to the State's data warehouse.

Information Management to Support Claims Processing

We operate as a paperless company. This means that 100 percent of incoming documents, such as claims, authorizations, X-rays, and provider contracts, are scanned as electronic documents and available for online retrieval through our processing system. Data such as historical dental claim and authorization data, third-party liability (TPL), dental providers, provider rates and fee-for-service information, covered procedure codes, payment information and Remittance Advices, as well as MMIS system edit codes and recipient data, are held in our software system and retained indefinitely and never purged.

Our system can also make all historical data available 24/7/365 for reference during processing edits, for detailed analysis reporting, for authorized users for immediate online access, and for ensuring continuity of claims administration and processing.

We understand the State's requirements for information management, and can maintain the following in our system:

- All dental claims data as well as all claims data with service limitations, including lifetime service limitations, to ensure the continuity of claims administration and processing;
- All recipient information it receives for recipients with dental coverage, and for individuals for whom dental services are payable;
- All dental provider information it receives for the State's dental providers;
- All MMIS system edit codes and criteria in effect on or after the "Go-Live" date, to ensure proper adjudication of claims with dates of service on or after the "Go-Live" date, in accordance with dental program regulations;
- All prior authorization information;

- All TPL carrier information;
- All provider rates information;
- Fee-for-service information;
- Covered procedure codes in effect on and after the "Go-Live" date, to ensure proper adjudication of claims in accordance with program regulations;
- Payment information as determined necessary for customer support; and
- Payment remittance advices for distribution to dental providers.

DATA EXCHANGE TO SUPPORT CLAIMS PROCESSING – OPERATIONS

We have performed data connectivity with each of our 65 clients in the past six years. Because our team is so strong in this area, there have been no operational or connectivity issues since our inception. We comply fully with all HIPAA standard transactions. Working in collaboration with the State, we will gather and analyze the specific business requirements and technical specifications for mutual data exchanges with the State to support claims process, and then recommend an appropriate approach. As required by the RFP, our approach will include the following:

1. Our automated enrollment system has built-in flexibility that allows us to easily accommodate the preferred schedule for eligibility and TPL data updates, including nightly new recipient and recipient change files, nightly new provider and provider change files, and a full file load of TPL carrier information as required by the RFP. Business rules can be applied against the imported data to ensure it matches the original file data, and customized data edits can be applied to meet the States requirements.
2. We will receive and process nightly a file of dental provider data from the State.
3. We will receive and process monthly, or when requested, a file of TPL carrier information.
4. We will update our claims history as determined necessary for dental provider support using financial information data files received weekly from the State's systems.
5. As necessary, we will update our system using fee-for-service information received from the State.
6. Our dental benefits management software is designed to accept data loads of data files determined by the State as necessary for the administration and processing of dental claims.
7. We will submit paid claims files weekly in the Claim File and Claim Reversal File formats as specified by the State to facilitate payroll processing in MMIS, payment processing by the Nevada State accounting/reporting system and the Treasury and storage in MMIS claims history and the State's data warehouse. These files will be delivered no later than 7:00 a.m. Central Time each Thursday, using secure transmission methods. All claims files that we generate undergo a series of edits to ensure complete, accurate data before they are transmitted. We use HIPAA compliance software to ensure that electronic file data complies with HIPAA standards. We transmit outbound encounter files using encrypted secure FTP (SFTP) protocol for all data exchanges.

8. Our technical processing abilities support member linking. We will work with the State on business and technical requirements concerning the unlinking of members. On a weekly production basis, no later than 8:00 a.m. Eastern time each Thursday, we will transfer to State systems those administrative adjustments created by our system due to member linking and unlinking for processing in MMIS. This data transfer will meet the administrative adjustment format specified by the State.

9. On a weekly basis, we will receive from the State claim status files that we will use to verify the successful transfer of claims and claim reversal data to MMIS. We will take appropriate actions to resolve and issues associated with reject claims or claim reversals that are our responsibility. We will work collaboratively with the State and your MMIS vendor to successfully resolve rejection discrepancies.

10. We will receive on a weekly production basis from your administrative adjustment status files. We will use these files to confirm the successful transfer of administrative adjustment data to MMIS and to correct any issues associated with rejected administrative adjustments that are our responsibility. We will work in partnership with the State and the State's MMIS vendor to resolve any rejection issues.

    Remittance advice files, representing all providers who had at least one dental claim in the weekly claim cycle, will be received on a weekly production basis by us from the State. We will post these remittance advice files timely to the provider web portal for provider access, view, and retention.

REMITTANCE INFORMATION

We will respond to all dental provider requests for original and duplicate remittance advices following your protocols. In our standard process, we produce a detailed remittance advice for the provider that lists every dental service submitted and processed to resolution.

These reports explain the processing decisions made related to every procedure/service submitted for payment consideration, including all known reasons for denial, as applicable. After the payment cycle is confirmed, payment reports are made available as PDF documents for online retrieval through web portals. In our experience, this procedure offers providers the flexibility and convenience of self-service and reduces administrative cost. We will upload remittance advices into our system when received from the vendor.

Our benefits management software retains and never purges historical claims payment documents, including remittance advices. Providers can access these documents online at any time, through the provider web portal. For providers without Internet access, we will make remittance advices available, as directed by the State.

Our benefits management software retains and never purges historical claim data files, including EDI 835 transaction files and complete transaction history. This data can be accessed online at any time.

As described above, we retain and never purge historical claims data, including provider remittance advices. Historical claims data and electronic documents are always available online, any time, to users with appropriate security permissions.

For claims submitted and processed prior to our administration of the Nevada program, we have the capability to access the State's Support Console EDI 835 content for customer encounter support. We are also open to exploring the option of importing claim history into our software system.

Processing of Paper Attachments on Electronic Claims

Because of the many benefits associated with the submission of electronic claims, we prefer to receive claims electronically and works closely with providers to encourage and support electronic claim submission (whether through a claims clearinghouse, a secure direct claim data file submission from the provider, or claim data entered via our provider web portal).

Our technology includes the ability to receive paper attachments with electronic submissions and includes imaging software that attaches each item to the claim file in our system. All documents received are imaged with a unique encounter ID that reflects the actual receipt date received by us. In addition, our system will automatically generate and store a unique ICN that meets the State's format requirements with each claim record.

Through our well-developed and time-tested secure permissions, our clients have full, view-only access to recipient and provider information along with all documents related to each claim. All received attachments are viewable within the claim document and each claim is identified by encounter ID and State-defined ICN.

Our benefits management software is designed to be HIPAA and (ARRA) HITECH security compliant. We ensure that appropriate security measures are in place to safeguard Protected Health Information (PHI) and electronic Protected Health Information (ePHI) received on original documents and subsequent received attachments. We use HTTPS protocol for all Internet-based transactions to encrypt the data connection across the Internet, and our benefits management software also encrypts certain data elements within our servers (user logins, passwords, etc.)

Our employees have restricted system access based on their assigned roles and responsibilities. Newly hired staff members attend orientation sessions that include review of the company's privacy, email, Internet, and confidentiality practices. In addition, all employees are required to attend annual HIPAA training sessions, which include guidance on how to properly send and receive ePHI data.

We are skilled in receiving additional documentation that is received after the claim has been processed. The additional attachments are reviewed and upon determination, images are scanned and attached to original documentation within our benefits management software to complete the adjudication process.

Electronic Claims Attachment Processes

Our experienced implementation team will work with you to ensure that all required services are put in place prior to go live production. Our team approach ensures that all areas are informed and prepared for any new business implementation. We will support all of the requirements including but not limited to:

- Implementation of new business and technical processes;
- Pre-production testing for trading partners;
- Trading partner education;
- Attachment review requirements; and
- Privacy and security protections

Our benefits management software already accepts and manages electronic attachments. Our system supports attachment references submitted within 837D electronic files that allow attachments to be referenced and retrieved from either an external website or our own document management system. Electronic attachments can be imported into our internal document management system and linked to the appropriate claim record via the attachment reference number submitted in the 837D file.

Our benefits management software already accepts and manages electronic attachments. Documents are instantly available online, any time.

PAPER CLAIMS WITH ATTACHMENTS

We scan all paper claims and attachments upon receipt. If a claim has X-rays or other medical document attached, the system automatically creates a post-treatment review for clinical consideration, if no matching prior authorization is found and one is required. All claims with attachments can be routed to work queues for manual review and either approval or denial.

We will process all claims with non-TPL attachments in accordance with the State's requirements. As described above, any claims with attachments can be automatically routed to work queues for consideration and either approval or denial.

When paper claims with attachments are scanned, the ADA claim form and all related attachments are assigned the same Encounter ID but coded with different Document Types. Attachments, including X-rays, are automatically associated with the claim record via the assignment of unique barcode labels. The unique barcode label allows the system to electronically link claims with their related attachments. The Document Type can be used to help route claims with attachments to appropriate work queues.

We process all paper claims submitted with TPL attachments as follows:

1. We thoroughly review the claim and its attachments to ensure correct adjudication. For claims submitted with an explanation of benefits (EOB), (TPL information), we review the EOB and enter all pertinent information (paid amount, collected amount, allowed amount, deductible, copay, etc.) to ensure each line item is paid correctly and coordination of benefits occurs. If a recipient carries an additional source of coverage for dental services and a claim is submitted without an EOB from that carrier, the claims are denied. The provider's Remittance Advice identifies the reason for the denial.

2. We will accurately capture TPL-related information as required by the claim file.

3. Our quality control processes are in place, including auditor review and system edit checks, to ensure appropriate screening and capture of all claims submitted with TPL information. We will follow Nevada-approved protocols to further ensure accuracy of TPL screening.

4. Our quality control processes will identify dental providers and billing intermediaries who incorrectly submit dental TPL information and those who develop a history of denied claims. Our provider relations representative will collaborate with our electronic outreach team for personalized education and training for these providers and intermediaries to provide effective education and training.

5. When paper claims are entered, other insurance information can be indicated during data entry. This information can be used to immediately identify discrepancies between other insurance information submitted on the claim and State insurance carrier codes.

6. We will forward other insurance information to the State or its designee for updating.

7. Our practice is to continually pursue process improvements and workflow enhancements to improve the quality and efficiencies within data entry processes. We will recommend solutions to the State to improve the paper claim handling processes (with or without attachments) to streamline workflows and improve efficiencies, including collaborating with providers to adopt electronic claims submission practices.

CLAIM VOIDS

Our benefits management software fully supports all paper and electronic claim voids requested by our clients, dental providers, or internal departments. Void requests will be processed within 12 business days of receipt of the request and will be in effect with dates of service on or after the State's contract effective date.

Our benefits management claims processing software was designed and built as a dental benefits management software platform. Dental-specific program edits and correction mechanisms are integrated throughout the system and business rules to deny all paper and electronic claim voids with dates of service prior to the implementation date are easily established within the system. We will work closely with the State to meet all exception edits regarding these voids as well as the message that will appear on the dental provider's remittance advice.

We have created client-specific policies and procedures and claim audit protocols which are used to monitor and evaluate the accuracy of, and improve the quality of, our dental claims processing. A comprehensive quality control process will be designed specifically for the State to ensure all voiding of claims is completed accurately and in compliance with State-approved protocols.

Our dental reimbursement department has established process and procedures for the voiding of claims to include the recording of the reason for the void within the void claim record itself. Reporting for the purpose of identifying trends and patterns will be in place for the State.

As noted above, all reasons for claim voids are recorded on the voided claim record by our reimbursement analysts, making it easily available for reporting and analysis of dental provider claim void requests. We will coordinate the completion of all required functions listed below and will communicate outreach results, report on reasons for void request and void request trends, and communicate process improvement recommendations to the State:

- Perform outreach to those dental providers to reduce their claim void rate;
- Recommend solutions to improve the claims voiding process and implement those solutions approved by the State; and
- Maintain an electronic record log of dental providers with large numbers of claim voids, listing the issue and the resolution, as well as the details of the outreach efforts.

CLAIMS PRICING

Our EDI analysts will work with the State to format, transmit, and load fee schedule data into our system databases. We have a proprietary file format already defined for fee schedules, and we will make our File Format Guide available to appropriate State personnel.

We take advantage of built-in efficiencies in our benefits administration software platform to import, process, and manage data file imports, including fee-for-service rate data. The system performs automated data import and processing tasks, based on either a fixed interval or a specific daily, weekly, or monthly schedule.

Because our system supports fully automated data file import and processing, we can configure business rules to automatically update fee schedule data from the State on any schedule that meets your needs, including within three business days of receipt.

Our benefits management software applies all claim pricing and application of TPL payments automatically in the adjudication cycle based on predefined business rules after claims are validated and edited within the claims adjudication process. When claims are adjudicated within our system, the adjudication process calculates payee reimbursement and patient responsibility amounts for claims that have successfully passed pre-adjudication edits. In accordance with Nevada regulations, our benefits management software has existing built-in rules to never pay greater than the billed amount for any claim.

Our system is designed to support and configure the requirements of various government-sponsored dental programs. Business rules that are exclusive to this contract and claims payment will be established and executed to include all applicable state regulations and laws.

Our experienced and skilled claims adjudication reimbursement analysts use established reimbursement policies and procedures to analyze claims in process at several points during the claims edit and adjudication processing cycles. All outlier exceptions are reviewed and responded to in real-time. If provider outreach is required, our reimbursement analysts and provider services teams coordinate to resolve provider claim issues.

Real-time claims status information is available 24 hours a day, seven days a week, and 365 days a year from the provider web portal. Providers can generate a real-time claim status report at any time through the portal, and can search for submitted claims by state, recipient, encounter ID, date of service range, entered date range, and other criteria. The real-time report returns a condensed claims status summary, with drill-down links to complete claim and service line details, automated references to matching authorizations, and live links to attached documents.

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.

The claims processing system is the first line of defense for Medicaid program integrity. We stop payment of claims that are inappropriate by relying upon our industry-leading claims platform, which automatically identifies all claims and/or claim lines that may potentially be a duplicate or may have been bundled for appropriate payment. We immediately deny those that can be definitively identified as duplicate and pend those that require further research. Our integrated claims platform immediately applies appropriate clinical edits to avoid overpayment claims.

Our processing platform and associated policies allow us to do the following:

- The detection and denial of incidental, and redundant services through a robust clinical editing system, with clinical editing software based upon CMS NCCI criteria

- Duplicate claim detection, age and gender editing, eligibility verification and matching to required prior authorizations and referrals through a processing system built with a multitude of editing capabilities
- Detection of fraudulent billings through a dedicated Fraud Unit
- Identification of payment errors and correction prepayment through a rigorous prepayment audit program, further allowing management the opportunity for reeducating staff members based upon identified discrepancies

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.

We agree to pay interest to a provider of dental services 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. As required, the interest will be calculated 30 days after the date on which the claim is approved until the date on which the claim was 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.

We work collaboratively with our provider network on many issues, including establishing and documenting in our network contracts an alternative payment schedule. We comply with the requirement 42 CFR 447.45d.

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

We confirm that will maintain 95 percent claims accuracy.

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

We believe that combating fraud, waste and abuse is something in which all employees participate. We train everyone from claims analysts to call center representatives to watch for abnormal situations and refer such cases to our Program Integrity Unit (PIU). The PIU performs fraud and abuse investigations with a particular focus on allegations of health care fraud. We have staff that is specially trained to verify the provisioning of reimbursed services through our Claims department's well-established fraud, waste and abuse processes, including:

- Specially trained staff are assigned to analyze utilization reports and conduct random and target audits on high-volume providers and on providers for whom a recipient complaint was received regarding rendered and/or billed services.

- We have implemented customized reporting to scrutinize claim submission and utilization patterns for inconsistencies or deviations from any established patterns, including billing, utilization and demographics.

In alignment with the requirements of this RFP, we will implement a Verification of Services process to validate that reimbursed services were provided to the enrolled recipient.

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.

Our commitment to communication with all of our long-standing state partners is a top priority and that communication includes notification of any changes affecting our claims processing system.

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).

In compliance with the requirements of this RFP, we conduct a medical review of claims whenever the appropriateness of service, procedure or payment is in question. Coding issues are addressed by our internal clinical review staff, which reviews claims to determine accurate coding levels for processing.

All reviews are conducted by licensed dental clinicians.

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:

The claims and utilization management teams collaborate to ensure all services-related provider preventable conditions (PPCs) are reviewed and denied per Medicaid requirements as outlined in A-G. If claims have already been paid for such services, these payments are retrieved. The claims and utilization management data is saved in the same claims adjudication system.

All services related to PPCs will be classified as denials in the claims adjudication system. Each case has notes outlining why the service is denied. Since a PPC is considered a type of denial, a medical director would make the decision as to whether a condition should be classified as such based upon evidence-based guidelines. The dental director would evaluate the recipient's condition to determine if the recipient experiences negative consequence related to the provider's lack of adherence to standards of care. The intake, clinical review, and claims denials for PPCs can be audited retrospectively.

All service requests are reviewed according to evidence-based criteria. We thoroughly review all available clinical information and request additional information from all stakeholders as needed to ensure accurate decision-making. If the health plan determines the request is the result of a PPC, we collaborate with provider services and claims to ensure these services are not covered by us. We process the claim as it was authorized. If utilization management denies, we deny the claim payment.

A. Is identified in the Medicaid State plan;

Please see Question Response 3.11.4.14.

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;

Please see Question Response 3.11.4.14.

C. Has a negative consequence for the recipient;

Please see Question Response 3.11.4.14.

D. Is auditable;

Please see Question Response 3.11.4.14.

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

Please see Question Response 3.11.4.14.

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

Please see Question Response 3.11.4.14.

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

Please see Question Response 3.11.4.14.

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.

Our financial strength is virtually unmatched in our industry. We consistently maintain higher comparative margins than many of our competitors. We credit several things for this achievement, including our investment in technology which creates significant value. Our approach to long-term viability in an ever-changing marketplace remains a measured balance of innovation and consideration.

Our investment program is administered on a centralized basis with both internal and external oversight. As of December 31, 2015, our cash and investment portfolio totaled $31.7 billion. On this date, the portfolio had an unrealized net capital gain position of $56 million. We have had little or no exposure to troubled investment classes.

Our capital structure complements our business strategy. We focus on having a strong financial position in any economic or market environment. We continue to monitor the economy, the financial markets, industry conditions of our businesses, including the expected impact from health care reform and our mix of businesses. As this evolves, so will our financial strategy as we strive to maintain a strong financial position.

Our business is strategically diversified across the Health Benefits and Health Services sectors driving revenues, operating earnings, and cash flows from many sources.

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.

We can submit a copy of our annual Independent Audit Report to DHCFP.

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

We will submit our quarterly and annual financial reports to the DHCFP.

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.

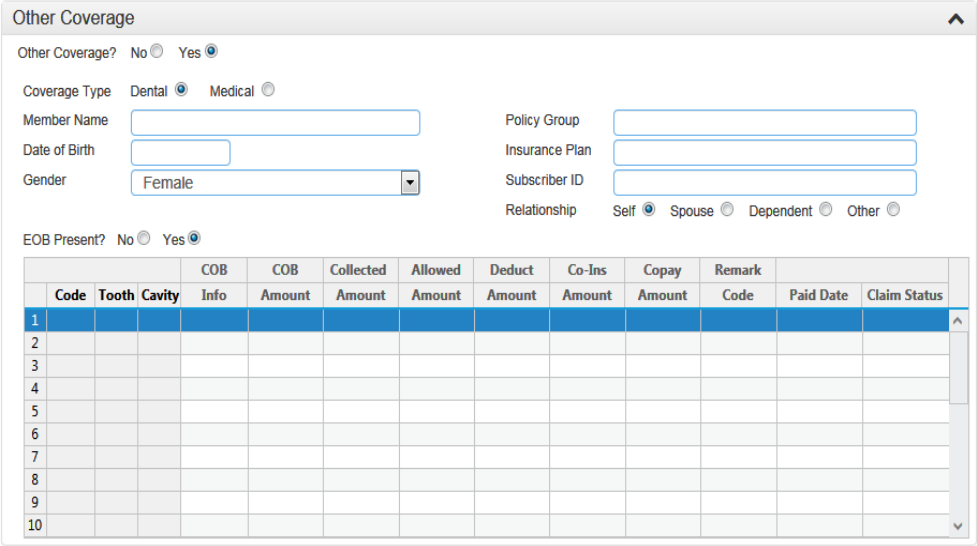
The benefits management system captures other coverage for dental services at the enrollee level, for example, submitted in an 834 eligibility file, and this information is taken into consideration during claims processing. We also capture other insurance information on the claim itself, including prior amounts paid, any patient responsibility amounts, related CARC and RARC codes, etc.

When other insurance information is stored with an enrollment record, the system evaluates the other insurance during claim processing and applies client-defined business rules, and then either calculates a COB payment amount, automatically denies claims if no payment is due, or routes claims to work queues for special handling.

We validate TPL whenever we receive a first-time claim with a COB indicator, when an Explanation of Benefits (EOB) is attached, or when we receive an adjustment for other insurance request from the provider.

- If other insurance is indicated when a claim is submitted and COB information is missing, the system triggers an exception and a Dental Reimbursement Analyst (DRA) handles the claim.
- When we receive a paper claim with EOB or COB documentation attached, both the claim and its related documentation are scanned, and the documentation is attached to the electronic claim record. When the claim data is entered into the system through the data entry interface, the information included on the EOB is also entered directly into the claim record, including specific procedure codes, dollar amounts, and other insurance information. The system then uses this information to adjudicate and accurately pay or deny the claim.
- When a provider enters a claim through the Provider Web Portal, an Other Coverage section of the online form makes it quick and easy for providers to include coordination of benefits information that is then used in claims processing.

OTHER COVERAGE INFORMATION IN PROVIDER WEB PORTAL



Images in this response are subject to change and show fictitious provider, location, and recipient information.

If a claim is denied because required documentation is missing, the resulting remittance advice report notifies the provider that third-party EOB information must be submitted with the claim.

Our benefits management software is designed specifically to automate functions such as TPL-related processing in order to increase both efficiency and claims payment accuracy for our clients. We're able to capture COB/EOB documentation in paper or electronic formats, identify discrepancies, and work with each client's business rule requirements for TPL information exchanges. With our technology and extensive industry experience, we are well-equipped to support TPL recoveries and ensure our client is the payer of last resort.

C**ost-Avoiding Claims.** Our benefits management software can accept, load, and capture third-party insurance information for an enrollee at any time and at any frequency, in 834 Enrollment file format, except for those claims that have an EOB attached from another insurance carrier which shows that the information from DHHS is inaccurate. Our Client Support Services staff is highly experienced in managing and loading data files.

TPL Information for Members. The benefits management software currently captures all third-party insurance information at the enrollee level, as an example, through a HIPAA-compliant 834 eligibility file. When claims are processed through the edit cycle of our software, they are evaluated for other insurance coverage components and the appropriate client business rules applied to the claim.

Based on these client-defined business rules, the system calculates COB payment amounts, denies appropriately if there is no payment due, or routes the claims to a work queue to be reviewed by our Dental Reimbursement Analysts. Whenever there is TPL in the recipient's record, our client will always be the insurer of last resort when confirming payments.

If paper or electronic claims are received and include COB and/or EOB documentation, all documents are imaged and automatically attached to the claim record. In our data entry area, both claim data and any applicable COB/EOB information are also entered directly onto the claim record, to include such items as specific service codes, dollar amounts, and other insurance carrier information. This information is then systematically reviewed in the adjudication cycle so that the claim pays or denies appropriately.

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.

We have existing system logic within our benefits management software to prevent payment of dental services when we are notified of third-party insurance dental program coverage for a recipient if requisite information is not provided. Our system captures other coverage for dental services at the enrollee level, and this information is taken into consideration during claims processing.

If a claim is submitted with no Explanation of Benefits (EOB) present and the recipient has third-party dental coverage, our system denies payment. The resulting Remittance Advice notifies the provider that third-party EOB information must be submitted with the claim. Likewise, if an incoming claim has third-party insurance indicated, the system applies the third-party payment information when adjudicating the claim and considers our client to be the secondary insurer.

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.

Our sophisticated information technology infrastructure uses proprietary software to expedite identification of recipients with other forms of insurance and isolate any claims that must be submitted to other payers prior to payment.

Once TPL is identified and verified directly with the other payer, we coordinate activities to make certain costs for services are either avoided or recovered from the liable party. If we cannot establish TPL timely, the claim is adjudicated and post-payment recovery is pursued, as appropriate. Our policies and procedures makes sure Medicaid is always the payer of last resort through thorough investigation of claims for potential third-party payers. Claims with suspected TPL are automatically forwarded to staff dedicated to TPL who contact recipients to solicit information on additional insurance.

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.

We will act as the State's authorized agent for the limited purpose of TPL collection. We pursue vigorously billing prior resources. We comply with all DHCFP requirements regarding:

- All TPL and subrogation reporting requirements cited in Attachment T Forms and Reporting Guide
- Meeting or exceeding baseline target collections as determined by DHCFP and its actuaries, with baseline target amounts built into future rates
- Remediating a potential failure to meet or exceed baseline TPL and subrogation collection targets

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.

We comply with these requirements and identify evidence of overlapping coverage through a variety of information resources including, but not limited to:

- TPL resources identified and communicated to us by DHCFP
- DHCFP's EVS eligibility system
- Our internal units (e.g., prior authorization and member services)
- Provider claims
- Member COB questionnaires
- Signed member/authorized representative acknowledgements confirming any prior resources
- Any vendor of 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.

We use an auto-recoupment process for overpayments through our core claim adjudication system. When an overpayment to a provider has been identified post-claims payment, we send the provider a letter requesting 60 days. At the end of that time, if we have not received a payment, the affected claim is down adjusted and/or the overpayment is referred for outside collection. We continue to pursue recoveries. In accordance with ur established procedures, post-payments from third parties are recorded as offsets to claims payments. We report to DHCFP monthly any monies recovered from third party or primary payers via an encounter file and a COB subrogation report.

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.

We comply with this requirement as our data is maintained for a minimum of seventy-two (72) months. Coordination of Benefits is maintained in our claims adjudication system and subrogation reports are saved in an online format.

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.

We do not cover services provided by Indian Health Service (IHS) Facilities and Tribal Clinics. DHCFP directly pays IHS facilities for services rendered. On behalf of our Native American recipients who choose to seek care for covered services at Tribal Clinics, we agree to:

- Provide coordination of services with IHS
- Request medical records of treatment provided through IHS
- Provide covered services recommended by IHS, or indicate in writing to DHCFP why the recommended service is not medically necessary

Member advocates will use a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and provide options and services to meet an individual's and family's health needs through communication and available community resources to promote the child's quality of life and health outcomes.

We acknowledge that claims for state victims of crime are not subject to TPL and claims are adjudicated accordingly.

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.

Within the department dedicated to TPL, locally based specialists focus on areas of payment integrity initiatives, including analysis and investigation of FWA, TPL, coordination of benefits (COB), subrogation and recoveries. We confirm that our TPL business function complies with applicable rules of the MSM, CMS State Medicaid Manual and other State and federal rules and regulations.

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.

We evaluate claims to determine if they are connected to an illness or injury sustained by one of our recipients for which a third party may be responsible.

Approach: We believe the most effective approach to TPL, including Subrogation, is cost avoidance, under which claims covered by other available resources are proactively prevented from processing. Once TPL is identified and verified directly with the payer, we coordinate activities to ensure costs for services are either avoided or recovered from the liable party. If we cannot establish TPL timely by us, the claim is adjudicated and post-payment recovery is pursued, as appropriate, once TPL is validated.

Subrogation-focused Staff: We have a unit specifically dedicated to Subrogation, in which the employees are well-trained and versed in Subrogation rights available to us as the carrier. The staff is embedded in the claim process.

Identification of Potential Subrogation Cases: Our sophisticated IT infrastructure uses proprietary software to expedite identification of recipients with other forms of insurance and isolate any claims that must be submitted to other payers.

Investigation: When a claim is suspected of having third party liability, it is forwarded immediately to our TPL/Subrogation department. Our subrogation unit uses all available resources to identify overlapping coverage and/or confirm third party liabilities. Our main resource used is our recipients directly. We contact our recipients directly to obtain information on additional insurance coverage and/or provide us with details for any accident-related injuries or diagnoses. We obtain information from other internal units (e.g., prior authorization and member services). We carefully review the information on claims and dental records for indications of a third party being liable.

Follow Up: Our Subrogation Unit prepares the applicable paperwork and liens, then handles the necessary monitoring. We work to ensure collection of all potential recovery dollars available.

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.

We use all available resources to identify potential casualty claims, including:

- Medicaid EVS eligibility
- TPL reports provided by state Medicaid programs
- Review of the information on claims and medical records from providers for indications of casualty injuries
- Information received from our membership directly via personal injury inquiry responses and telephone calls
- Information received by other internal processing units (e.g., prior authorization, member services, claims processing)

We apply our current processes and any additional data resources, which become available to us to file and recover costs through subrogation on behalf of both Medicaid and CHIP recipients to ensure Medicaid is the payer of last resort.

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.

We have tracking reports of all TPL which are maintained and updated on a regular basis. We have ability to extract data from our reports for any of our insured groups, which can be provided to DHCFP for monitoring and evaluation of our performance as it relates to TPL. We strive to meet or exceed target metrics. We understand that in the case of DHCFP, that our TPL collections will be monitored and used by the state in rate-setting processes.

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.

To be in full compliance with the requirement of Section 3.12.8 of this RFP, we have established an actuarially sound process for estimating and tracking incurred but not reported claims (IBNRs) as part of our accounting and budgeting operational procedures. We provide DHCFP documentation of actuarial review and certification of IBNRs.

The IBNR/RBUC reserves are estimated monthly based upon our actuarial reserving models, with appropriate adjustments for any particular aspects in the current month's data (e.g.,variations in claims payment and reporting patterns, emerging claims cost trends) and any potential liabilities arising from claims disputes with providers.

The reserves are also actuarially reviewed at the national business unit level before being finalized each month. We will conduct annual reviews to assess the actuarial validity of our reserving methodology.

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

We meet the requirements of Section 6505 of the ACA in all states where we operate. We do not provide payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.

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.).

Confirmed. Please see Question Response 3.11.9.

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.

Confirmed. Please see Question Response 3.11.9.

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.

Confirmed. Please see Question Response 3.11.9.

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.

Confirmed. Please see Question Response 3.11.9.

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.

Confirmed. Please see Question Response 3.11.9.

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.

We have created a system for all of our recipients enrolled in each of our dental Medicaid programs that ensures they have access to 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.

We strive to avoid grievances and appeals by delivering high-quality, responsive and culturally competent services and communications to our recipients. We have significant experience implementing recipient grievances, appeals and State Fair Hearing programs that verify the appropriate and timely processing and resolution of recipient grievances or appeals when a recipient does not agree with a decision we made.

We also know it is important for our recipients to have a process to express dissatisfaction and for us to receive information toward continuous improvement. While we know it is stressful for recipients to feel the need to file a grievance or appeal, we have designed our process to be easily accessed, responsive and effective. We watch each detail of the process including appeal overturn rate; compliance rate; and the acknowledgement letter rate to maintain high standards, reduce rework of appeals and improve customer service.

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.

Please see Attachment 3A1_Grievances and Appeals Flowcharts.

Recipient satisfaction is a key performance indicator and, we classify a complaint as any expression of concern about a component of covered dental services that is not an appeal. To ensure a thorough yet speedy resolution for every complaint, we've put in place a highly-trained appeals department staff supported by a vetted process and exclusive technology. We fully inform recipients of their rights related to grievances and appeals resolution, and we ensure they are treated with dignity and respect at all levels of the process. With our benefits management software, authorized users can monitor complaint activity in real-time for greater transparency and efficiency in resolving recipient complaints.

The benefit brochure and member web portal both include an explanation for recipients on how complaints are received and resolved. They also outline clear and concise instructions for recipients on how to file complaints, including an online process. In addition, our dedicated appeals specialists take active roles in assisting recipients who have complaints.

All complaints received, either orally or written, are analyzed, logged, and categorized in our electronic tracking system and automatically routed to the Appeals department for review and resolution. Appeals specialists' log, track, and assign case follow-ups to appropriate staff. When a case requiring follow up is created, the appeals specialist routes the case to the appropriate department, such as credentialing, client services, or claims, or to a specific provider relations representative or dental consultant. Each follow-up record includes due dates and hotlinks back to case details. When a note is entered on a follow-up assignment, the system automatically logs the date, time, and name/user ID of the person who entered the note.

The appeals department monitors member-initiated complaints about providers, including clinical quality of care complaints. Each month, the appeals department delivers a trending and analysis report. If a clinical quality of care issue is identified, the local field provider relations representative personally visits the provider office for further investigation.

The appeals department coordinates all clinical and non-clinical review of complaints. The entity with decision-making authority depends on whether the complaint is related to a non-clinical issue or a clinical issue.

NON-CLINICAL

Our specialists identify all components of a complaint received. Outreach is made to all parties and departments that have involvement in the complaint to gather statements and supporting data. The complaints specialist serves as the coordinator for reviewing the information collected during the "working" of the complaint. The data is reviewed against regulatory and NCQA standards for resolution determination. Written communication is sent to the recipient, and includes a description of the complaint, the basis for the decision, and identification of any documents reviewed and relied upon in the complaint decision.

CLINICAL

Clinical complaints are reviewed and determined by licensed dental consultants. Appeals specialists will investigate and coordinate review to resolve all complaints within the timeframes set forth. To handle emergency clinical situations, the appeals specialist follows department protocol to expedite the resolution, which includes immediately notifying an on-call dental consultant. Clinical documentation is routed for review and determination electronically through our web-based benefits management software.

In addition, each month, and as needed, the quality improvement committee (QIC) analyzes the complaint volume and turnaround times from the month prior to identify trends. Committee review of dental providers includes:

- Recommendations for any providers providing poor quality of care, including sanctions and/or terminations
- Analysis of providers with questionable service provision
- Fraud or abuse cases
- Trend review of member complaints against providers

The committee will determine the best approach to improve any negative trends identified.

The appeals department is fully staffed with an appeals and complaints coordinator who serves as the expert in the complaints process to coordinate appeal and complaint services for recipients, and ensures adequate tracking of complaint data. In addition, our trained appeals specialists are committed to excellent member-centered service and to meeting turnaround standards. The appeals department completes in-depth training on analyzing, investigating, and resolving complaints and appeals as outlined per regulatory standards. The specialists thoroughly analyze each complaint and work closely with recipients to ensure recipients are aware of the complaints process. They ensure that complaint resolution is thoroughly explained to each recipient and validate recipient satisfaction before closing a case. We will also provide recipients the ability to register a complaint via an online form.

Our appeals department is fully staffed with team members who serve as experts in the complaint process. Each complaint is analyzed to determine whether it can be resolved quickly by the appeals team, needs review and follow-up by another department or entity, or requires handling through a formal written approved complaint process.

Whenever possible, the appeals team resolves complaints quickly by discussing the issue and potential resolutions directly with the recipient and taking necessary steps to resolve the problem. All complaints, follow-up communications, and resolutions are documented and logged in our software system.

Denial of Service or Authorization: Upon receipt of a recipient appeal for a denied service request, the complaints and appeals specialist will enter the appeal into CSM for tracking, within five business days of receipt of the appeal; the complaints and appeals specialist will send a letter of acknowledgement to the recipient, with a copy to the provider. CSM has a letter-generating feature that ensures that the appropriate letter is generated and that all language is consistent with State guidelines. The acknowledgement letter and any appeal documentation is scanned and attached to the recipient's profile in the CSM. Once the case is documented in the system, it is assigned to either the Nevada Dental Director or a Nevada dental consultant not involved in the original determination.

The Nevada Dental Director or Dental Consultant will review the original authorization in the Authorization Determination Module (ADM), and will render a determination based on the existing information, as well as any new information submitted by the recipient or the recipient's representative. The Dental Reviewer will communicate the outcome to the Complaints & Appeals Specialist, via the Enterprise CSM, to ensure all documentation is tracked in a single source. The Complaints and Appeals Specialist will generate the letter of determination to be mailed to the caretaker of the recipient with a copy mailed to the provider within two business days of the decision. If the appeal is upheld in total or in part, the determination letter will contain information on the process for filing a fair hearing request. Finally, the determination letter is attached to the appeal case in CSM, and the case is closed.

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.**

We educate recipients about grievance and appeal processes in our Recipient Welcome Packet, Recipient Handbook, educational materials posted on the member Web Portal, and during telephone calls and personal interactions with recipients. In addition, authorization decision letters notify recipients of their appeal rights. The notification includes what to do if they disagree with a decision, along with a mailing address for submitting a written appeal and a toll-free telephone number for more information. Any recipient requiring assistance in filing a complaint will be referred to a member advocate. We also make information about grievances and appeals available to recipients in their primary language.

In order to meet the needs of our various state customers, we have developed a diverse and effective portfolio of provider training topics, including grievance and appeal processes.

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.

We attest that all required management reports can be produced from data maintained by the Enterprise System. The relational databases ensure that data for all operational reports including Complaints and Appeals can be derived natively. We design custom reports are from specifications, and generates them according to the State's schedule. Apart from the many reports detailed in the Uniform Managed Care Manual, the Enterprise System contains a wealth of integrated, real-time monitoring and data analysis tools, including online operational activity dashboards, an integrated Executive Dashboard, and the Enterprise Business Intelligence System (eBIS) reporting tool.

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.

The appeals department is fully staffed with an appeals and complaints coordinator who serves as the expert in the complaints process to coordinate appeal and complaint services for recipients, and ensures adequate tracking of complaint data. In addition, our trained appeals specialists are committed to excellent member-centered service and to meeting turnaround standards. The appeals department completes in-depth training on analyzing, investigating, and resolving complaints and appeals as outlined per regulatory standards. The specialists thoroughly analyze each complaint and work closely with recipients to ensure recipients are aware of the complaints process. They ensure that complaint resolution is thoroughly explained to each recipient and validate recipient satisfaction before closing a case. We will also provide recipients the ability to register a complaint via an online form.

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.

Our appeals department is fully staffed with team members who serve as experts in the complaint process. Each complaint is analyzed to determine whether it can be resolved quickly by the appeals team, needs review and follow-up by another department or entity, or requires handling through a formal written approved complaint process.

Whenever possible, the appeals team resolves complaints quickly by discussing the issue and potential resolutions directly with the recipient and taking necessary steps to resolve the problem. All complaints, follow-up communications, and resolutions are documented and logged in our software system.

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.

We conduct annual audits of our appeals process to ensure compliance with federal and state regulations, as well as contractual requirements.

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.

We will submit our grievance and appeal process in writing to the DHCFP for review and approval as outlined above.

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.

We will continue the recipient's benefits while an appeal is in process in accordance with the above conditions.

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.

We will continue or reinstate the recipient's benefits while an appeal ins in process in compliance with the above conditions.

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.

We will continue or reinstate the recipient's benefits while an appeal ins in process in accordance with the above conditions.

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.

Noted and agreed.

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.

Noted and agreed.

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.

Noted and agreed.

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.

Noted and agreed.

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.

We provide standard authorization decisions within 14 calendar days, with a possible extension of up to 14 additional calendar days upon request of an extension or receipt of additional information. We 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.

If the recipient's life or health is at risk, the recipient may file an expedited appeal. To handle emergency clinical situations, the appeals specialist follows department protocol to expedite the resolution, which includes immediately notifying an on-call dental consultant. For expedited appeals, the Dental Director or Dental Consultant will make the expedited appeal determination within one business day from the receipt of the appeal and the complaints and appeals specialist will verbally notify the recipient. Written notification will follow verbal notification within two business days of the decision. All other steps are the same as the standard appeal process. For all inquiries that are clinical in nature, the appeals specialist gathers clinical documentation and routes it to a licensed dental consultant for review and determination.

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.

The Complaints & Appeals Specialist will acknowledge the recipient's complaint in writing within five business days of receipt. If necessary, the recipient will be re-contacted for clarification of his/her complaint. If the complaint involves a provider, the Complaints & Appeals Specialist will contact the provider to obtain any needed information. After obtaining all pertinent information, the Complaints & Appeals Specialist will make a determination and send a written resolution notice to the recipient within two days of the determination.

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).

We provide all communications, including Notices of Action, in the State-established prevalent non-English languages, in alternate formats for persons with special needs, and using easily understood language and format requirements.

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;

Confirmed.

B. The reasons for the action;

Confirmed.

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

Confirmed.

D. The recipient's right to request a State Fair Hearing after the recipient has exhausted the vendor's internal appeal procedures;

Confirmed.

E. The procedures for exercising the recipient's rights to appeal;

Confirmed.

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

Confirmed.

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;

Confirmed.

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

Confirmed.

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

Confirmed.

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.

Confirmed.

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.

In cases of termination, suspension or reduction of covered services, we give notice at least 10 calendar days before the date of action, or five days if fraud is verified.

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;

Noted and agreed.

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);

Noted and agreed.

C. The recipient's admission to an institution where he is ineligible for Medicaid services;

Noted and agreed.

D. The recipient's address is unknown and mail directed to him has no forwarding address; or

Noted and agreed.

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

Noted and agreed.

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.

Noted and agreed.

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.

Noted and agreed.

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.

Noted and agreed.

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;

Noted and agreed.

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

Noted and agreed.

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

Noted and agreed.

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.

Noted and agreed.

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.

Noted and agreed.

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.

We resolve all recipient and provider complaints/grievances and appeals within 30 days of receipt. All appeals and complaints/grievances received from the State will be resolved within a timeframe specified by a Service Level Agreement, depending on the more restricted timeframe.

If the recipient's life or health is at risk, the recipient may file an expedited appeal. To handle emergency clinical situations, the appeals specialist follows department protocol to expedite the resolution, which includes immediately notifying an on-call dental consultant. For expedited appeals, the Nevada dental director or a dental consultant will make the expedited appeal determination within one business day from the receipt of the appeal and the complaints and appeals specialist will verbally notify the recipient. Written notification will follow verbal notification within two business days of the decision. All other steps are the same as the standard appeal process. For all inquiries that are clinical in nature, the appeals specialist gathers clinical documentation and routes it to a licensed dental consultant for review and determination.

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.

We will adhere to all requirements outlined in 3.12.5.4 A –D. Any recipient requiring assistance in filing a complaint will be referred to a member advocate, who will provide guidance and support as required, including arranging for non-emergency transportation services to be present at the appeal hearing, and providing interpreter services.

To ensure appropriate guidance and impartiality, the provider issuing the appeals determination will hold the same licensure or have the same specialty practice or knowledge as the appealing provider, and the Dental Consultant reviewing the appeal will not be the same consultant involved in making the initial determination.

We also require the following attestation for each appeal which is saved and documented with the respective complaint/grievance or appeal record:

I, (insert name of reviewing consultant), attest that, to the best of my knowledge, I have a scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review, as well as current, relevant experience and/or knowledge to render a determination for the case under review. (Insert what is being appealed)

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;

Noted and agreed.

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;

Noted and agreed.

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

Noted and agreed.

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.

Noted and agreed.

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;

Noted and agreed.

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

Noted and agreed.

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.

Noted and agreed.

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.

Noted and agreed.

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.

Noted and agreed.

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.

The Quality improvement committee (QIC) receives regular written reports from Provider Relations, Quality Management and Marketing. It provides information on member and provider satisfaction survey results, recipient complaints, grievances, telephone access, disenrollment, credentialing and preventive health services—all of which are used for developing service improvement projects. The QIC and CAC analyze the information and make recommendations for improvement.

The Quality Improvement Program (QIP) encompasses both clinical care and service activities, involving multiple committees (Quality Improvement Committee (QIC), Clinical Policy and Technology, Clinical Affairs Committee (CAC), Peer Review, and Credentialing) in the improvement process.

The annual QIP incorporates findings from the program evaluation; for example, needed improvements, changes in process or structure and follow-up studies, in addition to activities mandated by state and federal regulations and customer expectations. The board of directors reviews and approves the QIP evaluation and annual QIP.

The national dental director for quality management and chief dental officer are responsible for monitoring follow-through when clinical and service improvements are identified. We maintain documentation about implementing recommendations of system changes, corrective actions, educational endeavors and overall effectiveness.

We use the QIP to make sure goals are met and improvements are effective. We evaluate the scope, activities, goals and objectives. We trend key clinical and service indicators and note quantitative improvements in care and service, based on the quality improvement initiatives. We evaluate our resources and make recommendations for the coming year.

The QIC provides an annual written evaluation of our QIP to the board of directors. This evaluation focuses on strengths and weaknesses, trends/patterns, barriers to improvements and demonstrated accomplishments in improving care and services to recipients.

The committee reviews and revises the QIP for the upcoming year to submit to the board of directors for approval. The work plan incorporates aspects of the annual evaluation, relevant state and federal requirements, indicator requirements and employer requests for monitoring and reporting.

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.

Noted and agreed.

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).

Noted and agreed.

3.12.6.3 The vendor will participate in the State Fair Hearing process, at the vendor's expense, in each circumstance in which a recipient for whom the vendor has made an adverse determination requests a State Fair Hearing. The vendor is bound by the decision of the Fair Hearing Officer. (Please refer to the Chapter 3100 of the MSM for timeframes for standard and expedited State Fair Hearings.)

Noted and agreed.

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

Noted and agreed.

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.

We will continue or reinstate the recipient's benefits while an appeal is in process in compliance with the above conditions.

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.

We will continue or reinstate the recipient's benefits while an appeal is in process in accordance with the above conditions.

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).

Noted and agreed.

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.

Noted and agreed.

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.

Please see Attachment 3A1_Grievances and Appeals Flowcharts.

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.

We accept written and oral grievances and appeals that are submitted directly by the provider as well as those that are submitted from other sources, including the DHCFP, as required above.

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.

At the time of contracting we notify all providers of our appeals process, including the right to a fair hearing. We agree to the fair hearing timeframe and components as outlined above.

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.

We acknowledge and agree to the State's timeframe and requirements with regard to expedited fair hearings.

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.

We acknowledge and agree to the State's timeframe and requirements with regard to expedited 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 acknowledge and agree that we will be bound by the decision of the Fair Hearing Officer and must comply with any decision resulting from the Fair Hearing process.

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.

The Enterprise System information technology (IT) team maintains a platform that provides processing solutions that include, but are not limited to:

- Eligibility, enrollment and disenrollment management and data exchange
- Provider network management, credentialing, enrollment and confirmation file exchange
- Member and provider information access through secure online portals
- Report generation and transmission to facilitate standard and ad hoc reporting
- Care coordination and case management for physical health and behavioral health with social components for whole-person care
- Claims processing, edits and adjustments
- Claims adjudication, payment and coordination of benefits (COB) for claims with third party liability (TPL)
- Financial management and accounting

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.

Our MIS is currently capable of documenting administrative and clinical procedures while upholding the HIPAA privacy and confidentiality requirements, including regulations and updates regarding administrative simplification, privacy and security.

Our information systems are compliant with the privacy, security and administrative simplification requirements associated with the broad HIPAA of 1996, as amended or modified. We comply with HIPAA Electronic Data Interchange (EDI) requirements, including the HIPAA-compliant formats. Our systems are compliant with HIPAA transaction and code set standards.

We are committed to safeguarding the confidentiality of Nevada recipients' personally identifiable information (PII) and protected health information (PHI) through compliance with HIPAA regulations, the Health Information Technology for Economic and Clinical Health (HITECH) Act, and Nevada privacy laws and regulations. We carefully monitor both federal and Nevada legislation and regulations, and take appropriate action when necessary to reinforce ongoing compliance.

Our encounter data reporting system assures the provisioning of aggregated, unduplicated service counts across service categories, provider types and treatment facilities. Our standardized reporting methodology supports CMS reporting categories for collecting service event data and costs associated with each category of service.

In further compliance with DHCFP reporting requirements as outlined in Attachment T-Forms and Reporting Guide, we also will provide all reports according to required time frames, as outlined in detail in our response to the requirements listed in Section 3.16.

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.

The Enterprise System includes management of enrollment and recipient ID numbers, to link recipient records that may have been established under separate programs or separate recipient identification numbers. To minimize the occurrence of duplicate recipient records, our process does not rely solely on the unique identification numbers when electronically processing enrollment additions, terminations or changes. We evaluate several key attributes about an individual using a tiered matching logic to determine if the recipient exists under a different program identification number.

Additionally, our enrollment system programmatically reconciles recipient enrollment-file discrepancies by looking at critical data elements, such as name, date of birth and Social Security number (SSN) to identify potential duplicates, which are resolved after confirmation from DHCFP.

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 update our eligibility data whenever recipients change names, phone numbers and/or addresses, and notify DHCFP of these changes. We monitor for changes through direct member interaction by our member services department and through daily/monthly (X12) 834 transaction files provided by DHCFP.

The eligibility system provides automatic error alerting that triggers error correction processes and procedures for manual correction by our eligibility team. Upon receipt of the monthly enrollment file from DHCFP, our eligibility team compares and reconciles the roster of recipients to verify that there are no discrepancies. We take the following steps to guarantee data integrity:

- Each month, the Enterprise System systemically compares the membership files received from DHCFP against our membership records and identifies changes in name, gender, group number, phone number, address, birth date, effective date and SSN

- DHCFP membership record updates are then electronically loaded using a generated batch input file into the eligibility database
- An exception report is produced identifying recipient information not meeting electronic update criteria
- Our enrollment team manually reviews exception reports daily, verifies recipient eligibility as needed with the State's enrollment system and makes corrections, as needed

We make updates to our integrated eligibility database online in real time and we communicate updates to DHCFP daily through the Provider Supplied Data File transmission.

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

We provide DHCFP with daily electronic notification of inaccurate recipient addresses through the required Provider Supplied Data File.

3.13.4 Encounter and Claims Records

We have a strong history of providing timely, accurate and complete data across the state Medicaid markets we serve and understand that continuing to do so has never been more important, especially given CMS' final rule to modernize Medicaid managed care regulations.

We are committed to meeting all standards of the new regulations, including new requirements related to encounter data submissions. We understand the final rule includes changes that implement provisions of the Affordable Care Act and strengthen encounter data submissions from managed care plans to states and from states to CMS. We will submit complete, timely and accurate encounter data submissions to the State in the level of detail and format required by CMS. This enables DHCFP to submit encounter data to CMS that meets the criteria for accuracy, completeness and timeliness.

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.

In compliance with the requirements of this RFP, our encounter data reporting system assures the provisioning of aggregated, unduplicated service counts across service categories, provider types and treatment facilities. Our standardized reporting methodology supports CMS reporting categories for collecting service event data and costs associated with each category of service.

As required, the Enterprise System will generate and provide person-level records that describe the care received by that individual during his or her enrollment period. We will provide these records at intervals specified by the State. Currently the State requests these data files be sent at the completion of each of the Contractor's financial cycles. The person-level record will include, at a minimum, those data elements listed in the State's Approved Encounter 837 Companion Guide and other associated HIPAA companion guides including updates issued by the State's designated Medicaid management information system ("MMIS") contractor.

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.

Our benefits platform includes several custom-built, integrated application modules, provides the integrated database that edits and collects data on recipients and providers along with the claims and encounters that document the services furnished to recipients.

By using a common platform and database of claims and encounters, our quality assurance procedures safeguard that the data submitted to the actuary balances with the data submitted to the DHCFP and that the data includes all services reimbursed by Medicaid. By using our dedicated IT team, we have the capability to submit the data in accordance with the requirements set forth in the contract. We use a robust regulatory monitoring process to maintain compliance with state and federal law. Our system fully complies with the HIPAA-compliant standards for information exchange, including the 5010 version**.**

Our technical team has worked with many different trading partners, each with unique requirements. We are experienced at transforming, validating, importing, and reconciling complex data transactions. We also offer support for individual providers who prefer to submit EDI files directly to us in HIPAA 837D format.

Our experienced EDI Analysts work closely with direct submitters to fully test HIPAA compliancy and data file quality in a test environment before accepting and processing electronic claims submissions in production.

We maintain and update written documentation about all aspects of electronic claims processing. Technical documents, including transaction Companion Guides, are available to dental providers and billing intermediaries online as PDF documents and can be sent in hard copy format, upon request.

- Written documentation describing electronic claims processes is maintained and updated as part of a context-sensitive online help system, which is integrated into the benefits management software system.
- Documentation of electronic claims testing, submission, and production protocols is covered in client-specific policies and procedures.
- Data file specifications and transaction Companion Guides are maintained, updated, and delivered as PDF documents in an Online Books Library, available in our integrated online help system.

We support all of the methods of electronic claim submission required by the State. We receive Third-Party Liability (TPL) claims in the same way as any other claims. Attachments submitted with TPL claims are automatically attached to and stored with the related claim records.

- We accept electronic claim files through a secure FTP site (Customer Web Portal). The preferred method for receiving files is for the client to “push” their files to us through an SFTP connection. With our preferred “Push-Push” process, clients simply drop their data files on our secure FTP site, and a software package automatically moves files into the appropriate directory folders for processing. When processing is complete, we “push” the response files back to the client’s FTP site.

- This process for exchanging data files is convenient, efficient, and allows for automated scheduling and processing. For those clients without the technical capability to transfer files through an SFTP connection, we can access the client’s site instead and download the data files, or clients can send feed files via electronic hard media (CD-ROM, DVD, other media) through postal mail or secured email.

- As described in (a) above, we can accept and process claims files received via electronic hard media, including CD-ROM, DVD, and other media and methods that comply with industry standards and dental provider demand.

- As described throughout this response, we encourage providers to submit electronic claims via direct data entry through our Provider Web Portal. A built-in verification process evaluates claim submissions for TPL information and prompts users to enter coordination of benefits information and attach related Explanation of Benefits documentation before submitting the claim.

Our integrated electronic transaction system automatically tracks all data import and processing activities, preserves a history of all files received, and logs details regarding rejected claim records and transactions.

When 837D files are imported into our automated system, they are evaluated and validated using a series of Strategic National Implementation Process (SNIP) tests, validation edits, and user-defined edits at various points during the import and transformation stages. The system automatically generates 277CA and 999 Implementation Acknowledgement files, which are sent back to the submitter and used to identify and resolve any issues.

Our HIPAA-compliant software is configured with “hands-off” automation to automatically import, validate, load, and retain electronic data and send resulting electronic acknowledgements.

3.13.5 Data Requirements and Certification

We have extensive experience processing electronic data files. Because our system retains a complete history of all files received and processed, and we can easily report any transaction data back to the State, as required.

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

We comply with HIPAA electronic data interchange requirements, including the HIPAA compliant format version. Our systems comply with HIPAA privacy and transaction and code set standards. We use standard HIPAA 820, 834, 835, 837D, 837I, 837P, 270/271U, NCPDP Post Adjudication History (PAH), 276/277 and 278 file formats for electronic transactions.

Additionally, we comply with the x12 5010 EDI standards.

3.13.5.2 All encounter data must reflect all adjustments and voids.

Our encounter data reflects all adjustments and voids, as required by DHCFP. Given the importance and complexity with processing accurate encounter claims across several entities, we have an established library of policies and procedures to support encounter data reporting.

We are providing DHCFP accurate, timely and complete encounter data submissions. The data are used for evaluating performance and quality and determining premium payments in the future. We believe accurate encounter data begins with accurate claims. All new claims are subject to a series of reviews to confirm we have all the data we need to not only process the claim, but produce accurate encounters. The Enterprise System serves as the main data source for encounter data extracts. It performs automated edits and HIPAA validations on all claims to confirm the accuracy and completeness of encounter data (e.g., presence of provider IDs, national provider identifier [NPI], taxonomy and member Medicaid IDs).

Our encounter data collection and submission process confirms all data provided to DHCFP is first tested for accuracy, completeness, logic and consistency. We submit encounter data in the HIPAA standard approved by DHCFP.

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.

All improper payments must be adjusted or voided from the encounter data within the time frame specified by DHCFP. Our encounter team verifies that encounter files contain settled claims, adjustments, denials or voids, including but not limited to, adjustments necessitated by payment errors, processed during that payment cycle as well as encounters processed during that payment cycle from providers with whom we have a capitated arrangement.

We will make an adjustment to encounter claims when we discover the data are incorrect, no longer valid or some element of the claim not identified as part of the original claim needs to be changed except as noted otherwise. We will make these adjustments within the time frames 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.

The encounter management team works with internal information technology partners to schedule file submissions to meet State-specific timeliness requirements. As required, we will include a certification that attests to the truthfulness, accuracy and completeness of all enrollments, encounter, payment and other submitted data.

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:

As required, data submitted to the State for the purposes of determining vendor payments will be certified by our chief executive officer, chief financial officer or an individual with delegated authority.

A. The vendor's Chief Executive Officer;

Please see Question Response 3.13.5.5.

B. The vendor's Chief Financial Officer; or

Please see Question Response 3.13.5.5.

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.

Please see Question Response 3.13.5.5.

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.

We will comply with the requirement of data certification as a condition for payment by the government. We will require the person responsible for data certification to read and understand the data certification requirements and agree to comply with all applicable laws and regulations.

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.

We have an established tracking system that provides up-to-date information on compliance with EPSDT service provision requirements in the following areas:

- A clinical dental examination at the eruption of the first tooth and no later than twelve (12) month and
- Every six months thereafter, or as indicated by the child's risk status/susceptibility to disease.
- Diagnosis and/or treatment, or other referrals in accordance with EPSDT screen results.

Our benefits management software platform is extremely comprehensive and flexible when it comes to client reporting, and it can be customized to generate reports with real-time data. The software system can extract data and repackage it into formats required by the State of Nevada without programming changes to the system. We have experience creating client-specific reports to monitor each recipient's profile. We track when the recipient last received treatment, what services were performed, who performed those services, any authorizations received for referrals to specialists, and when the recipient is due for their next preventive service.

We have sophisticated and customizable monitoring and reporting capabilities available to track recipient dental utilization. These include:

- HEDIS reports providing a snapshot summary of the Medicaid dental program's month-to-month performances by determining all recipients eligible for services, such as sealants, and those that have received preventive services, to provide a HEDIS score for each HEDIS eligible age group.
- Real-time dashboards to track the percentage of patients accessing care. Our reporting tools are integrated into our benefits management software system to analyze and compare the types of services being rendered, including preventative and restorative services.
- Detailed analytical reports that track by recipients by county, by zip code, and by age to analyze which counties outperformed others, and where targeted outreach could be best implemented.

These report outcomes allow us to identify the opportunities to drive EPSDT rates and thereby allow us to create targeted, focused outreach programs to these targeted recipients. Our targeted outreach programs take into consideration factors that are likely barriers to service for recipients. This analysis allows us to adapt the outreach plan, as necessary, to address utilization and increase percentages of preventative and restorative services for recipients.

The system enables us to report activities annually on the CMS reporting form, as required. This system can also be enhanced to meet any other reporting requirements instituted by CMS or the DHCFP.

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.

To provide support for this contract we will designate a dental director who will be responsible for the oversight, development, implementation and review of our Internal QAP, including implementation and adherence to any POC. As required, the dental director and the Utilization Management and Internal Quality Assurance Plan Committee will be accountable to our Board of Directors.

The assigned dental director will be licensed in Nevada as a Doctor of Dentistry with no restrictions or other licensure limitations. In this role he/she will be available during normal business hours for Utilization Review (UR) decisions and is authorized and empowered to represent our organization regarding clinical issues, UR and quality of care inquiries. In this role the dental director is responsible for the following functions and all activities included in 3.14.2 – 3.14.2.9.

- Ensuring provider profiling reporting is completed and reviewed with providers
- Conducting provider counseling on quality of care complaints or failure to comply with any Nevada provider guidelines
- Completing outreach to providers who show aberrant reporting results to monitor fraud and abuse patterns
- Participating in the Fraud and Abuse Program
- Conducting on-site reviews of providers with suspect utilization under the Fraud and Abuse Program
- Making recommendations to the peer review committee
- Monitoring the work of the Nevada based dental consultants and dental review specialists
- Making determinations on quality of care complaints
- Reviewing of credentialing files and recommendations on re-credentialing decisions
- Making determinations on all member appeals
- Monitoring the quality of the provider network
- Monitoring the work of Level 3 dental consultants
- Reporting to the dental director will be the quality improvement manager, quality management manager and benefit administration and utilization manager as it pertains to the contract.

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;

As requested, the dental director serves as a 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;

As requested, they will direct the development and implementation of the vendor's 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;

The dental director 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 director reviews all potential quality of care problems and oversees the development and implementation of, as well as the adherence to the POC.

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;

The dental director will also oversee the vendor's referral process for specialty and out-of-network services. All services prescribed but are denied will be reviewed a licensed dentist who will then document and log all information related to the claim.

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

The director will oversee all provider recruitment and credentialing activities.

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;

As part of our commitment to provide exceptional provider access and services, the dental director will serve as a provider liaison and will provide oversight to the provider relations staff that provides direct support to the network.

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

The dental director will serve as a consultant with regard to referrals, denials, grievances and problems.

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

As required, the dental director will provide guidance to support the coordination of out-of-network services.

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.

The dental director will be the liaison to DHCFP and will provide direct guidance to the manager of the utilization management program who will supervise the day-to-day operation of the authorization program.

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:

We have a highly experienced management staff with many years of service with our organization and significant years of collective managed care industry experience. This broad, diverse management team possesses the knowledge, education and expertise necessary to direct program operations and they have been instrumental in making us the highly successful organization we are today.

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 will provide DHCFP with an updated organizational chart every six months or whenever a significant change in the organization occurs that depicts 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 will include all key personnel and senior level management staff and will clearly delineate lines of authority over all functions of the contract.

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. Operations Manager;

B. Accounting and budgeting;

C. Dental Director's office;

D. Dental Management, including quality assurance/utilization review;

E. Recipient services;

F. Provider services;

G. Grievances, appeals, and fair hearings;

H. Claims processing;

I. Management information systems (MIS); and

J. Program Integrity.

We will put in place all requested organizational, management and administrative systems capable of fulfilling all contract requirements as outlined in A-J.

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.

As required, the Nevada Medicaid/CHIP Operations Manager will be housed in our Nevada administrative offices and will not be assigned to any other responsibility. We will ensure that all staff has appropriate training, education and experience to fulfill all requirements related to the service and administration of this program. As requested, we will inform DHCFP of any changes in key positions within 7 calendar days.

3.14.4 Subcontractors

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

We will comply with all federal requirements 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;

All subcontracts include the requirements of 42 CFR 438.6 that are appropriate to the services 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;

We oversee our network subcontract and are accountable for any responsibilities we delegate to any subcontracted provider. We maintain an extensive oversight program for our subcontracts, which we will use for this contract. For over a decade at the national level, we have garnered a substantial amount of information on working with subcontractors and integrating their services into our programs—and we have learned how to do this successfully.

With each experience, we become more educated on what works and what does not. We have taken this knowledge and sought to improve our subcontractor processes continually to strengthen our programs and to offer seamless, well-integrated services for our recipients and providers.

Oversight begins before we select a subcontractor. We select only subcontractors who support us in improving the effectiveness and efficiency of the delivery of services and have a strong reputation for administrative excellence. In accordance with HIPAA, we enter into business associate agreements with all subcontracted partners to verify compliance with privacy and security regulations.

Upon selection of a vendor, a method for reporting and measuring performance, based upon state contractual requirements (including RFP responses) and internal standards is agreed upon with the vendor. In addition, if the vendor handles recipient data or has direct connectivity to our systems, we conduct a thorough data security assessment to ensure full integration of these vendors with our own internal systems and processes.

Where appropriate, we include businesses that have been certified by the State Medicaid agency. The selection process also includes a due diligence review of the candidate's past performance and experience, financial strength, innovation, ability to perform the activities to be delegated, and the ability to meet our security standards. When selecting new subcontractors, our vendor management team evaluates each vendor in three categories: quality, accessibility and cost. Following our evaluation process, we select a subcontractor and establish an agreement to govern the operating relationship. This agreement includes delivery of administrative services at a standard to make sure all contract requirements are met.

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;

We agree to have our subcontract and delegation agreements prior approved by DHCFP. Prior to the award of any subcontract or execution of an agreement with a delegated entity, we will provide written information to the DHCFP disclosing our ownership interest of 5 percent or more in any subcontracted or delegated entity.

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;

We will submit names of any material subcontractors by the services start date and whenever a change occurs to obtain DHCFP for review and approval.

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;

We agree to maintain our delegated agreements and subcontracts in writing and comply with the DHCFP's requests for copies of agreements and subcontracts by providing copies of the requested agreements within five days of receiving such request. Our subcontractor agreements contain provisions relevant to the subcontracted service or activity including HIPAA requirements, insurance requirements and record retention. We also require that our subcontractors are adequately insured to the 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;

As the contracted entity, we accept full responsibility for meeting all requirements of the contract regardless of any subcontract agreements.

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;

We have a written agreement with our subcontractor specifying our delegation of activities and report responsibilities to them. The written agreement includes provisions for revoking delegation or imposing sanctions should the subcontractor's performance be 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;

We are responsible for oversight of all network subcontracts and accountable for any responsibilities we delegate to any subcontracted provider. We monitor our subcontractor's performance on an ongoing basis and subject them to a formal review schedule. We have provisions for corrective action plans in our contract with our subcontractor.

3.14.4.9 Notify DHCFP, in writing, immediately upon notifying any material subcontractor of the vendor's intention to terminate any such subcontract;

We agree to notify the DHCFP, in writing, immediately of our intention to terminate a material subcontractor, as evidenced by our internal policy, Termination of 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;

We will provide full and complete information about the ownership of any subcontractor with whom we have business transactions totaling more than $25,000 during a 12-month period. This information will be provided within 35 calendar days of the date of request. These details are included in our internal policy.

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

We agree to allow DHCFP to review our provider contracts.

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.

In the event that our subcontractors do not meet federal requirements that results in a federal disallowance of federal fund, we agree to be financially responsible and refund the amount of the federal disallowance and the corresponding state share to the DHCFP. Our network provider contracts and subcontracts meet current federal requirements and are amended as necessary.

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.

We will provide our detailed work plan and timeline for performing the obligations set forth in the contract within one month of receiving notice from DHCFP of our selection for Contract negotiations. This work plan and timeline will specifically outline our plans to implement all requirements.

Our significant experience, knowledge and capacity enabled us to minimize issues and challenges during implementation while maximizing the long-term viability, success and value of this important program for the recipients and providers we serve. As part of our governance process, we formalized our ability to continually improve and evolve based upon lessons learned and best practices. This includes eliminating duplicative work, leveraging the diverse skillsets of team members and delivering an implementation experience for our state partner that is seamless to recipients and consistently outstanding.

We have significant experience implementing managed care programs comparable in size and complexity to Nevada's Medicaid and Check Up Programs with special understanding of the needs and concerns of TANF, CHIP and Medicaid Expansion populations. Based on our experience implementing similar programs, our implementation plan will provide continuity of care and services for existing recipients as well as seamless transition for new recipients.

We are confident our experienced Medicaid and CHIP managed care program meets the requirements of this RFP. We are eager to partner with the state to expand to new geographic areas, and will adjust our implementation plan to include the additional network, staffing and outreach requirements to accommodate a geographic expansion. Should the State incorporate additional programs and/or population into Medicaid managed care, we will partner with the State to create program-specific updates, add specific provider types to the network and adjust benefits and clinical processes to serve the new populations appropriately.

Our implementation approach is proven, reliable and replicable. It enables continuity of care and services for existing recipients as well as seamless transition for new recipients by understanding and anticipating issues that may affect them and providing timely resolution of those issues.

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.

We will provide DHCFP with biweekly written updates to the initial work plan and timeline as described above and until the service start date; and thereafter as often as DHCFP deems necessary.

Our comprehensive work plan outlines each step of the readiness preparation process and guides every implementation we perform. For Nevada, it identifies the detailed steps, accountabilities and time frames to achieve a timely implementation beginning with pre-implementation activities and progressing through to enrollment and the July 1, 2017, start date. Our work plan includes a timeline with specific dates, events and dependencies that allow us to track progress through to completion of each task. The work plan is a dynamic tool, and the implementation management team uses it to monitor all aspects of the project and identify potential risks in upcoming phases.

Our leadership team will work closely with DHCFP to establish or update project management and reporting standards, communication protocols, key points of contact, and standing meetings, as well as ratify or adjust the transition schedule as necessary. Once these mutual expectations and understandings are confirmed, we will finalize our implementation work plan, subject to DHCFP review and approval. Among other things, the final implementation work plan will document the content and format of all contract deliverables, project management procedures (including steps or processes that require DHCFP involvement), transition reporting requirements and deadlines.

Our work plan clearly demonstrates the start and end dates of all tasks and subtasks based upon anticipated feedback and necessary interfaces with DHCFP. This plan will be internally managed and updated weekly. For the purposes of this proposal submission, we will provide to DHCFP a written update report to our work plan on a biweekly basis. The more detailed weekly plan is available upon request by the State.

We have an established structure in place for completion and DHCFP signoff on all deliverables and major activities including all aspects of implementation project preparation. We include action items identified in meetings or reviews on our Work Plan Action Log. We assign identified action items to a functional owner (e.g., enrollment, claims) per the accountability matrix. The functional owner is then responsible for completing the action, leading cross-functional completion of the item and escalating any further development decisions, in compliance with State requirements. The senior project manager will report regularly on the status of the item and communicates directly with the functional owner until the action item is resolved.

We update the work plan through regularly scheduled weekly meetings to verify the entire implementation team can adjust or compensate as needed for timely remediation.

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.

We agree to submit all deliverables to the DHCFP within a minimum of 10 business days of the service start date, unless otherwise required by the DHCFP.

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.

We agree to prepare and deliver an access report to the DHCFP at any time that such report is requested by the DHCFP. We have established and proven procedures for obtaining executed subcontracts and Medicaid provider agreements and we will provide network updates to the DHCFP upon request, including no later than 60 calendar days prior to the July 1, 2017, service start date, and as may be otherwise required per the contract or DHCFP.

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.

We have appropriate workplace requirements and will be fully operational to support continuity of care activities and readiness reviews with DHCFP including, but not limited to, functioning office space, post office boxes, telephones, information systems and equipment.

F. Ensure that there is no interruption of covered services to enrolled recipients and work cooperatively with the DHCFP to meet these requirements.

We offer DHCFP and our recipients continuity of care and no interruption of care or services. Our company has experience and a proven record of working successfully with State Medicaid agencies to confirm recipients have a seamless experience transitioning into or out of our Medicaid program. We have a transition of care policy that provides for transition of care into our dental plan.

As we have outlined in Section 3.6, Network Section we have aligned with our internal network partner, the Health Plan of Nevada. Current recipients will have the benefit of remaining with their existing provider or choosing a new dental home from the provider network that has been a valuable resource to Nevada Dental Medicaid recipients for the past 15 years.

Our approach to seamless recipient transitions is based upon our experience; working with Medicaid populations; accurately configured benefits and claims management systems and in applying lessons learned from successfully transitioning members in our other Medicaid markets.

New members will experience a smooth and seamless transfer to our program through our proactive member outreach programs; a comprehensive provider network; and our high-touch approach to educating recipients and providers about new program benefits. Recipients will have questions and concerns about transitions. Our member services and concierge staff, using member materials designed specifically for the Nevada Medicaid and Nevada Check Up Program recipients, will assist recipients, answer questions and address any concerns. Managing recipient expectations, eliminating gaps in care and delivering service with compassion is at the heart of our person-centered service model.

G. Establish and implement enrollment procedures and maintain applicable enrolled recipient data.

We will operate and manage the data exchange and processing requirements through the Enterprise System. Highly qualified technical staff members have over 20 years of experience handling Medicaid/Medicare EDI (Electronic Data Interchange) files. We import, process, and manage Medicaid/Medicare eligibility EDI files, understanding and applying different electronic file formats required by each state.

The data file import process manages enrollee updates through eligibility change files submitted in HIPAA-compliant 834 v. 5010 transaction sets and through full file data imports, which reflect full membership. Full files can be imported and processed on any schedule that meets each client's needs, including periodic replacement at the discretion of the State. Built-in logic compares full files against membership records stored in the processing system database, and customizable business rules are applied to correct any discrepancies. The process generates reconciliation reports that can be customized to meet the State's requirements.

H. Establish its Provider Network and maintain existing Provider Agreements with such Providers.

We meet or exceed the provider network requirements as outlined in Section 3.6 and Section 3.14.5. Throughout the course of the contract, we will continue to meet the requirements of the State to best serve our recipient's dental and service support needs. We will continually update our provider network as needed to maintain an exceptional level of service.

We maintain direct provider agreements in accordance with the provisions set forth in Scope of Work Sections 3.6. and 3.14.5.

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.

We agree to undergo any readiness reviews that the DHCFP or CMS conducts in association with this contract.

We will verify that our operations have been activated and can execute the transactions necessary to meet recipient expectations and DHCFP requirements for this contract. We will achieve readiness by:

- Assigning a team dedicated to manage readiness reviews
- Identifying subject matter experts
- Compiling required DHCFP documentation by due dates
- Developing materials and presentations for recipients, providers and other stakeholders that reflect the DHCFP requirements
- Responding quickly to DHCFP needs
- Meeting all deadlines

INTERNAL READINESS REVIEW MEETINGS

Based upon DHCFP requirements, our implementation and expansion team develops a summary version of the overall project plan that provides a detailed and complete overview of all implementation and go-live activities. We regularly conduct internal readiness review status meetings to compare our readiness to date alongside the implementation plan effective date. This validates that we are adhering to the readiness review schedule and are prepared to review all processes and upcoming milestone dates and activities with our state partner. Key items that we review during these internal status meetings include, but are not limited to:

- Enrollment processes
- Claims management processes
- Web access and portal setup
- Clinical programs and transition planning
- Quality Improvement
- Management information system development and testing
- Report preparation and delivery processes
- Provider network readiness
- Customer service call center processes (for providers and members)
- Administrative organization, including staffing levels
- Finance operations
- Business Continuity

STATE READINESS REVIEW MEETINGS

We are prepared and agree to participate in various types of readiness reviews with the DHCFP, such as:

- Paper readiness review where the DHCFP asks questions or requests information or documentation (e.g., policies and procedures, staffing plans, training curriculum and cultural competency plans)
- On-site testing readiness review where the DHCFP visits our facilities to assess our operations (e.g., data center or mail room) or to conduct an audit or an interview of our personnel (e.g., member services center representative)

After the readiness review(s), our readiness review team will continue to integrate feedback from the DHCFP and incorporate any additions, deletions or changes into our implementation plan, including updating operational processes and procedures to execute the contract.

CMS REVIEW AND APPROVAL

Our operations relating to the provision of services under this contract are subject to review and approval by CMS and we will comply with any requests received from CMS.

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.

We agree to obtain DHCFP's approval prior to publishing or making formal public presentations of statistical or analytical material that includes information about enrolled recipients. We have multiple written internal policies specifically addressing compliance with marketing requirements. Our marketing and compliance teams have developed a system of checks and balances to comply with marketing policies and procedures governing submission and approval of marketing materials and compliance to marketing policies and procedures.

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.

We fully comply with the requirements in Section 3.14.7 under the direction and leadership of our manager of community outreach and marketing events who oversees our Nevada Medicaid and CHIP marketing materials to confirm efficacy and maintain compliance with State and federal marketing guidelines. We request permission from the DHCFP to distribute materials during an open enrollment period, in other locations or to implement any advertising campaign.

We follow Nevada-specific processes and procedures for DHCFP marketing material review, and DHCFP approval that meet the specified timelines and confirm receipt of DHCFP's permission prior to material distribution.

We do not market directly to potential members, nor do our network providers or any contracted organization or agency. We follow multiple written internal policies that specifically address compliance with marketing requirements and prohibited practices, including non-compliant "cold-calls." We also follow written internal policies to confirm that all information provided in marketing materials is accurate and not misleading. Staff in multiple areas, including marketing and compliance, reviews all materials.

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.

We distribute only DHCFP-approved marketing materials and obtain DHCFP approval on any updated, previously approved materials. The DHCFP has the sole authority to approve our marketing materials.

We disseminate DHCFP-approved materials to our entire service area to raise awareness of the Medicaid and CHIP programs and to extend the reach of health care services to individuals living in all areas of the State. Marketing materials receive customization to provide equitable and meaningful engagement across the State with regard to demographics and language. We produce these materials at or below an eighth-grade reading level, according to the Flesch-Kincaid tool, to make sure individuals can easily understand the content.

We distribute approved materials in English and Spanish, and we will create materials in other languages that become prevalent in Nevada as needed. We do not use marketing materials that include influencers, such as private insurance offerings. We follow multiple written internal policies to confirm full compliance, directly and indirectly, with marketing requirements and prohibited practices, including non-compliant door-to-door or telephone "cold-calls."

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:

We confirm that our marketing materials are accurate, clearly stated and compliant with DHCFP requirements through management review of the materials, comparison to our contractual requirements and submission to the DHCFP for approval prior to use. We have policies and procedures in place to confirm accuracy of materials in content and translation, in language and alternate formats, and that our materials do not defraud, mislead or confuse potential enrollees. All public communications are subject to corporate communication policies and procedures, to include auditing of the material and content. Subject matter experts conduct formal interdepartmental reviews of marketing materials prior to dissemination and provide ongoing monitoring to confirm accurate representation.

A. The recipient must enroll with the vendor in order to obtain benefits or in order not to lose benefits; or

Please see Question Response 3.14.7.3.

B. The vendor is endorsed by CMS, the federal or state government, or similar entity.

Please see Question Response 3.14.7.3.

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.

We use the full breadth and depth of our Program Integrity program to identify, review, recover and report improper payments, including fraud, waste and abuse (FWA) activities. Our comprehensive program enables us to serve the Nevada Medicaid and Check Up populations in Clark and Washoe Counties and easily expand our focus to other geographic areas, as necessary.

A key component of the UnitedHealthcare's management of benefit costs is the identification and investigation of potential fraudulent, abusive, unusual services, or aberrant patterns of care. The program is comprehensive and managed in partnership with our Payment and Integrity Unit, a United subsidiary and the UnitedHealthcare Special Investigations Unit (SIU). The Fraud and Abuse Program is reviewed periodically as required by specific contract, state, and/or federal requirements. Cases that are verified as being "fraudulent", they are summarized at the appropriate internal committees, and referred to the appropriate authorities for further action. Annual reports of anti-fraud or abuse activity are filed with the state regulatory agencies when required.

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 are familiar with and comply with all federal and state regulations related to Program Integrity, as well as all Nevada Medicaid requirements. Our comprehensive Compliance and Ethics Program is the vehicle through which we develop, implement, maintain, comply with and monitor compliance. Our Fraud, Waste and Abuse (FWA) Program is an integral part of the overall Compliance and Ethics program and includes a Fraud, Waste and Abuse Compliance Plan that guards against FWA.

Our program takes into account that managed care anti-FWA efforts must encompass our entire entity (employees, executives and owners). Under the guidance of our False Claims Policy, everyone within our organization is required to comply with the federal False Claims Act, state false claims acts as well as similar state and local laws and agency policy. Our policy outlines key information about the federal False Claims Act, state false claims acts and similar state and local laws and agency policy pertaining to civil and criminal penalties for false claims and statements, whistleblower protections and the role of these laws in preventing and detecting fraud, waste and abuse in federal and state health care programs.

Our program integrity and FWA program relies on core elements of an effective compliance program such as written policies, procedures and standards of conduct that articulate our commitment to and processes for compliance, as well as initial and ongoing education for compliance officers, employees, executives, owners, subcontractors and providers. We enable effective communication between the compliance officer and employees by using technology, ongoing in-person training and day-to-day interactions. We enforce standards through well publicized disciplinary guidelines, internal monitoring and auditing to detect offenses, and prompt response to detected offenses, including the development of corrective action initiatives as required.

Compliance begins with our employees, as they are trained on our Principles of Ethics and Integrity and the obligation to contact our Compliance and Ethics hotline, compliance officer or their supervisor immediately upon suspicion of any incidence of FWA they encounter. Our FWA plan focuses on the entire process beginning by verifying that excluded providers are not allowed in the network, continual oversight with education and, when necessary, removal from the network to assure our recipients are receiving the highest quality care and that we are good stewards of public dollars.

3.15.2 Provider Credentialing

We maintain a comprehensive credentialing and recredentialing policy, which confirms all health plan providers are credentialed and recredentialed in a consistent, non-discriminatory manner. Verification of a valid NV license for all PDPs, specialists and other provider types, as well as review of federal sanctions and exclusions are included as part of our credentialing process. We do not employ or contract with providers excluded from participation in the federal health care programs under Section 1128 of the Social Security Act.

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.

Providers are initially credentialed and then recredentialed every three years.

We typically handle initial credentialing internally according to NCQA guidelines, Centers for Medicaid and Medicare Services (CMS), and any state-specific credentialing standards.

We collect the appropriate documentation, verify the practitioner's credentials, and the Credentialing Committee makes the decision. Our leased networks and some individual offices conduct their own credentialing verification in accordance with our standards. We perform oversight to ensure this delegated process matches our own.

A complete credentialing application package includes:

Completed application	Can be the Council for Affordable Quality Healthcare (CAQH) application, a state-mandated application, or our standard company application.
Education & Work history	Work history/Curriculum vitae (CV) for the last five years; dental school and graduation year; specialty program and graduation year and board certification (if applicable).
Malpractice information	A copy of the dentist's malpractice fact sheet and any malpractice or adverse actions explanations (if applicable).
Attestation and State licenses	The attestation must be signed and dated and we must receive copies of all state licenses.
DEA / CDS information	Federal Drug Enforcement Administration (DEA) certificate or Controlled Dangerous Substance (CDS) certificate or registration, if applicable

During primary source verification (PSV), all items must be verified except any static historical elements. Verifications may not be older than 180 calendar days when given to the Credentialing Committee for a decision. We use the following sources:

- The National Practitioner Data Bank
- Office of the Inspector General (OIG)
- State professional licensing board
- State specific Medicare/Medicaid Opt Out Reports
- Dental schools; and specialty boards

We may require an initial facility site review before the credentialing file can be approved by the dental director or sent for review by the committee (one visit for each facility). The site visit tool includes a site's accessibility, appearance, space, languages spoken, special needs availability, adherence to infection control, medical or dental recordkeeping practices, availability of appointments, and confidentiality procedures.

The Credentialing Committee meets twice a month and makes the decision to accept, retain, deny or terminate a provider's participation in the network.

We notify all applicant dentists of their right to appeal the Credentialing Committee's decisions. Dentists must submit an appeal within a specified date of the rejection letter. The Peer Review Committee (PRC) reviews the appeals. The PRC panel will include at least one member that is of the same specialty as the provider who is submitting the appeal. The PRC panel will consider all information and documentation provided with the appeal and decides to uphold or overturn the Credentialing Committee's decision. The PRC may request a corrective action plan, a site visit and chart review.

RE-CREDENTIALING PROCESS

UnitedHealthcare re-credentials all network providers, MDHPs, general dentists, pediatric dentists, and other dental specialties within three years of the previous credentialing decision. To ensure timely re- credentialing of our providers, the credentialing department begins the process by sending packets to the providers six months prior to their three-year target date. The packet includes the re-credentialing application and a list of required documents (i.e., attestation, current malpractice certificate and a current DEA certificate).

Re-credentialing generally follows the same processes we use for credentialing. The credentialing department will perform re-verification of credentialing information that is subject to change over time to assess whether network practitioners continue to meet our credentialing standards. The process also includes appraisal of professional performance, judgment and clinical competence through review of member complaints; provider site visit results, utilization management profiles, and information from other licensing and accreditation agencies. The credentialing department also reviews provider-specific complaint and quality of care review data obtained from our internal inquiry system.

We flag provider files for special review and refer them to the credentialing committee if they exceed the following thresholds:

- Five complaints per re-credentialing period in this contract
- Three complaints in favor of member per re-credentialing period
- Three or more quarters of outlier utilization patterns as documented by the Provider Profile report

The credentialing committee will review the files and make a determination on whether to keep the provider in the network. We use the same process for notifying the provider of a determination decision as we use for the initial credentialing.

ONGOING MONITORING

The credentialing department also performs ongoing monitoring of bi-monthly reports from the Office of Inspector General (OIG) and the Nevada State Board of Dental Examiners website to identify expired licenses and sanctions imposed against providers. In addition, we continue to monitor providers for issues of substandard professional conduct and competence. The credentialing committee reviews the data and determines whether providers should be terminated from the network.

We will report to the credentialing department when a provider is denied network provider status. Such denial can include when a provider is denied admission to the contractor's provider panel, is removed from the contractor's panel, or voluntarily withdraws from the panel when the denial, removal, or withdrawal is due to a substantive issue. Substantive issues include violations of the Department of Occupational and Professional Licensing's regulations, and allegations of fraud, waste or abuse.

We will electronically submit information relating to the non-inclusion of providers to the credentialing department within 30 calendar days of the non-inclusion action using the department-specified form. We will not report non-inclusion of providers when due to non-substantive issues.

NON-DISCRIMINATION POLICY

UnitedHealthcare will not discriminate against any applicant for participation in its programs or networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any other unlawful basis not specifically mentioned.

This does not preclude UnitedHealthcare from including providers in the network who meet specific demographic and specialty needs.

Credentialing committee decisions are based on the issues of professional conduct and competence as reported and verified through the credentialing process. If any provider is denied access to participate in the network, UnitedHealthcare will provide written notice of the reason for its decision.

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.

We are committed to providing credentialing criteria for review and approval by DHCFP's Provider Enrollment unit within the time frames specified in this requirement.

C. Provide Credentials for network providers, subcontractors, or subcontractor's providers to the DHCFP and/or MFCU upon request, at no cost.

We provide credentials for network providers, subcontractors or subcontractors' providers to DHCFP and MFCU upon request.

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.

We comply with the State's standards regarding provider enrollment and re-enrollment, which requires providers by way of the PPACA legislation to recertify with the Medicaid program every three years or face disenrollment from the Medicaid and managed Medicaid programs.

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.

We comply and do not contract with providers who are not already enrolled as a Medicaid provider.

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.

We comply and conduct monthly sanction and debarment checks, as well as monitor licensing board updates, to confirm professionals are in good standing with state licenses.

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.

We are committed to ensuring recipients receive high-quality services and sometimes this means accessing an out-of-network or out-of-state provider. We adhere to these requirements and refer providers who are not yet network providers, as well as those who are non-Medicaid providers, to the DHCFP to complete the Medicaid provider enrollment. Further, we appreciate that the State permits us to enter into single case agreements (SCAs) with non-Medicaid providers as needed, and understand that any provider located outside of Nevada must be licensed in his/her home state of practice to enter into an SCA with us. We are committed to providing useful reports to DHCFP regarding SCAs in the format and frequency required.

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.

We will comply and follow DHCFP notification policies when we dis-enroll, de-credential, terminate or remove a provider from the provider network. We will provide the cause and documentation, as allowed by law, to the DHCFP within the required notification time frames set forth by DHCFP.

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.

We will provide a list of providers who have been enrolled, disenrolled, deactivated, terminated, de-credentialed or have been removed from active provider enrollment to the DHCFP by the 10th calendar day of the each month. If a provider has been terminated, de-credentialed or disenrolled, we will provide the cause and documentation, as allowed by law, to the DHCFP within five business days.

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.

The professional networks team will ensure that UnitedHealthcare maintains a dental network sufficient to provide all recipients with access to the full range of covered services, as well as choice of provider. We monitor the network build by utilizing GeoAccess reports which demonstrate the strength of our network based on State access requirements. Our robust network will have sufficient coverage for recipients with the appropriate access requirements by the go-live date. If deficiencies are identified, we will make arrangements to provide services with an out-of-network provider for a recipient until we recruit an additional provider.

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.

Should DHCFP desire to review any of our contracts, they are available well within five business days of such a request by DHCFP. Our contracting department works closely with our compliance and legal teams to confirm that contracts are compliant with all applicable state and federal regulations. Contracts are reviewed, at a minimum, annually by our contract compliance and legal teams. Templates are available for review and approval by DHCFP and any substantial changes are communicated in writing to the DHCFP before implementation.

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.

All provider recruitment efforts occur in a manner that will meet the objectives outlined by DHCFP, with the goal of improving access to care. We have robust processes in place to provide recruitment of providers to meet the needs of our recipients.

PROVIDER RECRUITMENT

Our outreach to providers is an ongoing initiative throughout the year. We are actively expanding our provider network to ensure adequate coverage for all recipients close to home both within the defined service area of this RFP and throughout Nevada. These efforts include monitoring internal and external data sources, which identify new opportunities for contracting with newly established providers. We are also strong supporters of academic within our local markets institutions within Nevada, with the goal of developing and retaining high-quality providers.

Quarterly GeoAccess reports are reviewed to determine locations where recruitment outreach may be necessary, if any, to maintain compliance with required access and availability standards. These reports provide insight not only into geographic coverage but also ensure that enough specialists are available within a geographic location to cover the needs of the population.

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.

We currently have and will maintain written policies and procedures for monitoring our providers to ensure they are in compliance in adhering to the dental management standards. As required, we will submit our monitoring policies and procedures to DHCFP within five business days of a policy or procedure change or upon request.

Continual monitoring of the provider network's compliance with our dental management standards is of the utmost importance to ensure the recipients are receiving quality dental services. Our policies contain the monitoring mechanisms to assess compliance with these standards. As indicated in our Provider summary guide, our provider services department is responsible for ongoing monitoring of providers to detect deficiencies in compliance with our medical management standards. The provider network is also monitored by incoming complaints. The quality team reviews complaints regarding the quality of care a recipient received.

Appropriate research and investigation is completed for each complaint where a concern regarding quality and dental management policy compliance is discovered. If a deficiency is found, the provider services department addresses the issue with the specific provider(s) and requires compliance with their contractual obligations through implemented corrective action plans. Continued failure by the provider/provider group to comply would lead to further disciplinary action, up to and including termination of a provider or provider group contract.

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.

We comply and understand the specifics regarding the structure of the provider contract. All contracts will be submitted to the DHCFP for approval. We are committed to ensuring recipients have access to quality and accessible services and, as with contracts across the country, we do not incentivize providers to underserve or avoid medically necessary services.

3.15.4.6 The use of "gag" clauses in Provider contracts is prohibited.

We understand the specifics regarding "gag" clauses, do not include them in provider contracts and adhere to the requirement.

3.15.4.7 All provider contracts must be made available to the DHCFP and / or MFCU within five (5) business days upon request.

We will adhere to the requirement set forth in the Scope of Work Section 3.15.4.7 and supply the DHCFP or MFCU with provider contracts within five business days of request.

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

A. Initial and ongoing credentialing;

Please see Question Response 3.15.2.1.

B. Adding, deleting, and periodic contract renewal;

Though our network currently meets all required access standards, our provider relations team will continue to monitor the access and be responsible for adding, deleting and periodic contract renewal as required.

C. Provider education; and

In order to meet the needs of our various state customers, we have developed a diverse and effective portfolio of provider training methods. Training for providers, who participate in our Nevada Medicaid network will include, but are not limited to:

- Specific Nevada program requirements
- Billing requirements
- Specific federal guidelines including but not limited to: Section 1877(E)(3)(B) of the Social Security Act which prohibits participating providers from making payments directly or indirectly to a physician or other provider as an inducement to reduce or limit medically necessary services provided to enrollees
- Comprehensive instruction on medically necessary covered dental services in the Nevada plan
- Instruction on specific technology, administrative and program processes.
- Use of the Web Provider Portal and its features, including but not limited to: (a) checking eligibility; (b) submitting and checking claims; (c) viewing reports and fee schedules (d) accessing a PDF of the Provider summary guide; and (e) registering for and receiving electronic funds transfer (EFT) payments
- Coordination with a clearing house for claims and authorizations and the frequency of payments
- Use of the Interactive Voice Response system to communicate with members and providers
- Instruction on how to contact a member services advocate for one-on-one assistance
- Comprehensive instruction on Medically Necessary Covered Dental Services in the State plan

PROVIDER TRAINING

We will maximize provider participation in training by ensuring that they are aware of the training schedule and by making training sessions convenient for busy Providers. We use a diverse array of communication techniques to increase provider awareness of upcoming training. These include sending invitations and reminders through: “blast-faxing,” e-mailing, direct mailing, automated and live outbound calls and reminders on remittance notices and envelopes. We also encourage participation by offering the convenience of webinar-based training, which providers can attend without leaving their offices.

We will make certain that providers meet all current and future state and federal eligibility criteria, reporting requirements, and any other applicable rules and/or regulations related to the contract through our comprehensive provider training program, ongoing provider outreach and the use of social media outlets to connect with providers. By meeting the different needs of various states, we have developed a diverse and effective portfolio of Provider training methods.

We use a range of training modalities to meet the information and learning needs of our providers. Examples include:

- Distribution of the Provider summary guide to Providers during the contracting phase
- Targeted mailings, including copies of online training programs and presentations
- "Blast-faxing" Frequently Asked Questions (FAQs) and Quick Reference guides to Providers offices
- Live outbound introduction calls by our Provider Advocate to welcome Providers to the network and answer any preliminary questions from the Provider
- Webinars showing, use of the Web Provider Portal and its features, including but not limited to: (a) checking eligibility; (b) submitting and checking claims; (c) viewing reports and fee schedules (d) accessing a PDF of the Provider summary guide; and (e) registering for and receiving electronic funds transfer (EFT) payments. Coordinate with Clearing Houses for claims and authorizations and the frequency of payments
- Use of our Interactive Voice Response system to communicate with members and providers
- How to contact a Customer Service Representative for one-on-one assistance, comprehensive instruction on Medically Necessary Covered Dental Services.

FREQUENCY OF PROVIDER TRAINING

Go-Live Webinars will occur daily in the 30 days preceding activation and every day of the following week. Subsequent Webinars will occur monthly. We will schedule provider seminars before and after the network's go-live date and we will hold one annual Town Hall forum per region. Quarterly meeting to discuss and identify issues related to claims, enrollment and other issues will also be held via Webinar. Training materials relevant to the agenda will be provided to all attendees. Distribution of the Provider summary guide typically takes place during the Provider contracting phase of network development.

PROVIDER TRAINING PROGRAM EVALUATION

Following any Provider training program, our Provider Recruitment and Training staff will solicit and analyze Provider feedback through electronic or paper evaluation forms to determine which were successful and which require changes for future sessions. We also send online surveys to providers before sessions soliciting their input on which topics providers want addressed. The Executive Dashboard has tabs which cover claims, authorizations, member services and financials and includes metrics on provider call categories. If a particular category occurs repeatedly, it will be included in subsequent training sessions to ensure we are mitigating provider concerns and addressing provider questions.

D. Discipline/termination, etc.

Please see Question Response 3.15.2.1.

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.

Please see Question Response 3.15.2.1.

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;

We understand the importance of information sharing and welcome the opportunity to discuss which specific public channels of information are expected in this requirement. We comply with this requirement in that we monitor public forums such as news media and industry communications, and act upon this information relating to suspected Fraud, Waste and Abuse by taking appropriate disciplinary actions.

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

We access the Office of the Inspector General (OIG) website on a monthly basis to confirm whether any network providers are under sanction. If a network provider is found on the OIG report, the provider is recorded and forwarded to our Credentialing Committee and network management team for review and appropriate action. If a Medicaid provider is found to be active in our network and on the OIG sanction report or on any public source for disciplinary actions, we notify our Medicaid compliance department and will subsequently report this information to the DHCFP.

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.

If notified by the state of an action or imposed sanction against a network provider, we would review and monitor the provider's performance and take appropriate action or impose any sanction, up to and including termination from the provider network.

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.

We adhere to requirements prohibiting the hiring, continuing to employ, contracting with, or making payment to persons or entities, including those with ownership or controlling interest that have been excluded, debarred or suspended from participation or procurement with federal or State health care programs, as required. We also adhere to Nevada contract requirements specific to state sanction screening results.

B. The vendor may not be controlled by a sanctioned individual.

As a company with federal and state contracts, we do not permit anyone who sanctioned by the federal government or barred from federal contracts to perform work on any business related to our federal or state contracts or have a controlling interest in our company. Additionally, we also adhere to state contract requirements specific to state sanction-screening results.

Using exclusion information published by HHS-OIG and state-based agencies, a variety of monitoring strategies are employed to identify providers, vendors and our employees who are excluded from participation in federal and state health care programs.

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.

We carefully review the qualifications of all participating providers, including education; training, board-certification status, license status, and malpractice sanction history. If there are sanctions or issues with licensure, the provider file is submitted to the Credentialing Committee for further review. We only award contracts to providers after we verify that they meet the applicable credentialing and licensure requirements. Furthermore, we do not employ or contract with providers that have been excluded from participating in federal health care programs under Section 1128 or Section 1128A of the Social Security Act. Our provider sanctions team performs various tasks around monitoring and collecting sanctioned provider data on a monthly basis.

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.

According to federal regulation (e.g., 42 CFR § 1001.1901), when the HHS-OIG or a responsible state agency has excluded an individual or entity, federal health care programs are prohibited from providing payment to those individuals or entities. In such instances, we have established mechanisms to make sure those individuals and entities do not receive payment for any services or items furnished, ordered or prescribed and are not hired or contracted by one of our entities.

To supplement our proactive efforts to identify debarred or sanctioned providers, our claims department maintains a detailed process to prevent paying any claims that may be submitted by debarred providers. Upon notification that a provider has been debarred, we immediately apply a pay hold flag in our claims processing system, triggering a denial of any claims received from the provider for service rendered after debarment. Under no circumstances will we issue payments to disbarred providers for services rendered within the period they are debarred.

A detailed provider audit can detect FWA or other improper billing practices. Selective audits may be performed of specific providers to look for potential fraud, waste and abuse, or providers may be selected for audit using various sampling criteria (e.g., random, statistical) as part of a provider monitoring program. Provider audits may be performed as a component of retrospective fraud/abuse investigations.

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.

We are well versed on the federal prohibitions related to affiliations with debarred individuals as set forth in 42 CFR §455 and 42 CFR §438.610 and our prohibition from using funds received under this contract for goods and services furnished, ordered or prescribed by excluded individuals, directors, officers and partners included. We maintain a robust set of documented policies and procedures for internal fraud controls, including our Employee Handbook, which includes provisions pursuant to 42 CFR 438.610.

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.

We have not knowingly had a relationship with any individual who has ownership of more than 5 percent of the health plan's equity or who is debarred, suspended or otherwise excluded from participating in federal health care programs. Furthermore, as part of our routine employee hiring and development of contractor relationships, we actively seek to learn of such and are aware of any persons or affiliates of individuals who fit this description.

To prevent this from occurring, we conduct background checks, including criminal history checks on all applicants for employment before hiring them. We use these background checks to verify that the candidates have not been convicted of, pleaded guilty to, or pleaded nolo contendere to any felony or any Medicaid or health-care-related offense. We also verify that providers and employees do not appear on the Office of Inspector General (OIG) List of Excluded Individuals/Entities or the General Services Administration Excluded Parties List of Debarred Contractors to confirm that they have not been debarred or suspended by any federal or state governmental body. In addition, we have disclosure requirements for providers, as part of an enhancement to our credentialing process. These disclosure requirements will include data required by 42 CFR Part 455 and will address the debarment history for our contracted provider network.

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.

We comply with all federal and state requirements to assure that our providers, any persons with an ownership or control interest or managing employee of a provider, our employees and contractors do not appear as debarred or excluded on the following lists:

- The OIG List of Excluded Individuals/Entities
- The General Services Administration Excluded Parties List of Debarred Contractors
- The Social Security Administration's Death Master File
- The National Plan and Provider Enumeration System (NPPES)
- The Medicare Exclusion Database
- Other databases as required by the U.S. Department of Health and Human Services

Our process for credentialing includes provider disclosure requirements, as required by 42 CFR Part 455. We will suspend payment for goods and services furnished, ordered or prescribed by excluded individuals from Medicare, Medicaid and CHIP participation in accordance with statutes and regulations. In addition, as notified by the state agency and in compliance with 42 CFR §455.416, we deny or terminate the enrollment of any provider who is terminated under the Medicaid program or CHIP of any other state. Providers terminated or denied under §455.416, as required by the state agency, will be given appeal rights afforded to them under State law and regulations. We will notify the DHCFP if an enrolled provider and any person with an ownership or control interest or who is an agent or managing employee of the provider has been excluded from participation or of other adverse actions.

We confirm our monitoring of excluded individuals and entities includes, but is not limited to:

- Health care professionals and services within contracting/provider credentialing

- Upon hire of employees, vendors, contractors and subcontractors
- Ongoing monthly review of providers, employees, vendors, contractors and subcontractors

We notify DHCFP if we receive notice that action is being taken against us or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) or any contractor which may result in exclusion, debarment or suspension from the Medicaid or CHIP program.

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.

We understand the DHCFP will notify the Secretary of non-compliance if it learns we have a prohibited relationship with a person or entity disbarred, suspended or excluded from participation. We will use the methods and protocols described above to minimize the risk of a prohibited relationship.

3.15.6 Compliance Plan

In accordance with 42 CFR 438.608(a), our compliance program includes administrative and management arrangements or procedures, including a mandatory Fraud, Waste and Abuse Compliance Plan designed to prevent, reduce, detect, correct and report known or suspected FWA.

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.

Our comprehensive Compliance and Ethics Program serves as a roadmap for the prevention, detection, reporting and corrective action of suspected cases of fraud and abuse in the administration and delivery of services. Our plan validates that, at a minimum, we will meet the requirements in Section 3.15 of the Scope of Work and is based upon the seven elements of an effective Compliance and Ethics Program as specified by 42 CFR 438.608.

Our Compliance and Ethics Program leverages national processes and expertise to support activities that occur locally in business operations to uphold and enforce ethical and compliant practices. National resources used by the Compliance and Ethics Program include executives from the ethics, government relations, compliance education and privacy offices. The combined experience and oversight of these departments makes certain we achieve business objectives in compliance with applicable laws, regulations, standards of conduct and our company policies.

We are committed to providing recipients with access to high-quality medical care while complying with state, federal and local laws, regulations and other requirements of the DHCFP. As one of the country's leading health and wellness companies, our reputation ranks high among our most important assets. recipients, employees, regulators, health care professionals and investors expect honesty and integrity in their dealings with us.

UnitedHealthcare has an established and comprehensive Fraud and Abuse Program that has demonstrated results in detecting, combating and preventing aberrant billing and treatment patterns, recovering overpayments and minimizing the cost impacts of provider fraud, waste and abuse. With extensive early intervention and remediation efforts, potential issues will be resolved. The Fraud and Abuse program addresses all aspects of the fraud, waste and abuse continuum to control unnecessary and inappropriate costs. The continuum of aberrant provider behavior includes outright fraud and abuse, which is evidenced by inappropriate practices that result in unnecessary costs and over-treatment.

The Fraud and Abuse Program is part of a set of company-wide policies and procedures that define the structure and process of the activities to identify and investigate fraudulent, abusive or otherwise aberrant patterns of billing and treatment. These policies include information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections.

The Fraud and Abuse Program has demonstrated results in detecting, combating and preventing aberrant billing and treatment patterns, recovering overpayments and minimizing the cost impacts of fraud, waste and abuse. For example, for the New York Medicaid program, UnitedHealthcare initiated formal investigations on eight providers resulting in over $208,000 in recoupment. As a result of an enhanced utilization management program, and the provider community's awareness of the fraud and abuse investigations, provider practice and billing patterns were modified and the overall cost of care decreased 22 percent from 2009 to 2010 on a per member/per month basis. At the same time, UnitedHealthcare maintained access for children, as evidenced by consistent HEDIS scores above the 50 percent benchmark. These results demonstrate that UnitedHealthcare's Utilization Management and Fraud and Abuse Programs succeeded in reducing unnecessary treatment, while ensuring that children received appropriate treatment and had unhindered access to care.

With our extensive early intervention and remediation efforts, we are often able to identify and resolve potential issues before they reach the need for this program. The Fraud and Abuse Program addresses all aspects of the fraud, waste and abuse continuum to control unnecessary and inappropriate costs.

Aberrant provider behaviors that are identified in the dental benefits industry, center on inappropriate practices that result in unnecessary costs and over-treatment. To prevent member fraud, we put a fraud warning in every member manual as well as on the member portal. We also provide information on what to do if they identify potential fraud or abuse in a dental practice, member misrepresentations, and questionable vendor services and billing.

These policies include information about the False Claims Act, administrative remedies for false claims and statements, state laws on civil or criminal penalties for false claims, and whistleblower protections.

Organizational Resources and Accountability for the Fraud and Abuse Program

The Fraud and Abuse Program is under the overall direction of the chief dental officer and is staffed by a multidisciplinary team including the manager of fraud and abuse; clinical review director, chief dental director; dental review specialists; dental consultants; senior data analyst; benefit administration & UM managers; and data analysts. The program also includes a special investigations unit (SIU), which is made up of investigators, attorneys and dental consultants which pursues fraud cases leading to prosecution. The team also has access to sophisticated data mining and analytical tools to support their efforts in maintaining integrity of services and cost management.

The combination of a dedicated, multi-disciplinary team of experts, leading edge technology and a rigorous fraud detection and remediation processes creates a highly effective program.

To ensure that employees are fully aware of all Fraud and Abuse Program policies and procedures, we created a web-based learning module and include information on Fraud and Abuse in other employee training materials. The employee handbook supplements the initial training by providing information on the laws discussed in Section 1902(a)(68)(A) of the Social Security Act, the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, waste, and abuse.

Fraud and Abuse Investigation Processes

Early detection is essential to an effective fraud and abuse program. We employ sophisticated provider profiling and other data mining processes to quickly identify aberrant behavior. The Fraud and Abuse manager and her team of data analysts have primary responsibility for using SAS, the Enterprise Business Intelligence System (eBis), and other tools to identify suspicious or outlying provider behavior.

This suite of data mining, statistical and analytical tools allows advanced, dynamic queries to identify abusive claims or utilization patterns that would otherwise escape detection. Our data mining tools and techniques provide an interactive process to discern new and hidden patterns of provider behavior from large quantities of data and to uncover subtle relationships between data elements. We also maintain a **Fraud and Abuse Hotline** and publish its phone number to employees, recipients, providers and vendors.

The multi-disciplinary Fraud and Abuse team meets biweekly to review new potential cases that have been flagged for review, determine which cases warrant further investigation based on the particular findings or flags, and discuss the progress of ongoing investigations. This process allows for a continuous pipeline of cases in various stages of investigation. We call upon senior legal staff for guidance at various times throughout this process, particularly in the recovery phase.

We define cases of fraud as the intentional misrepresentation of facts to obtain payment or other benefits. They are referred to the SIU for handling, as these cases may result in criminal action.

Once a provider is flagged as being deviant from his/her peers, varying significantly from expected norms or displaying other aberrant patterns, a formal case is created and turned over to the clinical team for further investigation.

The clinical team will review various electronic records and reports to determine if the initial suspicion of aberrance is confirmed. For example, the clinicians will note abuses such as improper sequencing of treatment, up-coding, excessive services, inappropriate combinations of codes, etc. At that point, the clinical team will request copies of targeted recipient records, including copies of radiographs, from the suspect provider. If a pattern of abuse is confirmed, the Nevada dental director or another dentist with a current Nevada license reviews a statistically valid sample of records on-site at the provider's office.

The sample of records is determined by the analytics team using standard statistical methodology to ensure that the results will be valid and the findings will have an appropriate confidence level. The auditor will review the specified records and indicate his/her findings on a record audit form.

We tabulate the results of the audit and then an appropriate corrective action plan is created, which may include any action from an education session with the provider to recoupment and/or formal prosecution.

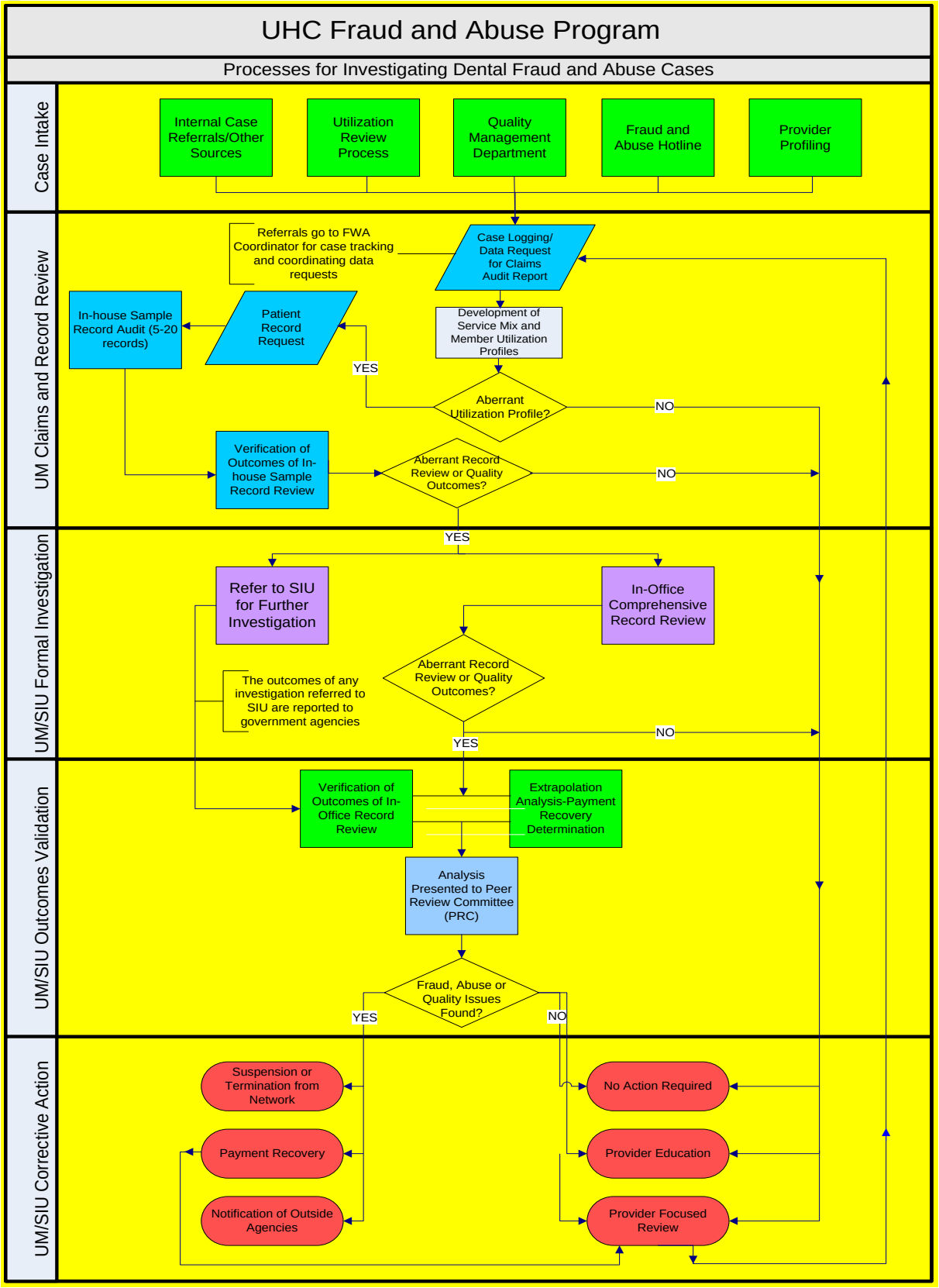
Recoupment, when indicated, is based upon a calculation of the over-billing or over-treatment for the audit period. A demand is then made for a refund of the overpayments and the provider is counseled about the aberrant behavior.

UnitedHealthcare's policy is that any overpayments recouped from a provider will be returned to the appropriate state or federal regulatory agency within sixty (60) days of discovering the overpayment. We will attach a detailed description of the fraudulent or abusive conduct, the investigation period, the findings of the investigation, and UnitedHealthcare's actions to recoup the overpayments.

When recoupment is not necessary, but some corrective action is still required, such as education sessions, all outlier dentists will be counseled by the dental director or other clinical staff with a Nevada dental license. The outlier dentist will be informed of the behaviors that do not conform to the clinical, quality and administrative guidelines of the program and be advised of expected changes. Other remediation methods include placing the provider on focused review, which will apply different and specific pre-authorization requirements. Additionally, the Provider may be required to submit pre- and post-operative radiographs in order to receive reimbursement.

We will monitor the utilization pattern of the flagged provider carefully post-audit to ensure that further abuse is not occurring. In certain cases, outlier dentists will be subject to expanded prospective authorization requirements to establish ongoing controls.

The end-to-end fraud and abuse process flow is shown in the chart below. UnitedHealthcare will report investigative results to the appropriate government entities at each step according to the required timeframes, and use formats that meet or exceed program standards.


UHC Fraud and Abuse Program
Processes for Investigating Dental Fraud and Abuse Cases
Case Intake
Internal Case Referrals/Other Sources
Utilization Review Process
Quality Management Department
Fraud and Abuse Hotline
Provider Profiling
UM Claims and Record Review
Referrals go to FWA Coordinator for case tracking and coordinating data requests
Case Logging/ Data Request for Claims Audit Report
In-house Sample Record Audit (5-20 records)
Patient Record Request
Development of Service Mix and Member Utilization Profiles
YES
Aberrant Utilization Profile?
NO
Verification of Outcomes of In-house Sample Record Review
Aberrant Record Review or Quality Outcomes?
NO
YES
UM/SIU Formal Investigation
Refer to SIU for Further Investigation
In-Office Comprehensive Record Review
Aberrant Record Review or Quality Outcomes?
The outcomes of any investigation referred to SIU are reported to government agencies
NO
YES
UM/SIU Outcomes Validation
Verification of Outcomes of In-Office Record Review
Extrapolation Analysis-Payment Recovery Determination
Analysis Presented to Peer Review Committee (PRC)
Fraud, Abuse or Quality Issues Found?
YES
NO
UM/SIU Corrective Action
Suspension or Termination from Network
Payment Recovery
Notification of Outside Agencies
No Action Required
Provider Education
Provider Focused Review

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.

Our Compliance and Ethics Program is the vehicle through which we develop, implement, maintain and monitor compliance. Through written policies and procedures, the Compliance and Ethics Program enables us to operate with the highest ethical standards expected by the State and to build integrity in its work, furthering a culture of compliance. The following response contains detailed information on specific policies, procedures and standards included in our program.

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.

Our national Compliance and Ethics Program provides overarching support for the local Compliance and Ethics Program to confirm the seven elements of an effective Compliance and Ethics Program, as specified by 42 CFR 438.608, are upheld and the needs of the State are met. This tiered Compliance and Ethics Program serves as a blueprint for ethical and compliant practices for our company's officers, employees, providers and subcontractors.

Detection, prevention and correction in a Compliance and Ethics Program is important and we meet the regulatory and contractual expectations, including measures to combat fraud, waste and abuse.

B. The compliance plan must be reviewed and approved annually by the DHCFP.

As requested, the compliance plan will be submitted yearly to DHCFP for review and approval.

C. The compliance plan must include the following elements, and any others as directed by the DHCFP:

SEVEN CORE ELEMENTS OF AN EFFECTIVE COMPLIANCE AND ETHICS PROGRAM

These seven elements are essential to the implementation of a comprehensive, effective Compliance and Ethics Program in Nevada.

1. Establish written standards, codes of conduct, policies, procedures and controls specific to Nevada that promote our commitment to compliance, address specific areas of potential fraud and confirm compliance with state laws, including Nevada Revised Statutes, Sections 357, 422.401-570 and 193.130, contract requirements and federal regulations.

2. Exercise effective compliance and ethics oversight through program governance by a compliance officer and Compliance Committee charged with operating and monitoring the Compliance and Ethics Program and who report to the chief executive officer and through the board of directors.

3. Develop and implement ongoing, effective education and training programs for all affected employees.

4. Establish effective lines of communication and reporting mechanisms to receive complaints from Nevada constituents to safeguard the anonymity of complainants to protect them from retaliation and establish clear processes and structure for addressing compliance concerns quickly and effectively.

5. Facilitate consistent enforcement and discipline of employees who have violated internal compliance policies, applicable statutes, regulations or state contract requirements.

6. Monitor and audit the effectiveness of Compliance and Ethics Programs in Nevada.

7. Respond appropriately to incidents and take steps to prevent future incidents.

1. Written policies and procedures for the functions in this section;

Our Compliance and Ethics Program requires employees and contractors to abide by the law and adhere to the company's contractual obligations. The Nevada program will include the following compliance policies and program materials:

- Code of Conduct—Our Principles of Ethics and Integrity (Code of Conduct)
- Government Programs Compliance Program
- Government Programs Fraud, Waste and Abuse Program
- False Claims Act Policy
- Employee Handbook
- Nevada-specific Supplemental Compliance and Ethics Program documentation to address contract-specific requirements

CODE OF CONDUCT

Our Code of Conduct and related policies promote compliance with legal and regulatory requirements, foster ethical conduct by employees and contractors, and provide guidance for employees and contractors on their conduct. We communicate the Code of Conduct to new employees and reinforce it through ongoing employee training programs that include either attestation or assessment activities to achieve review and understanding. The Code of Conduct also includes provisions for reporting suspicions of non-compliant, unethical or fraudulent activity.

GOVERNMENT PROGRAMS COMPLIANCE PROGRAM

The Government Programs Compliance Program provides a national framework for local compliance programs and includes established policies and procedures pertaining to compliance, auditing, privacy and security, and progressive discipline.

FRAUD, WASTE AND ABUSE PROGRAM

The Government Programs Fraud, Waste and Abuse Program includes established policies, procedures and standards of conduct pertaining to the detection and investigation of potential fraud, waste and abuse to verify both federal and state dollars are protected. The Fraud, Waste and Abuse Program includes robust payment prevention, recovery and reporting elements, which will be in effect in Nevada.

FALSE CLAIMS ACT POLICY

This policy addresses the Federal False Claims Act and provides information related to the Act's provisions, administrative remedies for false claims, and whistleblower protections. The policy also will cover Nevada's laws that include civil and criminal penalties for false claims, along with whistleblower protections.

On an annual basis, or more often as needed, we review and update our state-specific compliance and ethics policies and procedures to provide the local framework for guiding the Nevada Compliance and Ethics program. Some of the local policies include Medicaid Fraud Reporting, Potential Fraud Notifications, and Claims Investigation for Possible Misrepresentation Review Process. Up-to-date policies are available to all employees.

2. Standards for effective communication between the Compliance Officer, Program Integrity staff, management, vendor staff, and the DHCFP;

Our Compliance and Ethics Program requires the development of a communication and awareness strategy across business functions to confirm compliance resources, initiatives and other projects are being communicated to employees, managers and directors, Compliance Committee members and all other appropriate parties.

This strategy makes certain Compliance and Ethics Program expectations, including employees' responsibilities to report potential non-compliance or unethical behavior, and ongoing compliance efforts are communicated to employees through a variety of mechanisms, including the training programs described previously, electronic mail, internal newsletters, posters and face-to-face meetings.

Our compliance officer will be the primary resource available to all our Nevada employees for compliance-related information for the Nevada Medicaid program. The compliance staff also participate in new employee training, encouraging employees to contact them with compliance concerns. Additional compliance information will be disseminated in highly trafficked areas via posters and flyers placed in break rooms or close to office printers. Local managers also discuss legal requirements, company policies and contractual and regulatory obligations with their employees and evidence their commitment by their own conduct.

REPORTING MECHANISMS

All employees are required to report known or suspected non-compliance or unethical behavior. Failure to report suspected violations, misconduct or non-compliance is grounds for employee disciplinary action. We expressly prohibit retaliation for good faith reports.

Employees and others can report suspected misconduct to the compliance officer, a supervisor, the legal department, the internal audit department, corporate security or anonymously through the Compliance & Ethics Help Center, a website that provides for anonymous and confidential reporting. To the extent possible, we take reasonable precautions to maintain the confidentiality of those who report integrity or compliance concerns. Senior leaders monitor issues reported through these mechanisms and continually evaluate the effectiveness of the various communication channels available for fraud, waste and abuse reporting and engage with business partners to adapt to changing business needs. Throughout all levels of our organization, we respond to questions and refer tips of suspected fraud, waste and abuse to analysts and the appropriate investigative functions for review and assessment.

We investigate all reports of alleged non-compliance or unethical behavior and implement corrective actions as appropriate, based upon the results of investigations.

For escalated issues received from Nevada regulators, the compliance officer serves as the primary contact. Our staff receive, manage and respond to escalated regulatory issues and concerns. Those who are accountable for regulatory relationship management work closely with the business areas to assess identified issues and enforce corrective action as necessary.

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;

We provide training and education on the Compliance and Ethics Program for both individuals and entities. The training and education curriculum emphasizes awareness of the Compliance and Ethics Program, and focuses on the obligation to report suspicions of unethical or illegal behavior, understanding of the fraud, waste and abuse operations, including general Medicaid fraud and privacy and security requirements and expectations.

We provide training and education through various communication channels, including:

- Annual training courses
- Specialty training courses
- In-person training sessions
- On-the-job training
- Written materials
- Professional association and industry training

Training is required during onboarding for all new employees. New employees must complete and attest to this training within 30 calendar days of hire. Supervisors are responsible for making sure that each employee reporting to them completes the applicable training. Required training content includes, but is not limited to:

- Compliance, Ethics and Integrity Program overviews (Code of Ethics)
- Fraud, waste and abuse education, including:
  - Examples of potential fraud, waste and abuse issues and schemes
  - Resources available for reporting suspected instances of fraud, waste and abuse
  - Pertinent laws and regulations review, including federal False Claims Act and Whistleblower Protection
- HIPAA privacy and security
- Records management
- Conflicts of interest
- Pharmacy interactions
- Harassment prevention awareness
- Code of Conduct
- Compliance and Ethics HelpLine

Ongoing Training after New Hire

We provide ongoing training and education based upon specific requirements as well as the employee's job function and responsibilities.

Additional Training Program Information

Our training program also provides for:

- Evidence of completed, effective education for the compliance officer, our employees, providers and recipients about the compliance plan, FWA, erroneous payments and how to report any allegations regarding any of them.
- Effective lines of communication between our compliance officer, and our employees, providers, our state partners and its designee(s).
- Established written policies for all employees (including management), and any subcontractor or agent of the entity that include detailed information about the False Claims Act and the other provisions named in Section 1902(a)(68)(A) of the Social Security Act. We maintain detailed information about our policies and procedures for detecting and preventing FWA. In addition, our employee handbook contains a specific discussion of the laws described in the written policies and the whistleblower rights and protections of and for employees.
- Education regarding our toll-free provider compliance hotline number and an accompanying explanatory statement distributed to our recipients and providers through our member handbook and provider summary guide.

- Creation and dissemination of written materials for educating employees, managers, providers and subcontractors about health care fraud laws, including our policies and procedures for preventing and detecting FWA and the rights of employees to act as whistleblowers.

TRACKING OF TRAINING

We manage mandatory training through our web-based learning management system, which automatically tracks required training for all employees. The learning management system documents completion of training programs and human resources maintains the records. The system also generates automated reminders to employees who are due to complete annual training and managers whose employees have not completed the required training.

Compliance and Ethics Program staff monitors ongoing completion rates through review of compliance training completion reports on a quarterly basis, at minimum, and facilitates follow-up activities with employees and managers as needed. Targeted compliance or job function training may be managed through the learning management system or by the individual business units conducting the training.

4. Delineation of the staff and division of responsibilities within the vendor's Program Integrity Unit;

Our compliance officer, along with the Compliance Committee, oversees the Compliance and Ethics Program and the Fraud, Waste and Abuse Program in Nevada. Our oversight and governance framework focuses on the structures and processes necessary to drive improved compliance outcomes. Results of the Compliance and Ethics Program and Fraud, Waste and Abuse Program activities in each health plan are periodically reported to the Government Programs Corporate Responsibility and Compliance Oversight Committee and the Medicaid Compliance Oversight Committee. The Compliance and Ethics Program and the Fraud, Waste and Abuse Program are approved annually through this governance structure.

The following recipients are responsible for implementing and overseeing the Compliance and Ethics Program for our company:

- National compliance officer
- Medicaid administrator
- Board of directors
- Compliance Committee

Our Medicaid compliance officer manages the execution and coordination of our Compliance and Ethics Program. The compliance officer directly accesses regional and national senior management and local legal counsel to confirm compliance with Nevada contract requirements and state and federal laws and regulations and:

- Functions as the local, compliance and ethics leader accountable to our Medicaid administrator and the national compliance officer, providing oversight and monitoring of the Compliance and Ethics Program
- Reports compliance activity to our Compliance Committee, the health plan Compliance Oversight Committee and reports issues to the company's board of directors
- Identifies and manages compliance risk through collaboration with business partners and reports compliance risk and progress made toward remediating risk to the Compliance Committee
- Investigates and responds to Code of Conduct or other policy violations
- Verifies policies and procedures are created and maintained to address company requirements and that they align with company policies
- Coordinates regulatory audit activity in concert with Audit Management and the appropriate functional areas
- Facilitates response and monitors any regulatory corrective action plans (CAPs).
- Reviews processes and functional areas to make sure the Compliance and Ethics Program complies with state contract requirements regarding fraud, waste and abuse prevention, detection, deterrence and reporting
- Makes certain the Compliance and Ethics Program complies with state and federal fraud and abuse laws and regulations
- Periodically reviews and revises the compliance and fraud, waste and abuse policies to meet changing regulations or trends
- Verifies employees, providers, subcontractors and members receive training and education by overseeing a comprehensive ongoing training program that addresses fraud, waste and abuse prevention, detection and reporting; and encourages reporting of suspicions of non-compliance, unethical behavior and fraud, waste and abuse without fear of retaliation
- Develops and implements a well-defined reporting process, promoted among all employees, to report suspicions of non-compliance, unethical behavior and fraud, waste and abuse without fear of retaliation
- Maintains and monitors systems and tools to detect and help investigate fraud, waste and abuse
- Independently investigates and acts on compliance matters

- Refers potential member and provider fraud, waste and abuse cases to the program integrity unit
- Regularly attends and participates in the state partner work group meetings
- Provides oversight of the services provided by subcontractors

NATIONAL CHIEF COMPLIANCE OFFICER

Our national chief compliance officer is the overall leader for national Compliance Program activities and oversees our Compliance and Ethics Program, including FWA, in collaboration with our local compliance officer.

DENTAL MEDICAID ADMINISTRATOR

Our Dental Medicaid administrator understands that the business owns compliance, and along with our compliance officer, makes sure the Compliance and Ethics Program is upheld, all contractual, state and federal requirements and regulations are met, and that organizational risks are remediated. The compliance officer is accountable to our Medicaid administrator and she will report and escalates information directly to that individual.

COMPLIANCE COMMITTEE

Our Compliance Committee will acts an oversight and governance body and is accountable to our board of directors. The Compliance Committee meets at least quarterly, or more often if needed. Our Compliance Committee assists our compliance officer with oversight and monitoring of the Nevada operations, assessment of compliance risk areas, and review of policies and procedures. The committee also addresses DHCFP changes and evaluates their impact to business processes, taking action when necessary. Ultimately, the Compliance Committee facilitates the implementation of and adherence to the Compliance and Ethics Program, and reviews and assesses its overall effectiveness.

BOARD OF DIRECTORS

Our compliance officer and the Compliance Committee are accountable to the board of directors. The compliance officer reports compliance information to the Medicaid administrator. Additionally, the board of directors receives reports on key compliance information.

5. Specific objectives and goals for Program Integrity operations in the coming year;

In accordance with 42 CFR 438.608, we will provide an updated administrative and management plan which will include a mandatory written compliance plan and specific objectives and goals which are designed to guard against fraud and abuse. An electronic copy of the our written compliance plan, including all relevant operating policies, procedures, workflows, and relevant chart of organization will be submitted to the State for review and approval within 90 days of the execution of this renewal Agreement and then on an annual basis thereafter.

6. The process that the vendor will use to enforce program integrity standards through well publicized disciplinary guidelines;

We enforce disciplinary guidelines fairly and consistently throughout the organization, and managers are encouraged to work with human capital to implement disciplinary measures. When we determine that disciplinary action is necessary, such action may include verbal, written and final warnings, suspension or termination. Employees who commit criminal or illegal acts may face immediate termination and possible legal action. Finally, we reserve the right to terminate an employee at any time for any reason with or without prior disciplinary counseling or notice to the employee. Enforcement and disciplinary guidelines are publicized via the Code of Conduct, the Compliance and Ethics Program, the Fraud, Waste and Abuse Program, our employee handbook, policies and procedures and through communication methods such

7. The process that the vendor will use to complete internal program integrity monitoring and auditing;

A key focus of the Compliance and Ethics Program is to measure our own effectiveness. The monitoring activities performed by compliance, business functional areas, or other organizational areas, serve to identify, prevent and correct regulatory risk for the organization. Monitoring activities also provide verification that the Compliance and Ethics Program is effective and drive routine feedback on organizational performance and compliance with our policies, applicable laws and regulations.

Our compliance infrastructure incorporates monitoring activities that support the Compliance and Ethics Program at the business operations level. Activities include, but are not limited to, internal audits and reviews, internal operational/functional area reporting of key compliance metrics through the Compliance Committee and implementation of appropriate corrective action where necessary. We track, trend and report the results of these activities.

Throughout our organization, we continually evaluate and measure the success of the Compliance and Ethics Program using an internal audit function. In Nevada, we conduct audits of functional areas and areas of interest on a risk basis, focusing on the highest risks.

The results from these audits will be included in quarterly compliance report and will be presented to the Compliance Committee, and key compliance matters are reported to our national Medicaid Compliance Oversight Committee.

These internal audits detect non-compliance and misconduct, and the results are used to identify risk areas and opportunities for improvement. Elements of the program include:

- Collection, reporting and comparison of audit and monitoring results and findings
- Analysis of results to identify risk areas
- Focused reviews, where applicable
- Submission of reports as required and requested by DHCFP

- Implementation of CAPs to address identified risk items

Business units develop CAPs to cure identified deficiencies, remediate non-compliance matters, and uphold compliance with all contractual requirements and state and federal regulations. Additionally, we employ self-monitoring activities to assess programs and processes, evaluate process data and suggest internal process and systemic improvements. Our compliance officer initiates self-monitoring and auditing of compliance with laws, policies and regulatory obligations.

RISK ASSESSMENT PROCESSES

As part of the Compliance and Ethics Program, the compliance officer conducts a Compliance Risk Assessment at least annually to identify compliance risks so they may be evaluated and prioritized.

The Compliance Risk Assessment is documented and risks are ranked to determine which risk areas have the greatest impact. A mitigation plan is established in collaboration with the accountable business leads and it is reviewed at least quarterly at the Compliance Committee meeting to assess progress made toward remediation. Risk Assessments are also completed annually at the regional and national levels. National remediation plans are divided by functional area, and the compliance and ethics regional compliance officers as well as the national chief compliance officer will collaborate to determine solutions for items identified in these remediation plans.

Possible risk areas include:

- CAPs required by regulators
- Internal and external auditing and monitoring
- Implementation of new regulations
- State-specific issues
- Ethics and Integrity reports
- Audit recommendations

Items identified on the Risk Assessment provide the basis for internal auditing and monitoring strategies.

8. How the vendor will promptly respond to detected program integrity offenses and develop corrective action initiatives; and

Pursuant to the Compliance and Ethics Program, in conjunction with the appropriate business areas, we promptly respond to all credible reported concerns and instances of identified non-compliance and suspected misconduct. If appropriate, we make timely and reasonable inquiries, and compliance, legal or special investigations personnel conduct preliminary investigations.

When appropriate, we take corrective and disciplinary actions in response to the associated findings to promptly reduce the potential for recurrence and support ongoing compliance with applicable regulatory requirements. If required, we submit timely reports to state regulatory agencies. By design, corrective actions correct the underlying issues contributing to program non-compliance or violations and help prevent future program non-compliance.

9. A report on the success of the objectives and goals from the previous year.

As required, we will submit a report to the State which will outline the success of our compliance plan and any action steps taken.

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);

We have established policies and procedures pertaining to compliance, internal auditing, privacy and security, fraud, waste and abuse and progressive discipline. There are also policies related to the Federal False Claims Act, which provide information related to the act's provisions, administrative remedies for false claims and Nevada laws relating to civil or criminal penalties for false claim and whistleblower protections. Policies and updated information are available to all employees and subcontractors through our internal website.

The purpose of our policy is to outline:

- Key information about the False Claims Act
- State false claims act(s) and similar state and local laws, and agency policy pertaining to civil or criminal penalties for false claims statements
- Whistleblower protections provided by such laws
- The role of these laws in preventing and detecting FWA in federal or state health care programs

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

We are committed to the highest standards of ethical behavior, including the submission of accurate claims to all payers. Federal and state law and agency policy prohibit knowingly submitting claims for payment to the government or its agents that are false or fraudulent or based upon material misrepresentations. Our written policies include provisions regarding our policies and procedures for preventing FWA as detailed below:

The company and its employees shall not knowingly present, or cause to be presented, a false or fraudulent claim, for payment or approval, to any federal, state or local government agency, or to any managed care organization or other entity that acts as a government subcontractor for administering health care benefits.

- The company and its employees shall not knowingly:
  - Falsify, conceal or cover up a material fact
  - Make any false, fictitious or fraudulent statement or representation material to an obligation to pay or transmit money or property
  - Make or use any materials known to contain false, fictitious or fraudulent information to get a false or fraudulent claim paid or approved by any federal, state or local government agency, or any managed care organization or other entity that acts as a government subcontractor for administering health care benefits
- The company and its employees shall not knowingly conceal or improperly avoid or decrease an obligation to pay or transmit money or property to the federal, state or local government agency, or to any managed care organization or other entity that acts as a government subcontractor for administering health care benefits.
- The company and its employees shall make reasonable inquiries into and investigate any suspected overpayments made by the federal government, a federal agency, or any managed care organization or other entity that acts as a federal government subcontractor for administering health care benefits. The investigation will be conducted with deliberate speed.
  - If an overpayment is suspected, the company and its employees should immediately report the suspected overpayment to a compliance officer assigned to their business unit and consult with an attorney assigned to their business unit.
  - If a federally funded overpayment is identified, the company and its employees shall consult with an attorney assigned to their business unit to determine how to proceed with respect to the overpayment in accordance with federal law or an established governmental repayment process.
  - If a state-funded overpayment is identified, the company and its employees shall consult with an attorney assigned to their business unit to determine whether any repayment obligations exist.

- The following activities are examples of activities that may be considered violations of the federal False Claims Act or similar state or local laws:
  - "Double billing" – billing a payer multiple times for a single item or one-time service
  - "Unbundling" – submitting a bill for a panel of tests that includes individual billing codes to increase remuneration, rather than billing one all-inclusive code
  - Falsely certifying that a contract meets established requirements or guidelines
  - Conspiring with others to get a false claim paid
  - Claims resulting from an anti-kickback violation
  - Knowingly keeping and not reporting funds improperly paid under Medicaid, Medicare, TRICARE, other state-based health care programs or other government health programs—otherwise known as a reverse false claim
  - Knowingly submitting claims for services ordered or provided by an excluded provider
  - Submitting reports or claims to government agencies that are known to be false, erroneous or that are submitted with reckless disregard for the accuracy of the information
  - Knowingly charging for services not rendered or charging for more complex and costly procedures than those actually provided ("upcoding")
  - Billing for brand-name drugs when generic drugs are actually provided
  - Submitting false or forged enrollment applications for a government-funded program
  - Submitting claims for services that were actually rendered but were not medically necessary
- The company and its employees shall not knowingly conceal or fail to disclose knowledge of an event affecting a right to any benefit or payment.
  - Employees should report any suspected violations of the federal False Claims Act, applicable state false claims act(s), any similar state or local laws or agency policy, or company policies and procedures. Reports of potential improper activities can be made to a manager, compliance officer, or corporate security. Anonymous reports of suspected misconduct may be made by calling the our toll-free Compliance & Ethics HelpCenter, or online at the Compliance & Ethics HelpCenter website, available 24 hours a day, seven days a week.
- An employee's failure to comply with our policies could lead to disciplinary action, up to and including termination of employment and legal action.

- We do not retaliate against employees, agents or contractors, who, in good faith, investigate, file, or participate in a whistleblower action.

We require our contractors and agents, and their employees, who perform services for our government program health plans (i.e., Medicaid, CHIP, Medicare) or other government business, comply with this policy and all federal and state laws or agency policy that prohibit the submission of false or fraudulent claims in connection with federal health care programs.

We also require that our contractors and agents distribute this information to their employees to educate them on the federal and state statutes.

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.

Our Employee Handbook contains a specific discussion of the laws described in the written policies and the whistleblower rights and protections of and for employees. The Employee Handbook is designed to serve as a quick reference for many issues relating to employment with our company.

To remain current, the Employee Handbook provides links to our Enterprise Governance Risk and Compliance (eGRC) Policy Center. The eGRC provides the best way to manage the full lifecycle of our policies and procedures. It is designed to safeguard our process from the initial policy or procedure draft through the reviews, approvals, publication and subsequent revision processes necessary to have an effective policy and procedure program.

The Code of Conduct—Our Principles of Ethics and Integrity—is part of our Employee Handbook. The Code of Conduct is a standard of conduct guide to acceptable and appropriate business conduct by our employees and contractors. All employees must complete mandatory Code of Conduct training upon hire.

Additional enterprise compliance and FWA-related policies support the execution of a compliance program, these policies include:

- False Claims Act Compliance Policy
- Non-Retaliation Policy
- Anti-Kickback Policy
- Antitrust Policy
- Avoiding Conflicts of Interest (and Outside Directorships)
- Gifts and Entertainment (Business Courtesies)
- Delegation of Binding Authority
- Anti-Corruption Policy
- Federal Government Contracting
- Honoraria Paid to Employees

- Insider Trading
- False Claims Act Compliance Policy
- Interactions with Pharmaceutical, Medical Device or Biotech Manufacturers, Wholesalers or Distributors
- Reporting Misconduct Policy
- Various privacy and security policies

These policies are accessible by all employees via eGRC, and employee familiarity with policy content is maintained through required annual FWA training. Corporate compliance manages our overall program. Each segment and corporate department has established designated leaders to manage their policies and procedures as part of the overall 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:

We monitor the utilization patterns of our recipients and providers to confirm that we are providing health care services to our recipients in the amount, duration and scope necessary to achieve desired recipient health outcomes. Monitoring utilization through various means, such as HEDIS measures, confirms recipients receive needed services; helps identify at-risk populations and notifies the clinical team of health status changes that may cause gaps in care.

When a recipient is underutilizing services or has gaps in care, the identification provides us the opportunity to engage the recipient and create specific interventions to close gaps in care, thereby reducing or preventing future inappropriate utilization or overutilization of services.

We have developed a comprehensive utilization management (UM) program, discussed in detail in our response to RFP Section 3.10.19, that comprises an interdisciplinary set of documented, integrated UM, quality improvement (QI) and care management principles, policies and systematic processes that manage the appropriate utilization of health care resources. Through our UM Program, we have implemented a multifaceted approach, comprising an oversight structure, policies, processes, data analysis tools and provider outreach programs, which allows us to evaluate recipient and provider utilization patterns, including underutilization, so that we can improve our health plan operations. Core components of our approach, discussed in the following sections, include:

- Monitoring underutilization through clinical oversight and integration with QI. We provide oversight of our program through our clinical leadership team and monitor utilization through integration with our quality management team and QI Committee (QIC) structure.

- Identifying underutilization through UM tools and data analysis to identify individuals that may benefit from care coordination, evaluate the effectiveness of care coordination interventions, monitor utilization patterns, identify opportunities for improvement and develop interventions to combat aberrant trends.
- Evaluating the efficiency and appropriateness of service delivery through:
  - The adoption of evidence-based, nationally recognized guidelines and review criteria
  - Our process to determine if a requested procedure, treatment or device meets established medical necessity criteria
  - Ongoing monitoring of utilization metrics that indicate the appropriate use of services
- Identifying and resolving critical quality-of-care issues and aberrant practice patterns by tracking, trending and profiling provider-level data. We use a variety of methods and data sources through our quality of care (QOC) program. Our Peer Review Committee monitors these issues and can take a variety of actions to resolve them.
- Ensuring a high-quality, clinically appropriate, highly efficient and cost-effective delivery system through provider profiling, which identifies opportunities for reducing variation in practice patterns, improves recipient health outcomes and provides us with a tool to discuss best practices, track practice-level improvements and partner to implement initiatives that improve the quality of care and service provided to recipients.

MONITORING UNDERUTILIZATION THROUGH CLINICAL OVERSIGHT

Our clinical leadership team continuously monitors our UM Program through our quality management team and QIC structure, which includes our QIC and UM Committee. The UM Committee, a subcommittee of the larger QIC collects, monitors, analyzes, evaluates, trends and reports utilization data to evaluate the ongoing effectiveness of clinical care management interventions, monitor utilization patterns, identify opportunities for improvement and develop interventions to combat aberrant trends that include measurable outcomes so we can determine the intervention's effectiveness. The continuous monitoring of our UM Program includes:

- Collecting quality measures, prior authorizations and claims data and producing reporting that provides clinical, QI and UM analyses. This reporting allows us to monitor and evaluate our program related to medical and behavioral health management and care management, including identifying underutilization of health care services.
- Clinical leadership review of UM reporting to verify we provide appropriate, cost-effective care and services to our recipients that meet their individual needs.
- Quarterly QIC and UM Committee review and analysis of UM reporting that allows us to detect and correct utilization variances against our targets and national standards. During these meetings, the committees evaluate and make decisions on UM Program effectiveness and the effectiveness and continuation of programs and interventions.

- Analyzing utilization reporting to make decisions about the effectiveness and continuation of clinical programs and interventions to combat utilization variances. Reports include a description of the utilization variance, the intervention, responsible party, evaluation and recommendations or modifications.

- Our department managers and directors regularly review and analyze reporting, dashboards and scorecards to verify we provide appropriate care and services to our recipients in a cost-effective and cost-efficient manner that meets their individual needs.

- Executive management team review of daily and weekly UM reporting, dashboards and scorecards to evaluate our performance against goals.

Our quality management team serves as a critical interface between recipients, their representatives, practitioners, providers, the State and other regulators and various internal departments to identify opportunities for operational improvement and to implement appropriate interventions. UM analysis of quality measures, utilization data, clinical data and claims data helps QI and UM leadership understand trends necessitating further evaluation and identify opportunities for improvement.

INVESTIGATING AND CORRECTING UNDERUTILIZATION

If performance on a metric does not meet the established goal, we analyze opportunities for improvement, and develop and monitor corrective action plans (CAPs) to improve performance and meet or exceed the stated goal. When we detect underutilization and overutilization or inappropriate utilization, we recruit functional experts to analyze the data and determine if the variation can be explained and is expected based upon current circumstances.

If the variation cannot be explained or is unexpected, we conduct a root cause analysis to identify the factors driving the variation. Once we identify the factors driving the variation, we develop a member- or provider-specific plan to correct the variance and monitor ongoing performance. If our analysis identifies a systemic problem, we develop CAPs, such as education for care managers to use during member interactions. If the issue is broad enough, we incorporate the change into our member or provider manuals and newsletters.

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;

Our Nevada UM Program is based upon our parent company's national UM Program, which we implement across the state Medicaid programs we serve nationwide. Our national UM Committee develops, implements and evaluates our national UM Program. At least quarterly, the committee develops, reviews, updates and approves UM criteria, guidelines and new dental policies specifically for emerging technology or new treatments, and updates preventive service guidelines, dental policies, clinical practice guidelines and the list of services that require prior authorization for use across our UM Programs nationwide.

After considering State-specific mandates and guidelines, the national UM Committee reviews all services requiring prior authorization using eligibility criteria and federal/state requirements.

Once the national committee approves the list of services that require prior authorization, our Nevada UM Committee reviews it for acceptance and adoption for recipients in the Nevada Medicaid and Nevada Check Up Programs.

On an annual basis, our national UM Committee and Nevada UM Committee review all medical necessity and medical appropriateness guidelines to make sure they are responsive to local health plan needs. We may review criteria more frequently if a new version of the criteria is published before the annual review date. In addition, our Nevada UM team meets regularly to review prior authorization codes for potential changes to the list of services that require prior authorization.

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

We review our appeals processes annually to confirm that we administer our grievances and appeals program according to State specifications. Using the tools discussed previously, our UM team collaborates with our quality management team, compliance department (which provides oversight of our grievances and appeals program) and clinical leadership to collect, review, analyze and trend grievances and appeals data to:

- Confirm our compliance with contract requirements for processing prior authorizations
- Assess member satisfaction and identify opportunities for improving the member experience
- Identify issues with other aspects of our operations that may be causing an unnecessary increase in the number of denials
- Identify opportunities for improvement in our operations
- Identify and resolve potential quality-of-care issues with network providers

C. Ongoing monitoring of vendor service denials and utilization in order to identify services which may be underutilized.

We analyze grievances and appeals data to identify issues with other aspects of our operations that may be causing an unnecessary increase in the number of denials. We also monitor access to and adherence with preventive care services. We use several tools that allow us to identify gaps in care and conduct targeted outreach to providers and recipients to remediate those care gaps.

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.

We monitor for and respond to potential incidents involving embezzlement and theft in full accordance with the FWA provisions of our Principles of Ethics and Integrity. Strategies crucial to monitoring for embezzlement and theft are outlined below.

MANDATED EMPLOYEE REPORTING

All employees must report the following suspected incidents:

- Misconduct by any officer, employee, provider, subcontractor or vendor

- Violations of policies and procedures
- Violations of federal or state laws

Employees may file reports through their supervisor, the legal department, the internal audit department or corporate security. Employees also can file an anonymous report online at the Compliance and Ethics HelpCenter secure website or by calling the HelpCenter's toll-free hotline.

Posters containing Compliance and Ethics HelpCenter contact information are dispersed throughout employee common areas. Postcards with a punch-out wallet card containing the Compliance and Ethics HelpCenter phone number are distributed to all employees at new-hire orientation.

PROCEDURAL SAFEGUARDS:

We monitor for and detect potential embezzlement and theft through a variety of procedural measures, including:

- Check Register Audits: We prevent inappropriate payments by routinely auditing check registers before mailing each check run.
- Claims Dollar Thresholds: We apply security thresholds in our claims processing system restricting the dollar amounts employees can release on individual claim payments. The ICQC unit audits claims in excess of an analyst's security threshold before release.
- We have restrictions established regarding employee access, and our Information Systems (IS) department runs reports to verify accesses are business appropriate. In addition, our Information Systems (IS) department restricts employee access to business-appropriate activities through the following:
  - Employees with access rights are thoroughly trained on computer security awareness and acceptable computer practices.
  - Employees are granted access to information in applications on a "need to know" basis in accordance with their job functions.
  - Annual entitlement reviews are conducted to ensure that unnecessary access privileges are discontinued.
  - All non-employees, contractors, consultants, temporary workers and outsourcing organizations are assigned temporary accounts configured to require renewal at least every 30 days.
- Special Investigative Unit (SIU): SIU personnel work closely with the compliance officer to establish and maintain ongoing compliance.
- Our IS and claims operations departments have created reports that identify aberrant billing patterns, utilization trends, demographic patterns, and other deviations from what we consider normal patterns. In addition, we can customize reports created by our healthcare informatics department.
- Claims processing staff follow policies that outline potential billing issues. Once identified, suspect claims are referred to our SIU for further review and investigation.

- We can share electronic data mining and aberrancies across our multiple lines of business. As new-suspected schemes and practices are identified, we can expand our monitoring and reporting efforts.
- If trends are identified, our SIU works in conjunction with our provider services department to educate the providers.

Our SIU works closely with our compliance officers and legal department. Any validated identifications of FWA together with Embezzlements or Theft are immediately reported to the appropriate regulatory agencies. Some of the regulatory agencies we routinely work with are various state departments of insurance, attorney general offices, various state licensing boards, CMS and state Medicaid agencies. We will easily be able to comply with reporting to DHCFP SUR unit within the five-business-day requirement.

3.15.11 Verification of Services

3.15.11.1 The vendor must verify that services billed by providers were actually provided to recipients.

We are committed to protecting the integrity of Medicaid dollars by deploying our comprehensive FWA efforts in a person-centric way, resulting in a positive member experience. Our focus on the prevention, detection, investigation and reporting of suspected cases of FWA includes a process of verifying that services billed by providers were rendered to recipients. Our robust process includes monitoring and enforcing claims payment accuracy at all levels because often our recipients can provide great insight into situations that we cannot discover using claims data alone.

Following a practice currently used in some of our other markets, we will mail Verification of Services (VOS) notices to a random, sample group of Nevada Medicaid recipients on a monthly basis to verify services were actually provided to our recipients.

3.15.11.2 The vendor may use Explanations of Benefits (EOBs) or Verification of Services (VOS) letters for such verification.

Using Verification of Services (VOS) letters, we request the recipient to contact our member services center if he/she has any questions about a procedure or care received based upon the claims detail in the service verification notice.

Our service verification process will include additional analysis and verification by cross functional teams—member services, member outreach, care management and compliance—to validate services were provided to our recipients. If a recipient disagrees with a service identified on the service verification notice, our member advocate will review the claims data with the recipient. In some cases, the recipient will recall the claim; in other cases, he/she will not. For those recipients who do not recall the service, our member outreach specialist will conduct additional follow-up.

For recipients who state no services were received; the information is reported to our compliance and fraud and abuse departments for additional investigation. A dedicated fraud, waste and abuse investigations team will then employ a variety of methods to determine if the service or item was actually provided. These cases will be tracked through our FWA monitoring report. We also will refer these cases and results to DHCFP.

3.15.11.3 VOS letters, if used instead of EOBs, must be sent to at least 500 recipients each month.

Our service verification process will consist of VOS letters. We will select, at a minimum, a sampling of 500 claims per month. The statistically valid random sample of paid claims shall include all provider specialties and claim types proportionally represented in the sample pool.

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.

Public: We welcome the public's input on potential FWA. By doing a simple online search, someone can locate our dedicated fraud hotline number. For concerned citizens who file a report, they may do so anonymously and we will make every effort to maintain the person's confidentiality. However, we may not be able to guarantee anonymity if law enforcement is involved.

Members: Our Member handbook and member website provide information about fraud, waste and abuse prevention, detection and reporting, and encourages reporting suspicions of non-compliance, unethical behavior or fraud, waste and abuse. Our member handbook provides recipients with fraud and abuse hotline numbers, and our member services center information. The member handbook also provides common examples of fraud and abuse and reminds members to never give their member ID card to anyone else to use.

Recipients can report FWA tips to our FWA tip line. This phone number is listed on our Medicaid website, and in the member handbook. Recipients can also call our member services center to report any suspected fraud, waste and abuse.

Providers: Our provider orientation includes FWA education, laws and regulations. Each newly contracted provider is given a Provider summary guide, which includes information about the responsibility of the provider to report all suspected FWA, risks for not reporting suspected activity and mechanisms for reporting suspected cases through appropriate state agencies or us.

Our Provider summary guide is considered an extension of the provider's contract, and available to each of our contracted providers on our provider website. Providers can report Fraud, Waste and Abuse tips to our FWA tip line. This phone number is listed on our Medicaid website and in the Provider summary guide. Providers can also call our provider services center to report any suspected FWA.

Our Program Integrity Unit investigates every tip. Additionally, our Program Integrity Unit will take further action as necessary, including notifying the DHCFP, stopping payments to a provider and working with applicable law enforcement agencies.

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.

The FWA tip line will be clearly visible on the front page of our 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.

We are focused on combating health care FWA for all lines of business and as such offer a dedicated fraud hotline. However, realizing that stakeholders may prefer another method of reporting potential FWA, our telephone line is augmented by a webpage-based form that can be used by a complainant to communicate concerns with our PIU. The PIU will use this information for specifically collecting and reporting information received by the complainant.

The link to this online form will be located on our Nevada Medicaid website, listed in the member handbook and in the provider summary guide.

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;

The link on our webpage for receiving program integrity complaints will 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

Accessible from the front page of our website, it will be a stand-alone highlighted button and will clearly state the button is for use in reporting Medicaid FWA.

C. Be identified with language which states clearly the button or link is for use in reporting Medicaid fraud, waste or abuse.

As stated, the web page is identified with language which states clearly the button or link is for use in reporting Medicaid, fraud, waste or abuse.

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.

Our Program Integrity Unit (PIU) uses an array of program integrity activities to address the following:

Fraud includes intentional misrepresentation or deception with the knowledge that such misrepresentation could result in an unauthorized benefit, as well as any act that constitutes fraud under state or federal law.

Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program.

Abuse includes member and provider practices that result in unnecessary costs to the Medicaid program, improper payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary.

Within our PIU department, locally based specialists focus on areas of payment integrity initiatives, including analysis and investigation of FWA, third party liability (TPL), coordination of benefits (COB), subrogation and recoveries.

PROGRAM INTEGRITY OVERVIEW

We are committed to leveraging the full extent of our capabilities to make sure the State is the payer of last resort by undertaking the following activities:

Special Investigative Unit (SIU): The SIU is a function within our PIU. Fraud and abuse investigations are performed by the SIU, with a particular focus on allegations of health care fraud. The SIU comprises highly qualified investigators with significant experience in dealing with health care and prescription drug fraud and abuse, as well as knowledge of industry business practices, systems and infrastructure. We keep abreast of the latest available research regarding new and emerging FWA schemes and practices, as well as new methodologies and technologies available for combating FWA by collaborating with SIU throughout the rest of our company. These investigators are also familiar with federal and state law enforcement and litigation practices. SIU investigators are responsible for conducting fact-based investigative activities and operations (a more detailed description of which can be found in the SIU's internal policies, procedures and investigative process documentation), and presenting evidence in support of civil and criminal prosecutions.

Cost avoidance: With extensive edits engineered to verify payments are not remitted on provider claims for non-covered services, our claims processing system is our primary cost-avoidance mechanism.

Third-party liability: We identify potentially liable parties through a variety of procedures, including claims system codes and edits, files of third-party coverage, provider claims and initial new recipient assessment by a case manager. Once a recipient has been flagged as having alternate coverage, subsequent claims edit to a COB review, with the claim not paying until we receive the other carrier's explanation of benefits (EOB) or notification from DHCFP or another source that the other payer is not responsible for the service.

Coordination of benefits: We contribute to copayments, coinsurance and applicable deductibles remaining after Medicare or commercial payment on behalf of recipients with Medicare or commercial coverage, up to the Medicaid allowable.

Post-payment recoveries: We recoup erroneous claims payments according to contractually compliant protocols. Recouped claims encounters are voided in full unless the recoupment is an adjusted claim value, in which case we submit a replacement encounter.

Fraud, waste and abuse: As part of our overall program integrity functions, the payment integrity team performs certain FWA components. Our payment integrity team keeps abreast of the latest research available regarding new and emerging FWA schemes, practices, new methodologies, and technologies available for combating FWA.

Compliance program: The Compliance Program facilitates operational accountability and provides standards of conduct for complying with the FWA requirements of our Medicaid program(s) through a focus on the structures, processes and outcomes that translate our program's values into actions.

Legal department: Our legal department works closely with the DHCFP, internal business partners, vendors and contractors to develop and implement the FWA Program. The legal department provides consultation on contemplated formal FWA enforcement actions, reporting of suspected FWA to law enforcement officials, compliance with regulatory requirements, and any other legal issues that arise in our FWA Program. The legal department also keeps abreast of relevant changes in the law and developments in the health care FWA arena.

Employees: Every employee is responsible for conducting business in an honest and ethical way, fostering a climate of ethical behavior that does not tolerate FWA. Employees shall not engage in any activities that impede the investigation of suspected FWA and are required to report suspicions or observations of FWA or non-compliant activity. Employees reporting suspicions of FWA or non-compliant activity may remain anonymous and are protected from retaliation for reports made in good faith. Employees regularly receive training and education regarding these standards and responsibilities, including required reporting methods.

The resulting findings from these activities are reported to the applicable federal and state agencies, as appropriate and quickly resolved.

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.

The Compliance Committee is chaired by the compliance officer who works closely with the PIU on a day-to-day basis. The compliance officer is accountable to the dental plan Medicaid administrator. In addition to overseeing and monitoring the enforcement of the FWA compliance program, the compliance officer facilitates compliance with the contract, as well as state and federal rules and regulations. The compliance officer has authority to report issues directly to the Medicaid administrator, who is also a member of the Compliance Committee, or if necessary, to our board of directors.

Our compliance officer will establish a relationship with the DHCFP and state enforcement officials and understand the nuances of the Medicaid and Nevada Check Up Programs and the State's expectations on combating FWA. The compliance officer and the Medicaid administrator are fully committed to protecting the integrity of the Nevada Medicaid and Nevada Check Up Programs by fostering a collaborative, cooperative partnership with DHCFP and federal regulatory agencies.

The compliance officer is available to communicate with the DHCFP Program Integrity staff by telephone, email or other communication methods during State business hours. Additionally, the compliance officer serves as the primary point of contact for our health plan on issues related to fraud, abuse and waste prevention.

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.

Our PIU consists of resources that meet or exceed the DHCFP's requirements. The PIU is responsible for triaging, investigating and resolving instances of health care fraud or abusive conduct by the dental profession, members or the public. Using information from tips and complaints from plan recipients, the dental community and law enforcement, employees conduct confidential investigations and document relevant findings and report any illegal activities in accordance with all laws and regulations. PIU staff may conduct on-site provider claim or clinical audits (using appropriate personnel) to gather and analyze all necessary information and documents related to the investigation. They identify, communicate and recover losses as deemed appropriate. Where applicable, testimony regarding the investigation may be required.

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.

Our PIU consists of qualified resources that will either in person or via telephone on a monthly basis with the DHCFP to provide information and updates on cases. In fact, the PIU and local leadership are actively involved in efforts with other entities that investigate and prosecute provider and member fraud, waste and abuse: We actively participate in quarterly meetings with regulators and other MCO(s) and will participate in the new monthly meetings.

E. Qualified staff shall have experience in health care claims review, data analysis, professional medical coding or law enforcement.

We hire qualified staff with 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.

Our PIU staff will be at a minimum of one investigator per 50,000 recipients assigned to our dental health plan.

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.

Our PIU staff receives ongoing training and will participate in periodic meetings and trainings with SUR Unit staff.

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.

We have policies and procedures to identify and refer credible allegations of fraud in compliance with ACA requirements. Our policies and procedures for detecting FWA and ensuring payment integrity include, but are not limited to:

- A comprehensive compliance plan
- Claim edits

- Pre- and post-payment review of claims
- Desk audits on post-processing review of claims
- Provider profiling and credentialing reports
- Surveillance and utilization management protocols
- Provider and member materials
- Confidential reporting provisions
- Investigation and follow-up provisions

We report all instances of suspected provider and member claims fraud, waste or abuse to the SUR Unit of the DHCFP.

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.

When we receive a tip or allegation related to potential fraud, our PIU performs a preliminary investigation to determine if a credible allegation of fraud exists. The preliminary investigation may include:

- Reviewing claim histories
- Contacting providers
- Obtaining and reviewing dental and billing records
- Interviewing providers or recipients or other witnesses
- Checking providers' qualifications, licensure status and disciplinary activity, civil litigation and criminal histories and financial records

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.

When we determine that a provider or recipient should be reported, the PIU will submit a fraud referral to the SUR Unit of the DHCFP within two business days.

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:

The fraud referral will include, but will not be limited to, any evidence we have on the provider's billing practices (unusual billing patterns, services not rendered as billed, and same services billed differently or separately). The report also will include the following information:

- Name and ID number of the relevant party
- Type of Nevada Medicaid provider
- Recipient's name and Medicaid number

- Date and source of the complaint
- Nature of the complaint, including specific laws or Medicaid policies violated
- Dates of fraudulent activity
- Approximate dollars involved
- Legal and administrative disposition of the case

A. Provider's name, Medicaid provider number or provider's National Provider Identifier (NPI);

Confirmed.

B. Nevada Medicaid provider type;

Confirmed.

C. Recipient's name and Medicaid number;

Confirmed.

D. Date and source of the original complaint or tip;

Confirmed.

E. Description of alleged fraudulent activity, including:

1. Specific laws or Medicaid policies violated;

Confirmed.

2. Dates of fraudulent conduct; and

Confirmed.

3. Approximate value of fraudulently obtained payments.

Confirmed.

F. Any other agencies or entities (e.g., medical board, law enforcement) notified by vendor, and any actions they have taken;

Confirmed.

G. The findings from the vendor's preliminary investigation and proposed actions;

Confirmed.

H. After submitting the fraud referral, the vendor will take no further action on the specific allegation until the SUR Unit responds;

Confirmed.

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

We understand that after submitting the fraud referral, we will not take any further action until we receive a response from the SUR. If the SUR notifies us that the fraud referral is declined, our PIU will proceed with an investigation to comply with the reporting requirements specified by DHCFP.

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.

We will provide the MFCU access to information and personnel as required in pursuit of an investigation.

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.

As set forth in 42 C.F.R. § 455.23, we will suspend provider payments as directed by DHCFP due to credible allegations of fraud (CAF) investigations. We have the capability to deploy system flags that immediately suspend all payments to a provider upon notification by the state. We understand that if we fail to suspend payments to an entity or individual as instructed by DHCFP, the Division may impose 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.

We are committed to the foundational aspects of detecting and preventing FWA. We have established standards of conduct, policies and procedures, and training, related to identification, review, recovery, prevention, reporting and improper payments.

Our Payment Integrity Unit uses the following sources to uncover potential improper payments:

Identification: Sources of provider fraud/suspicious claims referrals, via tips and data analytics: A variety of data-analytic tools is employed to facilitate prospective and retrospective detection of FWA. Awareness of real or potential fraud, waste and abuse is also realized through fraud hotline tips, employee referrals, claims data analysis, industry sources, and provider management activities and media sources.

Review: Validation and investigation of referrals from tips and data analytics: All referrals/tips and data mining analytic results are researched and tracked in a database. A recommendation is then provided based upon findings. Many result in prospective or retrospective investigations or a report to state agencies.

Responses to requests for information and regulatory reporting of suspected provider fraud/abuse: Our PIU is a dedicated team that handles reporting of suspected fraud and responds to requests for information or requests for investigative assistance from law enforcement agencies.

Responses to requests for information: Pursuant to their health care oversight responsibilities, and because of our reporting actions or active investigations by outside entities, state and federal regulators may compel responses to requests for information.

Recovery: Multiple levels and types of electronic data analysis are applied to claims already paid to prevent future payments induced by FWA and to identify retrospective audit, investigation and recovery opportunities. Post-payment data analytics includes payment error analysis whereby paid claims are analyzed to identify various types of billing errors and irregularities.

Prevention: We perform prospective FWA activities in compliance with contractual and regulatory requirements for reimbursement accuracy and understand that internal controls are critical for detecting FWA. If the DHCFP SUR notifies us that a provider is suspected of FWA or if a provider shows up on a federal or state provider exclusion and sanctions list, we will set system flags to prevent payments to the provider. Our PIU will monitor the situation to determine how long the flags should remain in place and whether they should be modified or removed.

Reporting: Reports of suspected fraud or abuse must be filed with the appropriate regulator(s) and other governmental entities, including law enforcement.

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:

We will work cases directly referred to us via the fraud hotline, our website or a referral from the DHCFP by investigating and performing data analytics to determine credibility of the allegation. Data collected from our own systems will be used to identify potential aberrant practices. In addition, we will implement a verification of services process upon award of this contract. Following an established best practice currently used in some of our other markets, we will mail VOS letters to a random, sample group of Nevada Medicaid members on a monthly basis to verify services were actually provided to our recipients. We will have processes in place to work referrals of potential fraud from this verification process.

A. Fraud hotline or website;

Confirmed.

B. Referrals from the DHCFP;

Confirmed.

C. Referrals from the vendor's own organization including utilizations of data systems to identify issues such as provider profiling or data analysis; or

Confirmed.

D. Verification of Service letters/EOB's complaints.

Confirmed.

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.

We will refer all tips, complaints and referrals, which allege recipient misconduct, to the DWSS and copy the DHCFP 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.

Using our sophisticated technology platform, our PIU will track all tips, complaints and referrals and report them to the DHCFP monthly, regardless of outcome.

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.

We conduct reviews using algorithms and queries to electronically collect and analyze available relevant information including, but not limited to, encounter data, provider credentialing and enrollment records, provider self-audits, provider treatment records, prior authorization records, recipient verification of service letters. We also will consult the Nevada Medicaid Service Manual (MSM) and Nevada Medicaid Billing Guidelines.

When issues are identified from data sources like these, we have a process in place to perform electronic data analysis or mining of claims data, which is generally regarded as the most effective method of prospectively detecting suspected FWA. We accomplish this by using algorithms and queries to electronically mine claims data and various other databases to detect suspected FWA. This process includes the following analyses:

Pre-Payment Data Analytics: We mine claims before payment to identify various types of billing errors and irregularities. The results of this mining can assist in the identification of suspected FWA for follow-up prospective audit and retrospective investigation.

Post-Payment Data Analytics: We apply multiple levels and types of electronic data analysis to claims that have already been paid to prevent future payments induced by FWA and to identify retrospective audit, investigation and recovery opportunities.

Payment Error Analysis: We analyze paid claims to identify various types of billing errors and irregularities. This analysis contributes to the identification of suspected instances of FWA for further analysis.

Industry Trends (Sharing Awareness): We review industry trends and information from multiple industry and professional association sources and assess the potential impact on benefit programs. We may use this information to inform future FWA activities.

Data Mining Queries/Aberrant Billing Patterns: We share electronic data mining queries and aberrant billing patterns throughout our company and across our multiple lines of business. We know that we can uncover suspected schemes and practices across many platforms and lines of business that might affect the Medicaid business. We use the knowledge that we gather from other platforms to identify suspected FWA. This includes general queries and criteria applicable to all health plan claims as well as queries and criteria tailored to common Medicaid FWA schemes. We use these criteria to perform electronic analytics of claims data and to analyze provider claim trends. We routinely identify, propose, test and implement new criteria as new schemes and methods to detect suspected FWA.

3.15.18.2 The PIU will determine which, if any, encounters were improper payments.

The PIU uses multiple techniques to determine if improper payments were made. Investigative activities can include:

- Perform additional electronic data mining of claim histories and trends
- Contact providers and obtain and review medical and billing records
- Interview providers or recipients or other witnesses
- Check providers' qualifications, licensure status and disciplinary activity, civil litigation and criminal histories, and financial records
- Review quality of care complaints against providers

When we detect suspected provider FWA, our PIU investigates so we can ascertain the appropriateness of stopping payment of some or all of the provider's claims.

3.15.19 Recovery and Education

3.15.19.1 The PIU will notify the provider of the identified overpayment. The notification will include:

We notify the provider of the identified overpayment through written communication in the form of a letter. Our provider services advocates work with providers to educate them on correct coding, billing procedures and billing issue resolution. Advocates also answer inquiries related to the letter. Providers and their office staff have direct access to an advocate who serves as a direct point of contact, which facilitates consistency. Advocates address any areas of concern and follow up for resolution, or to initiate disciplinary actions, as appropriate. Additionally, provider advocates may assist the provider in walking them through the appeals/Fair Hearing Process.

A. The amount of the overpayment;

Confirmed.

B. A detailed listing of the encounters affected;

Confirmed.

C. Education and citations supporting the findings;

Confirmed.

D. Options for repayment;

Confirmed.

E. Any internal appeal rights afforded by the Vendor; and

Confirmed.

F. The provider's right to an Administrative Fair Hearing through the DHCFP after internal appeals with the vendor are exhausted.

Confirmed.

3.15.19.2 The PIU must collect and retain the overpayments resulting from a vendor fraud and abuse investigation or audit.

We acknowledge our PIU will collect and retain the overpayments resulting from a fraud and abuse investigation or audit.

If we identify an overpayment to a provider post-payment, the provider receives notice for refunding the overpayment or appealing the overpayment notice. If the provider does not appeal or refund the overpayment within the designated time frame, the affected claim is adjusted, and the overpayment is offset from a future remittance to the provider. We reach out and request a check from providers who do not submit claims sufficient to offset the overpayment. During this process, we place outreach calls to the provider until we receive a check for the overpayment.

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.

Regardless of whether we recover the overpayment from the provider, our encounters team will adjust or void affected encounters within 60 calendar days following the identification of the overpayment.

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.

We will comply with the requirements pertaining to monetary recoveries by state or federal entities. We understand we have no claim to any portion of money recovered from any government entity and that the monetary recovery belongs exclusively to the State of Nevada.

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.

We are fully subrogated and require our 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 have or may have against any entity that directly or indirectly receives funds under this Contract.

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.

We understand the actuary will receive a report identifying any funds recovered or retained by a government entity and the actuary will use this information 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.

We adjust or void encounters for any specific payments that are identified as improper.

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.

We understand that 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 our place for the purposes of collecting against a third party.

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.

We will comply with all reporting requirements and time frames as required in Attachment T - Forms and Reporting Guide, and this RFP unless otherwise agreed to in writing by both parties.

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:

We will comply with the requirements of this section A-D, including reporting certain information to the DHCFP on a per occurrence basis such as overpayments, credible allegations of fraud, employee relationships with any provider enrolled with Nevada Medicaid and every provider that is de-credentialed or denied credentialing for any reason.

A. Every allegation, complaint, or referral pertaining to overpayments whether caused by fraud, waste, abuse or billing errors;

Confirmed.

B. Every CAF;

Confirmed.

C. Every employee of the vendor who is employed by, has ownership interest in, or contracts with, any provider enrolled with Nevada Medicaid; and

Confirmed.

D. Every provider that is de-credentialed or denied credentialing for whatever reason.

Confirmed.

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.

We will comply with the requirements A and B of this section including reporting certain information to the DHCFP on a monthly basis such as all active reviews and all completed reviews.

3.15.21.4 Upon request, vendor must provide encounter data to the MFCU at no cost.

We will provide encounter data to the MFCU upon request and at no cost.

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.

We understand the DHCFP may conduct reviews of encounter data and providers in our network to confirm compliance with Nevada Medicaid policies. Our compliance officer will serve as the point of contact for such reviews.

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.

We understand that any improper payments discovered by the DHCFP, which we have not reported 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.

We agree to send the DHCFP any money withheld from payment to a provider 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.

Our encounters team will adjust or void affected encounters within 60 days following the notification from DHCFP of an improper payment.

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.

Understanding the strategic philosophy and goals established as part of the Affordable Care Act (ACA), we support incentivizing quality-based performance initiatives by enforcing nonpayment to providers associated with provider preventable conditions (PPCs). This confirms recipients receive safe, effective care, and that states see a cost-savings associated with nonpayment for PPC-related errors.

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.

Confirmed. UnitedHealthcare Insurance Company is a Connecticut corporation has its home and principal executive offices at 185 Asylum Street, Hartford, Connecticut 06103. UHIC is licensed as a life, accident and health insurer in the Virgin Islands, District of Columbia, Commonwealth of the Northern Mariana Islands, American Samoa, Puerto Rico, Guam and in 49 states except New York. UnitedHealthcare Insurance Company is a directly wholly-owned subsidiary of UHIC Holdings, Inc, a Delaware general business corporation. UHIC Holdings,, Inc. is a direct wholly-owned subsidiary of United HealthCare Services, Inc. ("UHS"), a Minnesota general business corporation. UHS is a direct wholly owned subsidiary of UnitedHealth Group Incorporated.

You can find more information about UnitedHealth Group and its businesses by visiting our website:
www.unitedhealthgroup.com.

In regards to persons convicted of a crime, the requested information represents confidential and proprietary information that is exempt from disclosure pursuant to applicable provisions of Nevada law.

We carry a fidelity/crime bond through Great American Insurance Co. The bond amount is at least $5 million per occurrence. This bond covers the actions of all of our employees, regardless of job description.

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.

B. Upon the vendor executing the contract with the State.

C. Upon renewal or extension of the vendor's contract.

D. Within five (5) calendar days after any change in ownership of the vendor.

Confirmed with exception. UnitedHealthcare will provide the annual report, audited financial statements and 10-K, which will reflect ownership and control and business transactions, however information on persons convicted is not available as the requested information represents confidential and proprietary information that is exempt from disclosure pursuant to applicable provisions of Nevada law.

You can find more information about UnitedHealth Group and its businesses by visiting our website:
www.unitedhealthgroup.com.

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.

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.

c. Is an officer or director of a vendor organized as a corporation.

d. Is a partner in a vendor organized as a partnership.

Confirmed. UnitedHealthcare will provide the annual report, audited financial statements and 10-K, which will reflect ownership and control and business transactions.

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.

UnitedHealthcare is a wholly owned subsidiary of UnitedHealth Group. UnitedHealthcare will provide the annual report, audited financial statements and 10-K, which will reflect ownership and control and business transactions.

4. Date of birth and Social Security Number (in the case of an individual).

This information is not available as the requested information represents confidential and proprietary information that is exempt from disclosure pursuant to applicable provisions of Nevada law.

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.

Information related to business interests can be found in the annual report and audited financial statements and the financial 10K.

5. If your firm is not a Qualified Health Maintenance Organization, provide the disclosures described at 42 U.S.C. 1396b(m)(4)(A)."

This is not applicable.

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.

Confirmed. To the best of our ability and knowledge, we will survey persons with 5 percent or more interest or control for this information and do our due diligence to provide the State with the information as applicable.

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.

This is not applicable.

3.15.24.5 The name, address, date of birth, and Social Security Number of any managing employee of the vendor.

Upon contract award, we can provide the names of managing employees, however, the additional requested information is not available as the requested information represents confidential and proprietary information that is exempt from disclosure pursuant to applicable provisions of Nevada law.

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.

We are willing to share our standard provider agreement; however, individual provider fee schedules are confidential and proprietary. we expect that all external business partners comply with Federal and state regulations and laws.

1. **The vendor must require the provider or subcontractors to submit full and complete information about:**

Prior to selecting subcontractors, we complete a thorough review of their qualifications. In order to contract with us, vendors must agree to and meet specific service level expectations for quality, security, accuracy and pricing efficiency. We conduct both physical and electronic security checks of the vendors' facilities and secure information network to ensure their compliance with HIPAA regulations and our security standards, as established by our privacy office and information and business risk management teams. Additionally, where applicable, our standard vendor contract requires that vendors supplying critical services file a business continuity plan in demonstration of how they would continue processing business, should a force majeure event present a business interruption.

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**

This information is not available as the requested information represents confidential and proprietary information that is exempt from disclosure pursuant to applicable provisions of Nevada law.

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.**

This information is not available as the requested information represents confidential and proprietary information that is exempt from disclosure pursuant to applicable provisions of Nevada law.

3.15.24.7 Vendor's requirements for collecting and validating information related to providers/subcontractors convicted of crimes. (42 CFR 455.106)

All providers undergo criminal background checks, during and re-credentialing.

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 confirm that we require all providers disclose ownership or control interest and provide information about criminal offenses related to their involvement under Medicare, Medicaid or the Title XX services program.

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.

As outlined, we confirm our right to 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.

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.

As outlined, we confirm our right to refuse to enter into or may terminate a provider agreement if we determine that the provider did not fully and accurately make any disclosure required.

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 agree to notify the DHCFP Provider Enrollment Unit of any action it takes on the provider's application for participation in the program.

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 will 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.

We acknowledge the State's duty to disclose records required above, with the exception of those records labeled as "trade secret" or "confidential," and agree to the State's requirements accompanying such a label.

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.

Noted and agreed.

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.

Noted and agreed.

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.

Noted and agreed.

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 will provide the reports as described above. The Enterprise Business Intelligence System (eBIS) is an analytical reporting tool that provides customizable, on-demand reports that analyze costs, utilization, practice trends, outcomes, and benchmarks. eBIS reports are generated as PDF documents and can also be saved in Microsoft Excel or XML formats. A wide array of filters allows authorized users to generate precise answers to complex questions. For example, paid claim utilization reports can be based on date of service range, region, patient ages, procedure codes, providers, provider specialties, office locations, and many other attributes.

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.

We will provide the required reports as outlined above. The Enterprise Business Intelligence System (eBIS) is an analytical reporting tool that provides customizable, on-demand reports that analyze costs, utilization, practice trends, outcomes, and benchmarks. eBIS reports are generated as PDF documents and can also be saved in Microsoft Excel or XML formats. A wide array of filters allows authorized users to generate precise answers to complex questions. For example, paid claim utilization reports can be based on date of service range, region, patient ages, procedure codes, providers, provider specialties, office locations, and many other attributes.

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.

Noted and agreed.

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.

Noted and agreed.

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.

The Quality improvement committee (QIC) receives regular written reports from Provider Relations, Quality Management and Marketing. It provides information on member and provider satisfaction survey results, member complaints, grievances, telephone access, disenrollment, credentialing and preventive health services—all of which are used for developing service improvement projects. The QIC and CAC analyze the information and make recommendations for improvement. This information will be shared with the State as required above.

The Quality Improvement Program (QIP) encompasses both clinical care and service activities, involving multiple committees (Quality Improvement Committee (QIC), Clinical Policy and Technology, Clinical Affairs Committee (CAC), Peer Review, and Credentialing) in the improvement process.

The annual QIP incorporates findings from the program evaluation; for example, needed improvements, changes in process or structure and follow-up studies, in addition to activities mandated by state and federal regulations and customer expectations. The board of directors reviews and approves the QIP evaluation and annual QIP.

The national dental director for quality management and chief dental officer are responsible for monitoring follow-through when clinical and service improvements are identified. We maintain documentation about implementing recommendations of system changes, corrective actions, educational endeavors and overall effectiveness.

We use the QIP to make sure goals are met and improvements are effective. We evaluate the scope, activities, goals and objectives. We trend key clinical and service indicators and note quantitative improvements in care and service, based on the quality improvement initiatives. We evaluate our resources and make recommendations for the coming year.

The QIC provides an annual written evaluation of our QIP to the board of directors. This evaluation focuses on strengths and weaknesses, trends/patterns, barriers to improvements and demonstrated accomplishments in improving care and services to recipients.

The committee reviews and revises the QIP for the upcoming year to submit to the board of directors for approval. The work plan incorporates aspects of the annual evaluation, relevant state and federal requirements, indicator requirements and employer requests for monitoring and reporting.

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.

All departments work collaboratively to identify opportunities for quality improvement as part of our ongoing continuous quality improvement (CQI). Our CQI process ensures that we are constantly looking for ways to improve the services we provide and become more efficient in our operations. Every operational area has audits in place to ensure the highest level of data accuracy by utilizing three basic steps:

1. Identifying problems or opportunities for improvement
2. Selecting appropriate measures of these areas
3. Obtaining a baseline assessment of current practices and then re-measuring to assess the effect of improvement efforts on measure performance.

As part of our Quality Improvement and Compliance Committee monthly meetings, we monitor all service level and access standards, including but not limited to:

- Call Center statistics, such as average speed of answer, abandonment rate, and average wait time in queue.
- Preauthorization determination turnaround times from receipt to determination.
- Claims processing and payment turnaround times from receipt to payment.
- Grievances and appeals turnaround times from receipt to resolution.
- Network adequacy measured against State standards.
- PCD to Recipient ratio and effectiveness.
- Patient access to care and service utilization measurements.
- Any other performance standards required by the State that are not already part of our standard monthly measurements.

We are URAC accredited, licensed throughout the country and works with some of the largest Managed Care Organizations in the country. Achieving and surpassing performance measures is a norm in our operations. We monitor all measures closely to ensure we adhere to each individual requirement.

Every month, our operational departments generate statistical analysis to measure the quality of the Medicaid dental program, as described in above. Each department reports its results to the Quality Improvement and Compliance Committee and identifies unexpected results, missed metrics, and opportunities for improvement.

We will make these quality assessment reports available to the Contract Monitor on any schedule defined by the State.

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.

UnitedHealthcare will perform an annual survey to a representative sample of the membership. Survey questions are designed to access member satisfaction with access to care, quality of care, our staff and network provider attitudes, satisfaction with their dental office, communication and overall satisfaction with the Plan. We will use sampling methodology agreed to with the State. If the state does not provide the specific number, percentage or what is deemed to be "representative sample", our marketing team will use NPS (margin of error), mean score and proportion to determine what would be considered an acceptable number of completed surveys. The representative usually includes a portion of the completed surveys to be based on member primary language (most in English but a percentage to be done in Spanish). Our surveys are done by phone, due to a better completion rate, as well as costs. The survey script is submitted and approved by the State as is done with all member communications. Results, findings and corrective action as required, will be shared with the appropriate clinical committee.

We will collect and submit results to the State and any additional required parties prior to the third quarter of each contract year.

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.

We acknowledge and agree to the financial reporting requirements set forth in the Forms and Reporting Guide, including any revisions or additions to the document.

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.

When a client requests integration with external systems, we gather and analyze business requirements and technical specifications, and then recommend an appropriate Extract, Transform, and Load (ETL) approach and/or a real-time Web Service approach for accomplishing the integrations.

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.

Our reporting team currently generates and delivers thousands of client-defined reports each year based on different frequency types, including monthly, quarterly, annually, and ad hoc. We are confident in our ability to meet any additional requirements.

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;

3.17.1.2 Eligibility;

3.17.1.3 Provider Network Data;

3.17.1.4 PDP Assignment;

3.17.1.5 Claims Payment; and

3.17.1.6 Encounter Data.

We have extensive experience integrating with client systems and will perform all data mapping necessary to submit information to the State, and to respond to information provided by you, at no additional cost. We have successfully managed the data connectivity process with each of our customers in the past six years. The process is always unique to the specific client system and, in one recent implementation, even required our team to develop over 200 integration points. We will draw upon this same experience and expertise to skillfully manage the exchange of data with the State.

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 will draw upon our experience and expertise in interfacing with client systems to establish and test all necessary interface capabilities with State-designated systems. We are compliant with all regulations and CMS requirements. We maintain compliance and develop required interfaces at our own expense.

3.17.3 Encounter Data Report Files

The vendor must provide encounter data report files in prescribed data fields to the DHCFP's encounter data processing agent on a monthly basis. The DHCFP will provide the required data fields and data transfer instructions. In developing the encounter data interface, the vendor will be provided with companion guide and details of any applicable edits and descriptions of the edits. The vendor will have adequate access to fiscal agent staff to assist in the development of the interface.

We recognize that accurate, timely and complete encounter data submissions are evidence that we are fulfilling our responsibilities to DHCFP. Under the belief that accurate encounter data begins with accurate claims, all new claims are subject to a series of reviews to confirm, we have all of the data needed to process the claim and produce accurate encounters. The Enterprise database systems stores all inbound 837 data to confirm accurate encounter reporting.

3.17.3.1 Encounters must:

A. 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.

Noted and agreed.

B. 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.

Noted and agreed.

C. 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.

Noted and agreed.

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 will produce encounter files according to the format and frequency required by DHCFP. We have over 22 years of experience in producing HIPAA 837D or proprietary-format files for transmission to state agencies and their subcontractors, including regular monthly submission of 837D encounter files to HHSC today. We will apply our existing HIPAA- compliant processes to produce and submit full encounter and encounter adjustments data required by DHCFP in 837D format, using the transmission method and schedule specified by the State. Encounter data will use State-approved procedure and diagnosis codes, provider identifiers, and other codes. We have extensive existing quality control and assurance processes which we will apply to these encounter submissions and we will correct any errors or quality issues within the timeframe required by DHCFP. Our proven processes generate encounters in both 837D and proprietary formats.

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);

Noted and agreed.

3.17.4.2 Enrollment and disenrollment into a health plan (X12N 834);

Noted and agreed.

3.17.4.3 Eligibility inquiry and response (X12N 270-inquiry and 271-response and approval of authorization);

Noted and agreed.

3.17.4.4 Referrals and prior authorizations (X12N 278-both request and approval of authorization);

Noted and agreed.

3.17.4.5 Claims encounter data (X12N 837 and NCPDP);

Noted and agreed.

3.17.4.6 Claims status Inquiry and response (X12N 276-inquiry and 277-response); and

Noted and agreed.

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 fully comply with the above requirements and with all HIPAA standard transactions.

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.

UnitedHealthcare adheres to all required HIPAA requirements in the processing of Member's protected health information (PHI). UnitedHealthcare maintains HIPAA Policies and Procedures and performs the required training for all employees at our own expense.

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).

We will submit encounters electronically as described above.

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.

All providers contracting through UnitedHealthcare will be registered with the DHCFP as a Medicaid provider, including any providers who are required to have an NPI. We have the capability to process paper claims in compliance with the above requirements.

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 agree to capture encounter data from sub-capitated providers and transmit to the State's fiscal agent following the guidelines above.

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.

We maintain current International Classification of Diseases (ICD) and Electronic Data Interchange (EDI) compliance as defined by CMS regulation and policy at our own expense.

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.

We will provide all information required for the external quality review in the time frame and format requested by the EQRO designated by the DHCFP.

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.

Noted and agreed.

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.

Noted and agreed. We will work with the DHCFP regarding the responsibilities included in 3.18.2 and 3.18.2.2.

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.

We will work with the DHCFP regarding the responsibilities included in DHCP on-site audits.

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.

Noted and agreed.

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.

Noted and agreed.

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.

Noted and agreed.

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.

Noted and agreed.

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.

Using our UR findings, we will identify dental providers that require auditing. We view provider profiling as an important function of our network management responsibilities. By sharing outcomes with both our clients and providers, we influence provider behavior for the better, improving the quality of care for recipients and reducing overall costs.

Our Cost Containment and Child Protection Team has developed a comprehensive list of criteria to evaluate and review a provider's overall treatment patterns. These criteria include, but are not limited to:

- Provider efficiency of submitting electronic authorizations/claims, receipt of electronic payments
- Provider billing practices, including upcoding, unbundling, inappropriate coding
- Authorization determination history of approved services, services denied for medical necessity, services denied for incomplete documentation
- Trends in utilization, as compared to peers in their geographic area and specialty, as applicable
- Patterns of care for patients

With the State of Nevada's approval, our Quality Improvement or Provider Relations staff will conduct a survey with identified dental providers to verify compliance using our Site Survey Tool. During the site visits, QI staff interviews the provider's scheduler and requests appointment response time data that providers are expected to maintain. Providers who do not pass the audit must implement a Corrective Action Plan (CAP) and are re- surveyed within 30 to 60 days. If the provider fails the second audit, the provider is presented to our QI Committee for additional corrective action. While we will make every effort to assist providers in meeting minimum accessibility standards, continued noncompliance could result in network suspension or termination.

We will report monthly to the State on audits performed and audit status of the selected dental providers.

Our benefits management software is configured to ensure that services are billed appropriately and that services are provided only to eligible recipients by eligible dental providers. Our system automatically performs numerous edits and validations to verify member eligibility as of the date of service, the active status of providers, and the accuracy and appropriateness of billing.

However, because ensuring high-quality, appropriate care for patients is our highest priority; we go beyond simply verifying eligibility and checking for accurate service coding. Our benefits management software includes real-time profiling reports that take aim at highly organized entities that attempt to obscure inappropriate billing by using multiple locations, tax IDs, and providers for the same patient. Our system's multiple aggregation levels are designed to expose these types of abusive billing practices.

We are also deeply concerned about the many recent media reports of excessive dental work being performed on young children. To help combat this very disturbing type of physical abuse, we include age bands in all of our profiling reports that allow us to identify statistical outliers based on patient age ranges.

In addition, our online code ratio analysis reports identify unusual billing patterns (upcoding) in the same way that we identify overutilization of services—by identifying outliers. For example, if a particular provider codes 98percent of their amalgams as complex amalgams, while the panel codes only 4 percent of amalgams as complex, we can be quite confident that the provider is miscoding these services.

With our proprietary software tools, we're able to perform analysis at the individual provider level that allows us to monitor and evaluate patterns of claim submission, including specific dental services that fall outside of the norm. We identify providers that are trending with significantly different statistical variances from their peers in their delivery of dental services.

To identify provider trends, we compare one provider or a provider group against a panel of peers, and then filter by:

- Costs per patient
- Services per patient
- Upcoding ratios
- Age banding

Additionally, we separate and eliminate the profile's data from being used in the panel data. This is especially important when the profile is both a high utilizer and has an extreme deviation from the norm, as the profile's data can skew the averages up or down.

Once we have identified which providers are trending with significantly different statistical variances in their delivery of dental services, we can focus and investigation and intervene, if appropriate.

Our Provider Profiling analysis incorporates a variety of metrics based on those used by the United States Department of Health & Human Services. We use these metrics to help identify questionable billing patterns. Our method of identifying outliers utilizes interquartile ranges. The interquartile range (IQR) is the difference between the 75th percentile and the 25th percentile; 50percent of all data falls inside the interquartile range.

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 will comply with all terms and conditions and outlined and confirm that we understand our requirements and obligations as outlined in the RFP.