

6.20.2. No Vendor or individual, company or organization seeking a contract or provider agreement shall solicit any State employee to violate any of the conduct requirements for employees.

## 7. SCOPE OF WORK

### DEFINITIONS AND ACRONYMS

<i>Term or Acronym</i>	<i>Definition</i>
<i>Access</i>	A Member's ability to obtain medical care. The ease of access is determined by components such as the availability of medical services and their acceptability to the Member, the location of health care facilities, transportation methods, hours of operation, and cost of care.
<i>Actuarially Sound or Actuarial Soundness</i>	Refers to Capitation Payments/Capitation Rates that have been developed in accordance with generally accepted actuarial principles and practices; are appropriate for the populations to be covered, and the services to be furnished under the Contract; and have been certified as meeting the requirements of 42 CFR 438.4(b) by an Actuary.
<i>Actuary</i>	An individual, acting on the State's behalf in the development and certification of Capitation Rates, who meeting the qualification standards established by the American Academy of Actuaries for an Actuary and follows the best practice standards established by the Actuarial Standards Board.
<i>Administrative Cut-Off Date</i>	A date each month selected by the State. Changes made to the Medicaid Recipient eligibility system prior to this date are effective the next month. Changes made to the computer system after this date become effective the first day of the second month after the change was made.
<i>Advance Directive</i>	An Advance Directive refers to a written statement, completed in advance of a serious illness or condition, which allows the Member to direct health care decisions when the Member is unable to do so. The Advance Directive allows the Member to make decisions regarding the use or refusal of life sustaining treatments. An Advance Directive consists of Declarations (Living Wills) and Durable Powers of Attorney for Health Care Decisions, recognized under Nevada State law, which relate to the provision of care when an individual 18 years of age and older has an incurable or irreversible condition, and is unable to communicate health care decisions verbally.
<i>Adverse Benefit Determination</i>	The following decisions by the Contractor are appealable by the Member: (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an Adverse Benefit Determination; (4) The failure to provide services in a timely manner, as defined by the State; (5) The failure to process Grievances, Appeals

<b><i>Term or Acronym</i></b>	<b><i>Definition</i></b>
	or expedited Appeals within the required timeframes, including resolution and notification; or (6) For a resident of rural area with only one Contractor, the denial of a Member’s request to exercise his or her right, to obtain services outside the network (note the geographic service area for this program does not include rural areas); and (7) The denial of a Member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities (note is no financial liability for Members under the managed care program).
<b><i>AFDC</i></b>	Aid to Families with Dependent Children. Refer to definition for TANF.
<b><i>AFDC-UP</i></b>	Aid to Families with Dependent Children – Unemployed Parent Program. Refer to definition for two parent TANF
<b><i>AFDC – RMO</i></b>	Aid to families with dependent children related to Medicaid only.
<b><i>ADSD</i></b>	Aging and Disability Services Division.
<b><i>Appeal</i></b>	A Member’s request for review of an Adverse Benefit Determination.
<b><i>Authorized Representative</i></b>	An authorized representative is an individual who has been designated by an applicant or Member having authority to act on behalf of the applicant or Member.
<b><i>Behavioral Health Services</i></b>	Services covered under the Medicaid and CHIP State Plans that promote mental health, resilience and wellbeing, treat mental and substance use disorders, and support Members who experience and/or are in recovery from these conditions.
<b><i>Benefit</i></b>	A Service authorized by the Contractor.
<b><i>Business Day</i></b>	Any Monday thru Friday except for state observed holidays.
<b><i>Calendar Day</i></b>	All seven (7) days of the week, including State of Nevada holidays.
<b><i>Credible Allegation of Fraud (CAF)</i></b>	Credible allegation of Fraud (CAF) is an allegation from any source <i>when it has an “indicia of reliability.”</i>
<b><i>Consumer Assessment of Healthcare Providers and Systems (CAHPS)</i></b>	Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care.
<b><i>Capitation Payment or Capitation Rate</i></b>	A payment the State makes periodically to a Contractor on behalf of each Member enrolled under the Contract for the provision of medical services under the Medicaid State Plan and in accordance with 42 CFR 438.3(c). The State agency makes the payment regardless of whether the particular Member receives services during the period covered by the payment.
<b><i>Cardholder</i></b>	Means the person named on the face of a Medicaid or Nevada Check Up card.
<b><i>Care Coordination</i></b>	Care coordination links persons who have complex personal or social circumstances or health needs, which place them at risk of not receiving appropriate services. It also ensures coordination of these services. The requirements for Care Coordination are specified in Section 7.5.6.6.
<b><i>Care Management</i></b>	Care Management is a process by which an individual’s needs are identified and social and medical services to meet those needs are located, coordinated, and monitored. Care Management is comprised

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	of Care Coordination and Case Management as described in Section 7.5.
<b><i>Case Management</i></b>	Case Management is the Care Management process for Members identified as high-risk as specified in Section 7.5.6.7.
<b><i>Case Manager</i></b>	A professional, whose background is most frequently anchored in the disciplines of social work and/or nursing, who assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's health needs.
<b><i>Children with Special Health Care Needs (CSHCN)</i></b>	Children who have, or are at risk for, chronic physical, developmental, behavioral, or emotional conditions; and also require health and related services of a type and amount beyond that required by children in general; and are receiving services through family-centered, community-based, coordinated care systems receiving grant funds, under Section 501 (a)(1)(D) of Title V of the SSA (known as Nevada Early Intervention Program).
<b><i>Children's Health Insurance Program (CHIP)</i></b>	Children's Health Insurance Program (CHIP) provided under Title XXI of the Social Security Act to children whose families exceed Medicaid limits, but is equal to or less than 205% of the federal poverty level. Nevada's CHIP managed care program is referred to as the Nevada Check Up program (NCU).
<b><i>Claim</i></b>	Means (1) a bill for services; (2) a line item of services; or (3) all services for one Member within a bill. "Claim" is further defined as communication, whether oral, written, electronic or magnetic, which is used to identify specific goods, items or services as reimbursable pursuant to the Medicaid or CHIP State Plan, or which states income or expense and is or may be used to determine a rate of payment pursuant to the Medicaid or CHIP State Plan.
<b><i>Clean Claim</i></b>	Means a claim that can be processed without obtaining additional information from the Provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.
<b><i>Clinic Services</i></b>	As amended by the Deficit Reduction Act of 1984, section 1905(a) (9) describes clinic services as "services furnished by or under the direction of a physician without regard to whether the clinic itself is administered by a physician." Regulations at 42 CFR 440.90 define clinic services as preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that: <ul style="list-style-type: none"> <li>(1) Are provided to outpatients;</li> <li>(2) Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and</li> <li>(3) Except in the case of nurse-midwife services as specified in 42 CFR 440.165, are furnished by or under the direction of a physician.</li> </ul>

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<b><i>Centers for Medicare and Medicaid Services (CMS)</i></b>	Medicaid and CHIP programs are administered by the states with the Centers for Medicare and Medicaid Services, Department of Health and Human Services. CMS has responsibility for monitoring State compliance with federal requirements and providing federal financial participation (FFP). CMS monitors State programs to assure minimum levels of service are provided, as mandated in the Code of Federal Regulations (CFR).
<b><i>Code of Federal Regulations (CFR)</i></b>	Code of Federal Regulations
<b><i>Cold Call Marketing</i></b>	Any unsolicited personal contact by the Contractor with the Potential Member for the purpose of Marketing.
<b><i>Certified Community Behavioral Health Centers (CCBHCs)</i></b>	Certified Community Behavioral Health Centers (CCBHCs) are responsible for directly providing or contracting with partner organizations to provide a continuum of services, with an emphasis on the provision of 24-hour crisis care, utilization of evidence-based practices, Care Coordination and integration with physical health care. CCBHCs must provide crisis mental health services; screening, assessment and diagnosis; patient-centered treatment planning; outpatient mental health and substance use services; primary care screening and monitoring; Targeted Case Management; psychiatric rehabilitation services; peer support, counseling and family support services; and services for veterans. Prior authorization to access CCBHC services is not required.
<b><i>Competent</i></b>	Properly or well qualified and capable.
<b><i>Compliance Review</i></b>	Any investigation, audit, focused data analysis, or other assessment of whether improper payments have been made.
<b><i>Concierge Service</i></b>	A service that personally assists Members to find a Provider.
<b><i>Confidentiality</i></b>	Confidentiality pertains to all safeguards required to protect all information which concerns Medicaid and CHIP applicants and Members, Medicaid Providers, and any other information which may not be disclosed by any party pursuant to federal and State law, and Medicaid Regulations, including, but not limited to NRS Chapter 422, and 42 CFR 431.
<b><i>Contract Year</i></b>	A calendar year period within the Contract Term as described in Section 7.1.1.
<b><i>Contractor</i></b>	The company or organization that has an approved contract with the State of Nevada for services identified in this RFP. The Contractor has full responsibility for coordinating and controlling all aspects of the contract, including support to be provided by any Subcontractor(s). The Contractor will be the sole point of contact with the State relative to contract performance.
<b><i>Coordination of Benefits (COB)</i></b>	Coordination of Benefits means an individual has personal medical health insurance coverage that is or may be liable to pay all or part of the expenditures for medical assistance furnished under the State Medicaid Plan. COB includes cost avoidance and recovery when other medical health insurance exists.
<b><i>Co-payment</i></b>	A co-payment is a fixed dollar amount that an individual pays for health care services, in addition to what their health plan covers.

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<b><i>Covered Services</i></b>	Covered services are those services for which Nevada Medicaid and Check Up may reimburse Providers.
<b><i>Cross Reference</i></b>	A reference from one document/section to another document/section containing related material.
<b><i>Cultural Competency</i></b>	An awareness and appreciation of customs, values, and beliefs and the ability to incorporate them into the assessment, treatment and interaction with any individual to increase the quality and appropriateness of health care services and outcomes.
<b><i>Culture</i></b>	The integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. Culture defines the preferred ways for meeting needs, and may be influenced by factors such as geographic location, lifestyle and age.
<b><i>DCFS</i></b>	The Division of Child and Family Services.
<b><i>Denied Service</i></b>	Any medical service requested by a Provider for a Medicaid or CHIP Member for whom the Contractor denies approval for payment.
<b><i>DHCFP</i></b>	Nevada Division of Health Care Financing and Policy. Primarily referred to as “State” in this RFP.
<b><i>DHHS</i></b>	Nevada Department of Health and Human Services (NV DHHS) and United States Department of Health and Human Services (US DHHS).
<b><i>Disenrollment</i></b>	Process of terminating individuals from enrollment with a Contractor. Except where expressly required by federal or Nevada regulations, disenrollment may not occur mid-month. Under most circumstances, requests for disenrollment are effective the first day of the month following receipt of the request, providing that the request is within policy/contract guidelines and is submitted before the Administrative Cut-Off Date.
<b><i>Division/Agency</i></b>	The Division/Agency requesting services as identified in this RFP.
<b><i>Durable Medical Equipment (DME)</i></b>	Durable medical equipment is defined as equipment, devices, and gases, which can withstand repeated use and is primarily and customarily used to serve a medical purpose, and generally is not useful to a person in the absence of illness or injury.
<b><i>DPBH</i></b>	Division of Public and Behavioral Health
<b><i>Eligibility</i></b>	Term that references a person’s status to receive Medicaid or CHIP program benefits. The determination of Medicaid or CHIP eligibility is the sole responsibility of the Nevada Division of Welfare and Supportive Services (DWSS).
<b><i>Emergency Medical Condition</i></b>	Medical condition (including labor and delivery) manifesting itself by the sudden onset of acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonable expect that the absence of immediate medical attention could reasonably be expected to result in either placing an individual's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, resulting in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or serious physical harm to another.
<b><i>Emergency Medical Transportation</i></b>	Emergency medical transportation is use of a ground or air ambulance, as Medically Necessary, to transport a Member with an Emergency

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	Medical Condition. A ground or air ambulance resulting from a “911” communication is considered emergency medical transportation, as specified in Medicaid Services Manual, Chapter 1900.
<b><i>Emergency Services</i></b>	Emergency services means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a Provider qualified to furnish such services and are needed to evaluate or stabilize an Emergency Medical Condition. The Contractor must not require the services to be prior or post-authorized.
<b><i>Encounter</i></b>	A Covered Service or group of services delivered by a Provider to a Member during a visit, or as a result of a visit (e.g., pharmacy) between the Member and Provider.
<b><i>Encounter Data</i></b>	Data documenting a contact of service delivered to a Member by a Provider.
<b><i>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</i></b>	A preventive health care program, the goal of which is to provide to Medicaid eligible children under the age of 21 the most effective, preventive health care through the use of periodic examinations, standard immunizations, diagnostic services, and treatment services which are Medically Necessary and designed to correct or ameliorate defects in physical or mental illnesses or conditions. <i>See</i> section 1905(r) of the SSA and 42 CFR part 441, subpart B. In Nevada, EPSDT is also referred to as Healthy Kids.
<b><i>External Quality Review (EQR)</i></b>	The review and evaluation by an External Quality Review Organization of information on quality, timeliness, and access to the health care and services that a Contractor, or their Subcontractor(s), furnish to Medicaid Members.
<b><i>External Quality Review Organization (EQRO)</i></b>	An organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs external quality review, and other EQR-related activities as set forth in 42 CFR 438.358, or both.
<b><i>Essential Community Providers (ECP)</i></b>	A healthcare Provider that (a) has historically provided services to underserved populations and demonstrates a commitment to serve low-income, underserved populations who make up a significant portion of its patient population or, in the case of a sole community Provider, serves underserved patients within its clinical capability; and (b) waives charges or charges for services on a modified sliding fee scale based on income and does not restrict access or services because of a client’s financial limitations. In addition, the State has identified Essential Community Providers in Section 7.3.6.8 that may not meet the aforementioned requirements but are critical to ensuring access to Covered Services in the Contractor’s Provider Network and are deemed ECPs.
<b><i>Electronic Verification System (EVS)</i></b>	A means to verify an individual’s eligibility for services covered by the State of Nevada’s Medicaid program via the Internet.
<b><i>Exception</i></b>	A formal objection taken to any statement/requirement identified within the RFP.
<b><i>Excluded Services</i></b>	Excluded services are benefits that are not covered under the Medicaid Nevada Check Up managed care program.

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<b><i>External Quality Review Protocols</i></b>	A series of procedures or rules to monitor, measure, and document information on quality, timeliness, and access to the health care and services that a Contractor or their Subcontractors furnish to Medicaid and Nevada Check Up Members.
<b><i>Family Planning Services</i></b>	Section 1905(a)(4)(C) of the SSA requires states to provide family planning services and supplies (directly or under arrangements with others) to individuals of childbearing age (including minors who can be considered to be sexually active) who are eligible under the Medicaid State Plan and who desire such services and supplies. Section 1902(a)(10)(A) of the SSA specifies family planning services be made available to categorically needy Medicaid Members while section 1902(a)(10)(C) of the SSA indicates the services may be provided to medically needy Medicaid Recipients at the State's option. The term "family planning services" is not defined in the law or in regulations. However, Congress intended that emphasis be placed on the provision of services to "aid those who voluntarily choose not to risk an initial pregnancy," as well as those families with children who desire to control family size. In keeping with congressional intent, these services may be defined as narrowly as services, which either prevent or delay pregnancy, or they may be more broadly defined to also include services for the treatment of infertility. However, the Medicaid definition must be consistent with overall State policy and regulation regarding the provision of family planning services.
<b><i>Federal Financial Participation (FFP)</i></b>	Usually expressed as a percentage or fraction of certain expenditures for which the State is entitled to reimbursement by the federal government in accordance with applicable laws and regulations.
<b><i>Fee-for-service Reimbursement (FFS)</i></b>	Fee-for-service Reimbursement is a health care delivery program whereby the State's medical assistance program Recipients are served by health care Providers reimbursed on a per service or point of service basis.
<b><i>First Step Program</i></b>	The Division of Child and Family Services (DCFS) early intervention services for families and their children, ages birth through two (2) years (to third birthday), with suspected or confirmed developmental delays.
<b><i>Fiscal Agent</i></b>	The program's fiscal agent is an entity under contract to the State with responsibility for the prompt and proper processing of all claims for payment of Covered Services in accordance with policies and procedures established by Nevada Medicaid. In addition, the fiscal agent may: <ul style="list-style-type: none"> <li>(1) Provide the auditing function for Providers under cost reimbursement;</li> <li>(2) Perform a cursory pre-payment review on all claims;</li> <li>(3) Trace, identify and apply any and all Prior Resources, including third-party liability and subrogation;</li> </ul>

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	(4) Supply Provider education and Provider services; and,  (5) Other administrative services.
<b><i>Family Medical Coverage (FMC)</i></b>	Applications for Medicaid are treated as application for Family Medical Coverage. This includes parents, caretakers, and children in the MAGI medical groups of: AM, AM1, CH, CHI, CH5, TR, PM; Nevada Check Up (NC); and Childless Adults (CA).
<b><i>Fraud</i></b>	Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law. (42 CFR 455.2)
<b><i>Federally Qualified Health Center (FQHC)</i></b>	An entity as defined in 42 CFR 405.2401(b). An FQHC is located in a rural or urban area designated as either a shortage area, or an area that has a medically underserved population and has a current provider agreement with the State.
<b><i>Geographic Service Area</i></b>	The geographic service area included in the contract will be urban Clark and Washoe Counties. Other geographic areas may become mandatory managed care during the course of this contract and are to be considered as covered for this RFP. Members not residing in the areas included in the geographic service areas will be provided Medicaid Covered Services through fee-for-service provided by the State.
<b><i>Grievance</i></b>	Means any oral or written communications made by a Member, or a Provider acting on behalf of the Member with the Member's written consent, to the Contractor expressing dissatisfaction or making a complaint with any aspect of the Contractor's or Provider's operations, activities or behavior, regardless of whether the communication requests any remedial actions.
<b><i>Goods</i></b>	The term "goods" as used in this RFP has the meaning ascribed to it in NRS 104.2105(1) and includes, without limitation, "supplies", "materials", "equipment", and "commodities", as those terms are used in NRS Chapter 333.
<b><i>Habilitation</i></b>	Services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in a home and community-based setting. The repetitive services required to maintain function generally do not involve complex and sophisticated therapy procedures, and consequently the judgment and skill of a qualified therapist are not required for safety and effectiveness. As such, "maintenance" programs do not meet the requirement of being restorative or rehabilitative and are not a covered benefit by Nevada Medicaid. In certain instances, the specialized knowledge and judgment of a qualified therapist may be required to establish a maintenance program. Habilitation services are provided through Nevada's FFS delivery system.
<b><i>Home and Community Based Services (HCBS)</i></b>	Comprehensive services delivered in home and community based (HCB) settings depending upon the needs and preferences of the individual. The goal of services offered in HCB settings is to help

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	support individuals so they may safely remain in the community. Many services are offered under Medicaid State Plan authority and are included in this Contract. These include Personal Care Services, Home Health Services, private duty nursing, adult day health care, intensive outpatient services, and partial hospitalization.
<b><i>Health Care Services</i></b>	Any services included in the furnishing to any natural person of medical care or hospitalization or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person any other services for the purpose of preventing, alleviating, curing or healing human illness or injury.
<b><i>Healthy Kids</i></b>	The State refers to the EPSDT program as Healthy Kids.
<b><i>Hearing</i></b>	A hearing is an orderly, readily available proceeding before a hearing officer, which provides for an impartial process to determine the correctness of an agency action (See MSM Chapter 3100). Members and Medicaid Providers are afforded an opportunity for hearing in certain circumstances and when requested in a timely manner. An agency or Contractor Adverse Benefit Determination made against a Member's request for service or payment as well as a determination against a Provider that terminates or denies a Provider application may provide opportunity for a hearing.
<b><i>Healthcare Effectiveness Data and Information Set (HEDIS)</i></b>	The performance measurement tool of choice for more than 90 percent of the nation's managed care organizations. It is a set of standardized measures that specifies how health plans collect, audit, and report on their performance in important areas ranging from breast cancer screening, to helping patients control their cholesterol to customer satisfaction. Purchasers and others use HEDIS data to compare plan performance.
<b><i>HEDIS Compliance Audit</i></b>	A comprehensive assessment by a HEDIS Certified Auditor using findings from the HEDIS Baseline Assessment Tool (BAT), from audits in prior years (if applicable) and the HEDIS logical measure groups to select a core set of measures from all Contractor-reported measures. The auditor evaluates the core set of measures across all applicable domains described in the HEDIS specifications and extrapolates findings from the core set to all measures reported by the Contractor.
<b><i>Health Insurance Exchange (HIX)</i></b>	Nevada Health Link, the State-designated Health Insurance Exchange.
<b><i>Home Health Services</i></b>	Home health services are a mandatory benefit for individuals entitled to NF services under the state's Medicaid plan. In order to qualify for Home Health Services, the Recipient must have a face-to-face visit with qualified medical professional. Home health services must include nursing services, as defined in the state's Nurse Practice Act, that are provided on a part-time or intermittent basis by a HHA, home health aide services provided by a HHA, and medical supplies, equipment, and appliances suitable for use in the home. Physical therapy, occupational therapy, speech pathology, and audiology services are optional services States may choose to provide. To participate in the Medicaid program, a HHA must meet the conditions of participation for Medicare.

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<b><i>Hospice Services</i></b>	Hospice care means a comprehensive set of services identified and coordinated by an Interdisciplinary Group (IDG) to provide for the physical, psychosocial, spiritual and emotional needs of a terminally ill Recipient and/or family members, as delineated in a specific Recipient plan of care.
<b><i>Hospital</i></b>	Hospital means an inpatient medical facility licensed to provide services at an acute level of care for the diagnosis, care and treatment of human illness primarily for patients with disorders other than mental diseases. For purposes of Medicaid, a "hospital" must meet the requirements for participation in Medicare as a hospital. It is not an Institution for Mental Diseases (IMD), a Nursing Facility (NF), or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) regardless of name or licensure.
<b><i>Improper Payment</i></b>	A payment made for any Medicaid service that was not authorized, performed, documented, billed, and paid in accordance with Nevada Medicaid policy and all applicable federal and state laws. The term encompasses fraud, waste, and abuse, but also includes errors on the part of the Provider or the payer.
<b><i>Indian Health Programs</i></b>	These are services that the United States Government provides to federally recognized American Indian Tribes and Alaska Native Villages ("Indian tribes") based on a special government-to-government relationship. This relationship is the result of treaties between the federal government and Indian tribes and federal legislation. The Indian Health Services (IHS) is the primary source of medical and other health services for American Indian and Alaska Native people living on federal Indian reservations and other communities serviced by the IHS. The IHS delivery system includes over 500 health care facilities, including 51 hospitals, operated directly by the IHS or by Indian tribes or tribal organizations under agreements (contracts, grants, or compacts) authorized by Title I or III of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended).
<b><i>In Lieu of Services</i></b>	These are services or settings that a Contractor may cover that are not covered in the Medicaid State Plan but the State has determined such services or settings to be a medically appropriate and cost effective substitute for a covered service or setting. Services or settings may only be considered "in lieu of" to the extent the State has defined and approved the service or setting.
<b><i>Inpatient Hospital Services</i></b>	"Inpatient hospital services" means services ordinarily furnished in a hospital for the care and treatment of an inpatient under the direction of a physician or dentist and furnished in an institution that (a) is maintained primarily for the care and treatment of patients with disorders other than tuberculosis; (b) is licensed as a hospital by an officially designated authority for State standard-setting; (c) meets the requirements for participation in Medicare; and (d) has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of 42 CFR 482.30, 42 CFR 456.50-456.145 and 42 CFR 440.10 Inpatient hospital services do not include Skilled Nursing

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	Facilities (SNF) or Intermediate Care Facilities (ICF) services furnished by a hospital with swing bed approval.
<b><i>Institutions for Mental Diseases (IMD)</i></b>	Section 1905(i) of the SSA and 42 CFR 435.1009 defines an institution for mental diseases as a hospital, nursing facility, or other institution of more than 16 beds primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. The regulation also indicates that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases.
<b><i>IQAP</i></b>	Internal Quality Assurance Programs (IQAPs)
<b><i>I&amp;R Unit</i></b>	Investigation and Recovery Unit at DWSS
<b><i>Key Personnel</i></b>	Contractor staff responsible for oversight of work during the life of the project and for deliverables.
<b><i>LCB</i></b>	Legislative Counsel Bureau
<b><i>Limited English Proficiency (LEP)</i></b>	The inability to read, write or understand the English language at a level that permits one to interact effectively with health care Providers or the Contractor.
<b><i>Licensure</i></b>	The act or practice of granting licenses as to practice a profession.
<b><i>Managed Care Organization (MCO)</i></b>	Managed Care is a system of health care delivery that influences utilization, cost of services and measures performance. The delivery system is generally administered by an MCO, which may also be known as a Health Maintenance Organization (HMO). An MCO is an entity that must provide its Medicaid or Check Up Members inpatient hospital, outpatient hospital, laboratory, x-ray, family planning, physician, home health services, Emergency Services, and additional contracted Medicaid and CHIP State Plan benefits. The MCO provides these services for a capitation fee, regardless of whether the Member receives services. The MCOs awarded a contract resulting from this RFP are referred to as “Contractors.”
<b><i>Marketing</i></b>	Any communication from the Contractor, including its employees, affiliated Providers, agents or subcontractor, to a Medicaid or Nevada Check Up Recipient who is not enrolled with the Contractor that can reasonably be interpreted as intended to influence the Recipient to enroll with the Contractor or either not to enroll in or to disenroll from another Contractor’s plan.
<b><i>Marketing Materials</i></b>	Materials that are produced in any medium, by or on behalf of Contractor that can reasonably be interpreted as intended to market to Potential Members.
<b><i>Maternity Kick Payment (SOBRA)</i></b>	The Maternity Kick Payment is payment made to the Contractor, which is intended to reimburse the Contractor for costs associated specifically with covered delivery costs and postpartum care.
<b><i>May</i></b>	Indicates something that is recommended but not mandatory.
<b><i>Medicaid</i></b>	Title XIX of the Social Security Act is a federal program, which pays for medical benefits to eligible low-income persons needing health care. In Nevada, the Department of Health and Human Services, Division of Health Care Financing and Policy administers the program, subject to oversight by CMS. The federal and State governments share the program costs.

<b><i>Term or Acronym</i></b>	<b><i>Definition</i></b>
<b><i>Medicaid or Nevada Check Up Billing Number</i></b>	The Medicaid and Nevada Check Up identification is an eleven digit number format. Providers use the Medicaid identification number when submitting claims for payment on services provided to eligible program Members.
<b><i>Medicaid and Nevada Check Up Card</i></b>	An instrument or device evidencing eligibility for receipt of Medicaid or Nevada Check Up Covered Services. The card is issued by the Fiscal Agent for the use of the Cardholder in obtaining the types of medical and remedial care for which assistance may be provided under the Medicaid and CHIP State Plans.
<b><i>Medicaid Fraud Control Unit (MFCU)</i></b>	The MFCU is a federally funded and mandated State fraud unit, independent of the State Medicaid agency and authorized by the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977. The purpose of MFCU is to investigate and prosecute Provider fraud in the Medicaid program. In Nevada, MFCU was established by the 1991 Legislature within the Office of the Attorney General.
<b><i>Medicaid State Plan (aka "State Plan")</i></b>	<p>The Medicaid State Plan is a comprehensive statement submitted by the state Medicaid agency describing the nature and scope of its program and giving assurance that it will be administered in conformity with the specific requirements stipulated in the pertinent title of the Act, and other applicable official issuances of the Department of Health and Human Services (HHS). The Medicaid State Plan contains all information necessary for HHS to determine whether the State Plan can be approved as a basis for Federal Financial Participation (FFP) in Nevada's Medicaid program.</p> <p>The Medicaid State Plan consists of written documents furnished by the State to cover each of its programs under the Act including the medical assistance program (Title XIX, Title XXI). After approval of the original plan by HHS, all relevant changes required by new statutes, rules, regulations, interpretations, and court decisions, are required to be submitted so HHS may determine whether the State Plan continues to meet federal requirements and policies.</p>
<b><i>Medical Assistance to the Aged, Blind and Disabled (MAABD)</i></b>	MAABD is a Medicaid eligibility category which provides medical coverage for certain persons who are eligible for and/or may be receiving Supplemental Security Income (SSI), persons who qualify for Home and Community Based Services (HCBS) 1915(c) waivers, certain persons who qualify for Medicare coverage, and certain disabled children who would be eligible for nursing facility placement but who are being cared for in their home for less cost than what would be incurred in such placement. The MAABD population is currently excluded from the Medicaid managed care program.
<b><i>Medical Care Advisory Committee (MCAC)</i></b>	MCAC is a federally mandated advisory committee whose purpose is to act in an advisory capacity to the State Medicaid Administrator.
<b><i>Medical Necessity</i></b>	A health care service or product that is provided for under the Medicaid State Plan and is necessary and consistent with generally accepted professional standards to: diagnose, treat or prevent illness or disease; regain functional capacity; or reduce or ameliorate effects of an illness, injury or disability. The determination of Medical

<b><i>Term or Acronym</i></b>	<b><i>Definition</i></b>
	<p>Necessity is made on the basis of the individual case and takes into account:</p> <ol style="list-style-type: none"> <li>(1) Type, frequency, extent, body site and duration of treatment with scientifically based guidelines of national medical or health care coverage organizations or governmental agencies.</li> <li>(2) Level of service that can be safely and effectively furnished, and for which no equally effective and more conservative or less costly treatment is available.</li> <li>(3) Services are delivered in the setting that is clinically appropriate to the specific physical and mental/Behavioral Health care needs of the Member.</li> <li>(4) Services are provided for medical or mental/behavioral reasons rather than for the convenience of the Recipient, the Recipient’s caregiver, or the health care Provider.</li> </ol> <p>Medical Necessity shall take into account the ability of the service to allow Recipients to remain in a community based setting, when such a setting is safe, and there is no less costly, more conservative or more effective setting.</p>
<b><i>Member</i></b>	A Medicaid or Nevada Check Up Recipient who is enrolled in the managed care program. May also be referred to as enrollee, recipient, or beneficiary.
<b><i>Mid-Level Practitioner</i></b>	Includes physician assistants and nurse practitioners (advanced practice nurses).
<b><i>Medicaid Services Manual (MSM)</i></b>	The Medicaid Services Manual is a compilation of regulations adopted under NRS 422.2368 and 422.2369. It sets guidelines and limitations regarding how the Division operates and what services are covered. Changes to the MSM are approved at public hearings.
<b><i>Must</i></b>	Indicates a mandatory requirement. Failure to meet a mandatory requirement may result in the State’s imposition of a corrective action plan (also referred to as “Plan of Correction”), sanctions, liquidated damages, termination of the contract, or any remedies permitted under state or federal law.
<b><i>National Committee for Quality Assurance (NCQA)</i></b>	National Committee for Quality Assurance is an organization that develops health care measures that assess the quality of care and services that commercial and Medicaid Members receive.
<b><i>NCPDP</i></b>	<b>National Council for Prescription Drug Programs</b>
<b><i>Network</i></b>	A Network is a directory of doctors, health care professionals, hospitals, and health care facilities that a Contractor has written agreements with to provide medical care to its Members.
<b><i>Nevada Administrative Code (NAC)</i></b>	All applicable NAC documentation may be reviewed via the internet at: <a href="http://www.leg.state.nv.us">www.leg.state.nv.us</a> .
<b><i>Nevada Check Up (NCU)</i></b>	Children’s Health Insurance Program (CHIP) provided under Title XXI of the Social Security Act to children whose families exceed

<b><i>Term or Acronym</i></b>	<b><i>Definition</i></b>
	Medicaid limits, but is equal to or less than 200% of the federal poverty level.
<b><i>Nevada Division of Welfare and Supportive Services (DWSS)</i></b>	The Nevada Division of Welfare and Supportive Services (DWSS) determine eligibility for Medical Assistance, Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance to Needy Families (TANF).
<b><i>Nevada Early Intervention Services (NEIS)</i></b>	Clinics operating to serve children, from birth to their third (3rd) birthday, providing early intervention services for children with known or suspected developmental delays. These clinics receive Title V funding.
<b><i>Nevada Revised Statutes (NRS)</i></b>	All applicable NRS documentation may be reviewed via the internet at: <a href="http://www.leg.state.nv.us">www.leg.state.nv.us</a> .
<b><i>Non-Emergency Transportation (NET) Broker</i></b>	A NET Broker contracts with individual transportation companies who provide transportation for eligible Recipients of the State's medical assistance programs. The NET Broker manages, authorizes, and coordinates NET services for these Recipients. The NET Broker also provides various utilization management reports to Nevada Medicaid for quality assurance purposes. The NET Broker may perform the transportation services with limitations.
<b><i>Open Enrollment Period</i></b>	The annual opportunity for Members to change Contractors as described in Section 7.3.10.1.1.
<b><i>Orthodontics</i></b>	The branch of dentistry used to correct malocclusions (the "bite") of the mouth and restore it to proper alignment and function. Nevada Medicaid authorizes payment for orthodontics for qualified Medicaid Recipients less than 21 years of age and for qualified Nevada Check Up Recipients up to the birth month of their 19th year of age.
<b><i>Other Health Care Coverage (OHC)</i></b>	As defined by Nevada Medicaid, OHC means any private health coverage plan or policy, which provides or pays for health care services. Exclusions to OHC include but are not limited to Medicaid managed care, automobile insurance, and life insurance.
<b><i>Out-of- Network Provider</i></b>	These are certain types of Providers with whom formal contracts may not be in place with the Contractor. However, the Contractor's benefit package includes Medicaid services for which the Contractor will reimburse for specific services. The Contractor must negotiate a contract, often referred to as a "single case agreement", to determine the rate prior to services being rendered or pay no more than the FFS rate established by the State unless otherwise specified in the Contract.
<b><i>Outpatient Services</i></b>	Outpatient services are those Medically Necessary services provided for the diagnosis and/or treatment of an illness or disease for which the patient will not require care in a facility for more than 24 hours. Services are provided in variety of settings that include, but are not limited to the office/clinic, home, institution and outpatient hospital.
<b><i>Patient Protection and Affordable Care Act (PPACA) or Affordable Care Act (ACA)</i></b>	The Patient Protection and Affordable Care Act (PPACA) is a United States federal statute signed into law by on March 23, 2010. It represents the most significant regulatory overhaul of the health care system. Under the ACA, hospitals and primary physicians would transform their practices financially, technologically, and clinically to drive better health outcomes, lower costs, and improve their methods of distribution and accessibility. The ACA was enacted to increase

<b><i>Term or Acronym</i></b>	<b><i>Definition</i></b>
	the quality and affordability of health insurance, lower the uninsured rate by expanding public and private insurance coverage, and reduce the costs of healthcare for individuals and the government.
<b><i>Patient Liability (PL)</i></b>	Patient Liability is that portion of a Recipient's income that must be paid toward the cost of care.
<b><i>Performance Improvement Project (PIP)</i></b>	Activities conducted by managed care organizations designed to improve the quality of care or services received by Members.
<b><i>Performance Indicators</i></b>	Performance indicators are preset criteria, which involve the Member or Provider and show the outcomes and impact level of Contract performance on specified sets of the population.
<b><i>Personal Care Services (PCS)</i></b>	Services performed in accordance with a written service plan developed in conjunction with the Member, or the representative, and based on the needs of the Member being served as determined by a functional assessment. Assistance may be in the form of direct hands-on assistance or cueing the individual to perform the task, and relates to the performance ADLs and IADLs. Personal Care Services may be provided in the home, or locations outside the home, including employment sites, or wherever the need for Personal Care Services occurs. The time authorized for services is documented in the approved service plan, regardless of the location of services.
<b><i>Personal Representative</i></b>	A personal representative is: <ul style="list-style-type: none"> <li>(1) A parent, including a parent who is an emancipated minor;</li> <li>(2) A guardian of the person as defined in NRS Chapter 159, an executor or administrator;</li> <li>(3) A person who has authority to make health care decisions under a power of attorney for health care; or</li> <li>(4) A person who is designated, in writing, as a personal representative for a Medicaid or Nevada Check Up Member (this authority may be granted only by the Member or, in the case of a minor child or adult who is adjudicated incompetent, his/her parent or guardian).</li> </ul>
<b><i>Plan of Correction (POC)</i></b>	A detailed written plan describing the actions and/or procedures to remedy deviation from the stated standard(s) or contractual and/or legal mandates.
<b><i>Post-Stabilization Services</i></b>	Covered Services related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition or are provided to improve or resolve the Member's condition.
<b><i>Potential Member</i></b>	A Medicaid or Check Up Recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet a Member of a specific Contractor. (Potential Member definition is applicable to the Information Requirements in 42 CFR 438.10, not to the Marketing requirements in 42 CFR 438.104.)

<b><i>Term or Acronym</i></b>	<b><i>Definition</i></b>
<b><i>Preauthorization</i></b>	A decision by your plan or the State that a health care service, treatment plan, prescription drug or durable medical equipment is Medically Necessary. Sometimes called prior authorization, prior approval or precertification.
<b><i>Prescription Drug Coverage</i></b>	Prescription drug coverage is a policy of health insurance which provides coverage for prescription drugs in accordance with NRS 689A.405 and Sec. 1860D-4 of the Social Security Act.
<b><i>Prescription Drugs</i></b>	Prescription drug means (1) a controlled substance or dangerous drug that may be dispensed to an ultimate user only pursuant to a lawful prescription; and (2) any other substance or drug substituted for such a controlled substance or dangerous drug. See NRS 453.3628.
<b><i>Primary Care Provider (PCP)</i></b>	Physicians who practice general medicine, family medicine, general internal medicine, general pediatrics, or osteopathic medicine. Physicians who practice obstetrics and gynecology may function as PCPs for the duration of the Member's pregnancy.
<b><i>Primary Care Site</i></b>	A location, usually a clinic, where a Member chooses to access primary health care. The Member's medical record is maintained at this location, and a rotating staff of physicians manages and coordinates the Member's medical needs.
<b><i>Prior Resources</i></b>	Prior resources are any non-Medicaid coverage, public or private, which can be used to pay for medical services. These resources and benefits are payable before Medicaid benefits are paid.
<b><i>Private Duty Nursing Services (PDN)</i></b>	42 CFR 440.80 defines PDN services as nursing services for Members who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or NF, and are provided through an agency: <ol style="list-style-type: none"> <li>1. by a Registered Nurse or a Licensed Practical Nurse;</li> <li>2. under the direction of the Recipient's physician; and</li> <li>3. at the State's option, to a Recipient in one or more of the following locations: his or her own home, a hospital, or a nursing facility.</li> </ol>
<b><i>Provider</i></b>	Any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services. This includes a person who has applied to participate or who participates with the Contractor as a Provider of goods or services; or a private insurance carrier, health care cooperative or alliance, health maintenance organization, insurer, organization, entity, association, affiliation, or person, who contracts to provide or provides goods or services that are reimbursed by or are a required benefit of the Contractor. For the fee-for-service program any individual or entity furnishing Medicaid services under an agreement with the Division is a Provider. For the managed care program, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services is a Provider.
<b><i>Provider Dispute</i></b>	The term Provider Dispute encompasses both grievances and appeals. An appeal is a request to review an action as an "action" is described herein. A grievance is an expression of dissatisfaction with any aspect of the Medicaid managed care health plan's operations, activities or

<b><i>Term or Acronym</i></b>	<b><i>Definition</i></b>
	behavior, regardless of whether the communication requests any remedial actions.
<b><i>Provider Exclusion</i></b>	Refers to an action taken by the federal Office of the Inspector General (OIG) of the United States Department of Health and Human Services, which prohibits individual practitioners and/or providers from participating in providing services under and submitting claims for such services for reimbursement from all federally funded health care programs. An exclusionary action by the OIG is immediate grounds for termination of a State Medicaid Provider agreement and Contractor’s provider contract and offers no opportunity for hearing with Nevada Medicaid.
<b><i>Prudent Layperson</i></b>	A person who possesses an average knowledge of health and medicine, who could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
<b><i>Public Record</i></b>	All books and public records of a governmental entity, the contents of which are not otherwise declared by law to be confidential must be open to inspection by any person and may be fully copied or an abstract or memorandum may be prepared from those public books and public records. (Refer to NRS 333.333 and NRS 600A.030 [5]).
<b><i>Qualified Clinical Staff</i></b>	Those who are appropriately licensed or certified to perform Medically Necessary services or render clinical expertise, evaluation, and judgment in accordance with State and federal laws.
<b><i>Qualified Health Maintenance Organization</i></b>	As defined by 42 USC 300e-9(c)(1) a health maintenance organization which has provided assurances satisfactory to the Secretary that it provides basic and supplemental health services to its members in the manner prescribed by section 300e(b) of title 42 of the USC and that it is organized and operated in the manner prescribed by section 300e(c) of title 42 of the USC, and (2) an entity which proposes to become a health maintenance organization and which the Secretary determines will when it becomes operational provide basic and supplemental health services to its members in the manner prescribed by section 300e(b) of title 42 of the USC and will be organized and operated in the manner prescribed by section 300e(c) of title 42 of the USC.
<b><i>Quality Assurance (QA)</i></b>	A formal set of activities to review and affect the quality of services provided. Quality assurance includes quality assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services.
<b><i>Quality Improvement</i></b>	A continuous process that identifies problems in organizational systems, including health care delivery systems which tests solutions to those problems and constantly monitors the solutions for improvement.
<b><i>Quality Improvement Organization (QIO)</i></b>	Titles XI and XVIII of the Social Security Act (the Act) provide the statutory authority for the broad objectives and operations of the Utilization and Quality Control Quality Improvement Organization (QIO) program. The Peer Review Improvement Act of the Tax Equity

<b><i>Term or Acronym</i></b>	<b><i>Definition</i></b>
	<p>and Fiscal Responsibility Act of 1982 established utilization and quality control Quality Improvement Organizations (QIOs).</p> <p>QIOs operate under contract with the Secretary of Health and Human Services to review Medicare services, once so certified by CMS. They may also contract with State Medicaid agencies and private insurers. The utilization review/control requirements of 42 CFR 456, are deemed met if a State Medicaid agency contracts with a Medicare certified QIO, designated under Part 475, to perform review/control services (42 CFR 431.630).</p>
<b><i>Qualified Mental Health Associates (QMHA)</i></b>	A person who meets the minimum qualifications outlined in MSM Chapter 400, Section 403.3A.
<b><i>Qualified Mental Health Professional (QMHP)</i></b>	A Physician, Physician's Assistant or a person who meets the definition of a Qualified Mental Health Associate (QMHA) and meets the documented minimum qualification outlined in MSM Chapter 400, Section 403.3B.
<b><i>Rate Cell or Cohort</i></b>	A set of mutually exclusive categories of Members that is defined by one or more characteristics for the purpose of determining the Capitation Rate and making a Capitation Payment; such characteristics may include age, gender, eligibility category, and region or geographic area. Each Member should be categorized in one of the rate cells for each unique set of mutually exclusive benefits under the Contract.
<b><i>Recipient</i></b>	Means a natural person who receives benefits pursuant to the Medicaid or CHIP State Plan.
<b><i>Records</i></b>	Means medical, professional or business records relating to the treatment or care of a Member, or to goods or services provided to a Member, or to rates paid for such goods or services, and records required to be kept by the Contractor.
<b><i>Redacted</i></b>	The process of removing confidential or Proprietary Information from a document prior to release of information to others.
<b><i>Referral</i></b>	The recommendation by a physician, dentist and/or Contractor, and in certain instances, the recommendation by a parent, legal guardian and/or Authorized Representative, for a Member to receive Medically Necessary care from a different Provider.
<b><i>Regulation</i></b>	A U.S. Department of Health and Human Services statement of general applicability designed to implement or interpret federal law, policy or procedure; or a statement of Nevada Medicaid of general applicability designed to implement or interpret State or federal law, policy or procedure.
<b><i>Rehabilitation Services and Devices</i></b>	Rehabilitation services are an optional Medicaid benefit that must be recommended by a physician or other licensed practitioner of the healing arts, within the scope of practice under state law, for the maximum reduction of a physical or mental disability and to restore the individual to the best possible functional level. Nevada Medicaid provides for physical rehabilitation services and mental health rehabilitation services under separate programs within the Medicaid State Plan.

<b><i>Term or Acronym</i></b>	<b><i>Definition</i></b>
<b><i>Reinsurance</i></b>	Insurance purchased by a Contractor, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the claims of its Network Providers, policyholders, or employees and covered dependents.
<b><i>Request for Hearing</i></b>	A clear, written request from either a Provider or Medicaid or Nevada Check Up Member to the State or the Contractor for a hearing relating to a sanction and/or Adverse Benefit Determination. In the case of a Provider sanction or Adverse Benefit Determination, it is a request made after all Contractor and State remedies have been exhausted by the Provider.
<b><i>Risk Contract</i></b>	Means under which the Contractor assumes risk for the costs of the services covered under the Contract and incurs loss if the cost of furnishing the services exceeds the payments under the Contract.
<b><i>Rural Health Clinic (RHC)</i></b>	Rural Health Clinic, defined in 42 CFR 491.2, means a clinic that is located in a rural area designated as a shortage area. It is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.
<b><i>Sanction</i></b>	A sanction refers to an action taken by either the State or the HHS Office of Inspector General (OIG) against a Provider or Provider applicant. The term also includes sanctions imposed by the State on the Contractor pursuant to 42 CFR part 438, subpart I.
<b><i>Secretary</i></b>	The Secretary of the United States Department of Health and Human Services.
<b><i>Seriously Emotionally Disturbed (SED)</i></b>	For children, only a qualified Provider can make a determination of SED.
<b><i>Serious Mental Illness (SMI)</i></b>	For adults, only a qualified provider can make a determination of SMI.
<b><i>Service</i></b>	Means any procedure, intervention, or item reimbursable under Medicaid or CHIP.
<b><i>Service Area</i></b>	The geographic area served by the Contractor as approved by State regulatory agencies and/or as detailed in the certificate of authority.
<b><i>Service Levels</i></b>	Service levels are various measurable requirements that pertain to the delivery system structure of the Contract and are used for evaluating Contract performance and compliance.
<b><i>SFY</i></b>	State Fiscal Year, July 1st through June 30th.
<b><i>Shall</i></b>	Indicates a mandatory requirement. Failure to meet a mandatory requirement may result in the rejection of a Vendor's Proposal as non-responsive or result in imposition of sanctions or other remedies under the Contract on a Contractor.
<b><i>Skilled Nursing Care</i></b>	Skilled Nursing care means assessments, judgments, interventions and evaluations of intervention, which require the training and experience of a licensed nurse. Skilled Nursing care includes, but is not limited to: <ol style="list-style-type: none"> <li>1. Performing assessments to determine the basis for action or the need for action;</li> <li>2. Monitoring fluid and electrolyte balance;</li> <li>3. Suctioning of the airway;</li> <li>4. Central venous catheter care;</li> </ol>

<b><i>Term or Acronym</i></b>	<b><i>Definition</i></b>
	5. Mechanical ventilation; and 6. Tracheotomy care.
<b><i>Social Security Act (the Act)</i></b>	The Social Security Act (the Act), Pub.L. 74–271, 49 Stat. 620, enacted August 14, 1935, now codified as 42 U.S.C. ch. 7, was a social welfare legislative act which created the Social Security system in the United States and governs the Medicaid Program (Title XIX) and CHIP Program (Title XXI).
<b><i>Specialist</i></b>	A specialist is a doctor who has completed advanced education and training in a specific field of medicine.
<b><i>State</i></b>	The State of Nevada and any agency identified herein, generally used in the Contract to refer to the DHCFP.
<b><i>Statement of Work</i></b>	A statement of the work or services, which the Contractor is to perform under any contract awarded as, specified in Section 7 of this RFP and any attachments thereto. Also referred to as the “Contract”.
<b><i>State Quality Assessment and Performance Improvement Strategy</i></b>	A written document that describes methods the State uses to assess and improve the quality of managed care services offered by all Contractors.
<b><i>Subcontractor</i></b>	A third party, not directly employed by the Contractor, who will provide delegated services or administrative functions identified in this RFP. This does not include third parties who provide support or incidental services to the Contractor.
<b><i>Subrogation</i></b>	Subrogation is the principle under which an insurer that has paid a loss under an insurance policy is entitled to all the rights and remedies belonging to the insured against a third party with respect to any loss covered by the policy.
<b><i>Supplemental Omnibus Budget Reconciliation Act of 1996 (SOBRA)</i></b>	Legislation of the Omnibus Budget Reconciliation Act (OBRA) of 1986.
<b><i>Surveillance and Utilization Review (SUR)Unit</i></b>	The statewide surveillance and utilization program that safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments; assesses the quality of those services; provides for the control of the utilization of, including inpatient services provided in accordance with 42 CFR 456 Subpart B.
<b><i>Targeted Case Management (TCM)</i></b>	Targeted case management is a service that refers to the identification of a “target” group of Recipients for whom case management services will be provided. This targeting may be done by age, type or degree of disability, illness or condition, or another identifiable characteristic or combination thereof. These services are defined as “services which assist an individual, eligible under the plan, in gaining access to needed medical, social, educational and other service.” The intent of these services is to allow States to reach beyond the usual bounds of the Medicaid program to coordinate a broad range of activities and services necessary to the optimal functioning of the Medicaid Recipient. Targeted Case Management has a specific meaning for Nevada Medicaid & Nevada Check Up. TCM, as defined by Chapter 2500 of the Medicaid Services Manual, is carved out of the managed care contract. Care Management activities required of the Contractors

<b><i>Term or Acronym</i></b>	<b><i>Definition</i></b>
	determined to be duplicative of Targeted Case Management will not be provided to Members. All other Care Management activities will be required of Contractors.
<b><i>Temporary Assistance for Needy Families (TANF)</i></b>	Medicaid eligibility category, which became effective January 1, 1997 as a result of the Personal Responsibility and Work Opportunity Act of 1996. TANF eligibility allows for cash payments. In addition, States have the option of including Medicaid eligibility as a program benefit. Nevada has elected to include Medicaid coverage under this eligibility option.
<b><i>Third Party Liability (TPL)</i></b>	Third parties including health insurers, self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, MCOs, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service. TPL includes COB cost avoidance and recovery.
<b><i>Trade Secret</i></b>	Information, including, without limitation, a formula, pattern, compilation, program, device, method, technique, product, system, process, design, prototype, procedure, computer programming instruction or code that: derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by the public or any other person who can obtain commercial or economic value from its disclosure or use; and is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.
<b><i>Urgent Care</i></b>	Urgent care is medical care that is not life threatening, but could result in serious injury or disability if medical attention is not received.
<b><i>USC</i></b>	United States Code
<b><i>Utilization</i></b>	The extent to which the Members of a covered group use a program or obtain a particular service, or category of procedures, over a given period. It is usually expressed as the number of services used per year or per 100 or one 1,000 persons eligible for the service.
<b><i>Utilization Control</i></b>	Utilization Control refers to the federally mandated methods and procedures to safeguard against unnecessary or inappropriate utilization of care and services to Medicare and Medicaid Members. (42 CFR 456.50-456.145).
<b><i>Utilization Review</i></b>	A formal assessment of Medical Necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.
<b><i>Vaccines for Children (VFC)</i></b>	The VFC program is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay.
<b><i>Value Added Service</i></b>	A benefit offered to all Members in specific population groups covered by the Contractor for which the Contractor receives no direct Capitation Payment from the State.
<b><i>Will</i></b>	Indicates a mandatory requirement.

## **7.1. GENERAL CONTRACT TERMS, CONDITIONS, AND STATE RESPONSIBILITIES**

#### 7.1.1. Contract Term

The Contract shall be effective from January 1, 2022, to December 31, 2025, with the possibility of a two (2) year extension if in the best interest of the State.

#### 7.1.2. Certification as an Insurer

Authorization to operate as a certified vendor in the State of Nevada with the projected number of Medicaid and Nevada Check Up Members 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 Contractor 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 Contractor must provide proof of a valid certificate of authority prior to the Readiness Review.

#### 7.1.3. Required Insurance Coverages

The Contractor must maintain, for the duration of its contract, insurance coverages as set forth in **Attachment D - Insurance Schedule** and Section 16 of **Attachment C – Contract Form**. Work on the Contract shall not begin until after the Awarded Vendor has submitted acceptable evidence of the required insurance coverages. Failure to maintain any required insurance coverage or acceptable alternative method of insurance will be deemed a breach of contract.

#### 7.1.4. Accreditation

The Contractor must be accredited by the National Committee for Quality Assurance (NCQA), a nationally recognized organization that provides an independent assessment of the quality of care provided by the Contractor. Accredited organizations must meet quality standards related to various aspects such as consumer protection, Care Management, and quality improvement activities and facilitates comparison of Contractors due to consistent data requirements. The Contractor must authorize the NCQA to provide the State with all information specified in 42 CFR 438.332(b). NCQA accreditation must be obtained within one (1) year of the Go-Live date of the Contract, which is January 1, 2022. If NCQA accreditation is not achieved by January 1, 2023, and the State does not grant an extension of the timeframe as set forth in Section 1.1.5, the Contractor will be considered in breach of the Contract and the State will have the option to terminate the Contract in accordance with the termination provisions.

#### 7.1.5. Coordination with the State-Designated Health Insurance Exchange

7.1.5.1. In addition to providing Medicaid and NCU Managed Care services, the Contractor must also provide, at a minimum, one (1) Silver and one (1) Gold Qualified Health Plan (QHP) on the Individual Exchange of the State-designated Health Insurance Exchange (HIX) by the 2024

coverage year. Failure to provide a Gold and Silver QHP on the HIX by January 1, 2024, may result in termination of the Medicaid and Nevada Check Up managed care contract. The QHPs offered pursuant to this requirement must meet the qualifications of an *MCO Transition QHP* (to distinguish these plans from other QHPs that may not meet the following standards), as described below.

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

- 7.1.5.1.1. Meet the requirements of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (together referred to as the Affordable Care Act or ACA) and the associated Federal regulations;
- 7.1.5.1.2. Meet the licensing requirements of the Department of Business and Industry, Division of Insurance;
- 7.1.5.1.3. Be certified as a QHP in accordance with the criteria determined by the State-designated HIX;
- 7.1.5.1.4. Be able to accept enrollees during open enrollment of the State-designated HIX beginning October 1, 2023 for an effective date of coverage of January 1, 2024 or earlier should the Vendor secure participation in the State-designated HIX prior to 2024;
- 7.1.5.1.5. Make a good faith effort to use a similar Provider Network as is available to those eligible for Medicaid in addition to any Network adequacy standards set by the State-designated HIX;
- 7.1.5.1.6. Be available to consumers in the same geographic area as the geographic area served by the Contractor's Nevada Medicaid and NCU line of business;
- 7.1.5.1.7. Coordinate prior authorizations and edit patterns for members who transition between the Contractor's Nevada Medicaid and NCU line of business and the Contractor's QHP;
- 7.1.5.1.8. Use a formulary that is similar to that of the Contractor's Medicaid and NCU MCO. If a drug or its generic equivalent is covered by the Contractor's Nevada Medicaid and NCU line of business but is not

covered by the MCO Transition QHP, the MCO Transition QHP must cover that drug as it would any other similar tier drug (same cost sharing) for a period of time as determined by a transition plan dictated by Medical Necessity, potential side effects, etc.;

7.1.5.1.9. Cover any benefit required to be covered by Contractor's Nevada Medicaid and NCU line of business, that is not otherwise part of Nevada's Essential Health Benefits package, for a period of time as determined by a transition plan dictated by Medical Necessity, potential side effects, etc.; and

7.1.5.1.10. Be priced reasonably as compared to other QHPs available on the Exchange. To be "priced reasonably," MCO Transition QHP premiums (before the Federal Advanced Premium Tax Credit is applied) must be no more than 15% greater than the median premium offered on the Exchange for similarly situated individuals (based on age, smoking status, family size and geographic location).

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

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

#### 7.1.6. Sole Responsible Entity and Point of Contact

The Contractor will be the sole point of contract responsibility. The State will look solely to the Contractor for the performance of all contractual obligations, and the Contractor shall not be relieved for the non-performance of any or all Subcontractors.

#### 7.1.7. Activities Prior to Go-Live

Many activities must be satisfied by the Contractor prior to Go-Live to demonstrate readiness to meet the requirements and obligations under this Contract. Such activities may require, but are not limited to, timely and complete responses to document requests, revisions to policies and procedures, presentations, availability for and participation in on-site reviews conducted by the State, and demonstration of systems. This section describes the State's expectations for this phase and reserves the right to request any information, documentation or other methods for assessing the Contractor's readiness not otherwise specified herein.

#### 7.1.7.1. Contractor's Implementation Plan

- 7.1.7.1.1. The Contractor must submit to the State for approval, no later than one (1) month after notification that the State has selected the Contractor for contract negotiations, a detailed work plan and timeline (hereinafter "Implementation Plan") for performing the obligations set forth in the Contract for the first Contract Year. Any changes made to the Implementation Plan submitted as part of the Proposal to the RFP must be highlighted for the State's review and approval.
- 7.1.7.1.2. The Contractor must provide the State with updates to the Implementation Plan, identifying adjustments that have been made, and describing the Contractor's current state of readiness to perform all Contract obligations. Until the Go-Live date, the Contractor shall provide biweekly written updates to the Implementation Plan, and thereafter as often as the State determines necessary.
- 7.1.7.1.3. Unless otherwise agreed to by the State, the Contractor must submit to the State no less than thirty (30) Calendar Days prior to the Go-Live date, all deliverables to allow for timely State-identified modifications.
- 7.1.7.1.4. Beginning no later than sixty (60) Calendar Days prior to the Go-Live date, the Contractor shall implement procedures necessary to obtain executed subcontracts, if applicable, and Medicaid and CHIP provider contracts with a sufficient number of Providers to ensure satisfactory coverage of initial enrollments and compliance with the Network adequacy and timely access requirements under the Contract. The State reserves the right to require an access report at any time after the Go-Live start date when barriers to Access or Network inadequacies are identified or are questionable.

- 7.1.7.1.5. The Contractor must ensure that all workplace requirements the State deems necessary, including but not limited to, office space, post office boxes, telephones and equipment, are in place and operative as of the Go-Live date.
- 7.1.7.1.6. The Contractor must ensure there is no interruption of Covered Services to Members and work cooperatively with the State to meet these requirements.
- 7.1.7.1.7. The Contractor must ensure that a toll-free telephone number is in operation at the Contractor's office as of 8:00 a.m. (Pacific Time) no later than forty-five (45) Calendar Days prior to the start of the Contract for Member access and remains in operation for the duration of the Contract, unless otherwise directed or agreed to by the State. A single telephone number may be utilized as long as there is a menu option to channel different caller categories, e.g. Members, Providers, etc.
- 7.1.7.1.8. The Contractor must establish and implement enrollment procedures and maintain applicable Member data. This includes the technical means by which the Contractor's Enrollment Systems, including any Subcontractor Enrollment Systems, can determine the number of Members each enrolled PCP will accept as new patients and transmit Member elections regarding PCP assignment for the forthcoming month.
- 7.1.7.1.9. The Contractor must ensure its Provider Network is established and supported by a sufficient number of provider contracts by the Go-Live date.

#### 7.1.7.2. Pre-Implementation Readiness Review

The State will conduct operational and financial readiness reviews consistent with the requirements in 42 CFR 438.66(d) on all Contractors and will, subject to the availability of the State's resources, provide technical assistance as appropriate. The purpose of the readiness reviews is to assess the Contractor's readiness and ability to provide services to Members. The areas that may be reviewed include, but are not limited to financial operations; administration and organization; Member services; Provider network; quality improvement; and, management information systems, including claims processing and reporting systems. The Contractor shall provide necessary documentation specified by the State and cooperate with the State or its designees in conducting the review. The State will not assign Members nor make payment to a Contractor until the State has determined that the Contractor is able to meet the requirements outlined in this RFP. The

State shall determine when the Contractor 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.

7.1.8. Use of Data Derived from this Contract

The State shall have unlimited but not exclusive rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented or furnished by the Contractor resulting from this Contract. The State reserves the right to make information provided in reports, plans (e.g., Population Health Annual Strategy in Section 7.5.2, EPSDT Plan in Section 7.4.2.6.6, etc.), presentations, or other documentation, or the actual reports, documentation, or presentations from the Contractor available to the public on the State's website or through public information requests. However, the State will not disclose Proprietary Information that is afforded confidential status by state or federal law. Any documents provided by the Contractor to the State that will be made publicly available, or as otherwise directed by the State, must be submitted in accessible formats that comply with federal Americans with Disabilities Act of 1990 and applicable Nevada law.

7.1.9. The Contractor must guarantee that it will not avoid costs for services covered in its Contract by referring Members to publicly supported health care resources.

7.1.10. The Contractor must not issue any insurance certificate or evidence of insurance to any Medicaid or Nevada Check Up Member. Any insurance duty must be construed to flow to the benefit of the State and not to the Medicaid or Nevada Check Up Member.

7.1.11. If the Contractor 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 Contractor must furnish information about the services it does not cover to the State with its application for a Medicaid contract (i.e., the Proposal for the RFP) and whenever it adopts such a policy during the term of the Contract

7.1.12. The Contractor must support and participate in any future grants awarded to Medicaid that affect Contractors or Members.

7.1.13. The Contractor must adhere to any changes to the Medicaid or CHIP program passed by the Nevada State Legislature that impact the managed care program.

7.1.14. 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 Contractor will be financially responsible to refund the amount of the federal disallowance and the corresponding state share to the State. If such disallowance is treated as a default or breach, or otherwise subject the Contractor to sanctions under Section 11 of **Attachment C - Contract Form**, any such liquidated damages are not exclusive and are in addition to any other remedies available under this Contract. All existing subcontracts or provider contracts that require amendments to meet the requirements of this Contract must be amended. All future subcontracts or provider contracts must meet the requirements of this Contract and any amendments thereto.

7.1.15. Presentation of Findings

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

7.1.16. The State will not be liable for Federal, State, or Local excise taxes per NRS 372.325.

7.1.17. State agencies and local governments (as defined in NRS 332.015) are intended third party beneficiaries of any contract resulting from this RFP and any local government may join or use any contract resulting from this RFP subject to all terms and conditions thereof pursuant to NRS 332.195. The State is not liable for the obligations of any local government, which joins or uses any contract resulting from this RFP.

7.1.18. Any person who requests or receives a Federal contract, grant, loan or cooperative agreement shall file with the using agency a certification that the person making the declaration has not made, and will not make, any payment prohibited by subsection (a) of 31 U.S.C. 1352.

7.1.19. Pursuant to NRS Chapter 613 in connection with the performance of work under this Contract, the Contractor agrees not to unlawfully discriminate against any employee or applicant for employment because of race, creed, color, national origin, sex, sexual orientation or age, including, without limitation, with regard to employment, upgrading, demotion or transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including, without limitation apprenticeship.

The Contractor further agrees to insert this provision in all Subcontracts, hereunder, except subcontracts for standard commercial supplies or raw materials.

7.1.20. Award of Related Contracts

7.1.20.1. The State may undertake or award supplemental contracts for work related to this project or any portion thereof. The Contractor shall be bound to cooperate fully with such other contractors and the State in all cases.

7.1.20.2. All Subcontractors shall be required to abide by this provision as a condition of the subcontract between the Subcontractor and the Contractor.

7.1.21. State Owned Property

The Contractor is responsible for the proper custody and care of any State, owned property furnished by the State for use in connection with the performance of the Contract and will reimburse the State for any loss or damage.

7.1.22. Inspection/Acceptance of Work

It is expressly understood and agreed all work done by the Contractor is subject to inspection and acceptance of the State.

7.1.23. Inspection and Audit of Records and Access to Facilities

The State, CMS, the OIG, the Comptroller General and their designees have the right to audit records or documents of the Contractor and any Subcontractors for 10 (ten) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. These entities also may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The aforementioned entities also have the right to inspect and audit any books or records of the Contractor or any Subcontractors pertaining to the ability to bear the risk of financial losses and services performed or payable amounts under the Contract.

7.1.24. Right to Publish

7.1.25.1 The Contractor shall not use, in its external advertising, marketing programs, or other promotional efforts, any data, pictures or other representation of any State facility, except with the specific advance written authorization of the Director of Health and Human Services or designee.

7.1.25.2 Throughout the term of the Contract, the Contractor must secure the written approval of the Director of Health and Human Services or a designee prior to the release of any information pertaining to work or activities covered by the Contract.

7.1.25. State Responsibilities

7.1.25.1. External Quality Review

The State 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 Contractor covered under the Contract. These reviews will be conducted at least annually.

7.1.25.2. Due Process

7.1.25.2.1. 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 Members who request such a hearing for all Adverse Benefit Determinations taken on medical assistance program benefits.

7.1.25.2.2. The State will receive all Member requests for State Fair Hearings, arrange for the State Fair Hearings, and provide the State Fair Hearings officer. Upon receipt of a State Fair Hearing Request, the State will forward a copy to the Contractor.

#### 7.1.25.3. State On-Site Audits

The State may schedule on-site audits at the Contractor's primary place of business. The purpose of these audits is to confirm contract compliance and to more effectively manage the State's contract monitoring and oversight responsibilities of the Contractor. These audits will be scheduled in advance and will focus on contract sections prior identified by the State. The Contractor will be informed of the scheduling, focus of the audit and the expectations regarding Contractor's participation no less than thirty (30) Calendar Days in advance of the on-site visit. The Contractor will have all prior requested data and information available at the time the audit begins.

#### 7.1.25.4. Actuarial Services

The State will provide or contract to the extent required by federal and state law with an actuarial vendor to establish rates using a methodology that is certified as Actuarially Sound and in compliance with state and federal law, as specified in 42 CFR 438.4 through 42 CFR 438.7. The Nevada Check Up Capitation Rates will be based on public or private payment rates for comparable services for comparable populations, consistent with Actuarially Sound principles as defined at 42 CFR 457.10. Capitation Rate reviews will be conducted at least annually.

#### 7.1.25.5. Encounter Data Processing

The State will contract with an encounter data processing agent to accept, edit, process, and review Encounter Data submitted by Contractors. It is the State's sole responsibility to determine the format for Contractor's Encounter Data submissions. In addition, the Contractor's Encounter Data, when requested, must be submitted to the State's Actuary.

#### 7.1.25.6. Website Access

The State will maintain an Internet link on its official website at which the Contractor's website can be accessed and documentation required to be posted publicly per 42 CFR 438.602(g).

#### 7.1.25.7. Operation Oversight

The State has procedures for monitoring the Contractor's operations related to Member enrollment and disenrollment; processing Grievances and Appeals; violations subject to intermediate sanctions; violations of the conditions for receiving federal financial participation; and all other provisions of the Contract.

#### 7.1.25.8. Contracting Integrity

The State has in effect, and will maintain, safeguards against conflict of interest on the part of the State for the activities specified in 42 CFR 438.58 that are at least as effective as the safeguards specified in section 27 of the Office of Federal Procurement Policy Act.

#### 7.1.25.9. Entities Located Outside the U.S.

The State must ensure that the Contractor is not located outside the U.S. and that no claims paid by the Contractor located outside of the U.S. to a Network or Out-of-Network Provider, Subcontractor, or financial institution are considered in the development of Actuarially Sound Capitation Rates.

#### 7.1.25.10. Data Quality

7.1.25.10.1. The Contractor must enforce the enterprise data quality and governance policies and processes defined by the State.

7.1.25.10.2. The Contractor must implement data management policies to establish data quality monitoring and improvement practices and procedures in collaboration with the State.

7.1.25.10.3. The Contractor must incorporate metadata quality feedback into data governance. The Contractor must maintain all documents provided to the State, including but not limited to data dictionaries and Interface Control Documents.

7.1.25.10.4. The Contractor must resolve bad or otherwise corrupt data in accordance with the data quality review and process timelines.

7.1.25.10.5. The Contractor must provide quarterly reports to the State to demonstrate review, measurement, and resolution of data issues, as defined by the State. The State may request more frequent reporting from the Contractor.

- 7.1.25.10.6. The Contractor must utilize data standards that will promote data consistency and enhanced sharing through common data-access mechanisms.

## **7.2. CONTRACTOR ADMINISTRATIVE REQUIREMENTS**

### **7.2.1. Key Personnel Requirements**

The Contractor must ensure the State that the Contractor is adequately staffed with experienced, qualified personnel. The Contractor shall provide such assurances as follows:

- 7.2.1.1. Provide the State with an updated organizational chart whenever a significant change in personnel 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 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 documented on the organizational chart. The State reserves the right to request resumes and other qualifications for key staff, and the right to require the removal of any Member of the Contractor's staff from the project.
- 7.2.1.2. The Contractor must have in place the organizational, management and administrative systems capable of fulfilling all Contract requirements. For purposes of the Key Personnel requirements set forth below, Key Personnel are those individuals with management responsibility or principal technical responsibility for the minimum functional areas below (as opposed to multiple persons equaling a full-time equivalent position).
  - 7.2.1.2.1. A qualified individual to serve as the Chief Executive Officer (CEO). Such CEO must hold a senior executive or management position in the Contractor's organization. The CEO must be authorized and empowered to represent the Contractor regarding all matters pertaining to this Contract. The CEO may have responsibility for the Contractor's other lines of business.
  - 7.2.1.2.2. A qualified individual to serve as the Chief Financial Officer (CFO). Such CFO must hold a senior executive or management position in the Contractor's organization. The CFO is responsible for accounting and finance operations, including all audit activities. The CFO may have responsibility for the Contractor's other lines of business.

- 7.2.1.2.3. A qualified individual to service as the Chief Information Officer (CIO). Such CIO must hold a senior executive or management position in the Contractor's organization. The CIO must oversee and be responsible for all of the Contractor's information systems functions supporting this Contract. The CIO may have responsibility for the Contractor's other lines of business.
- 7.2.1.2.4. Chief Medical Director exclusively dedicated to the Contract who is licensed to practice medicine in the State of Nevada and will take an active role in the medical management team and in clinical and policy decisions. The roles and responsibilities of the Chief Medical Director and the Medical Director's Office are specified in Section 7.2.1.6.
- 7.2.1.2.5. Medical Director for Behavioral Health, defined as a board-certified psychiatrist in the State of Nevada, exclusively dedicated to the Contract, with at least five (5) years of combined experience in mental health and substance abuse. The Medical Director for Behavioral Health must oversee and be responsible for all Behavioral Health activities, with a focus on physical and Behavioral Health integration and secondary review of Behavioral Health related Appeals.
- 7.2.1.2.6. A full-time Nevada Medicaid/CHIP Operations Manager exclusively dedicated to the Contract. The Nevada Medicaid/CHIP Operations Manager is the Contractor's dedicated point of contact for the State. The same individual may serve the functions of the Nevada Medicaid/CHIP Operations Manager and Compliance Officer, described in Section 7.2.1.2.7, so long as all responsibilities are satisfied.
- 7.2.1.2.7. A full-time Compliance Officer exclusively dedicated to the Contract, who leads a Compliance Committee, oversees the Contractor's compliance plan, and is accountable to senior management in accordance with this Contract and 42 CFR 438.608(a)(1)(ii).
- 7.2.1.2.8. A full-time staff person dedicated to the Contract who must oversee and be responsible for Provider services and Provider relations, including all Network management issues, the Credentialing process, Provider payment issues, and Provider education.

- 7.2.1.2.9. A full-time staff person dedicated to the Contract who must oversee and be responsible for all Utilization Management, Quality Management (QM) and Quality Improvement (QI) activities.
- 7.2.1.2.10. A staff person designated as the Program Integrity Unit Manager to oversee activities related to the prevention, detection and remediation of Provider and Member fraud, waste and abuse.
- 7.2.1.2.11. A staff person dedicated to the Contract who must oversee Member services, including the Concierge Services, the Member Call Center, and Member materials.
- 7.2.1.2.12. A staff person dedicated to the Contract who must act as the Grievances and Appeals Coordinator to manage Member and Provider Disputes arising from the Contractor's Grievance and Appeals System.
- 7.2.1.2.13. A full-time staff person dedicated to the Contract who must oversee and be responsible for claims management, including development and implementation of the claims processing and management information systems, payment of claims in accordance with state and federal law, development of processes for cost avoidance, and Encounter Data reporting requirements.
- 7.2.1.2.14. A staff person that is responsible for coordinating with the Nevada Department of Corrections to support transitions of justice-involved individuals to the Medicaid managed care program.
- 7.2.1.2.15. A staff person or title that is responsible for oversight of the Population Health program described in Sections 7.5.1 and 7.5.2.
- 7.2.1.2.16. A staff person that is responsible for oversight of the Cultural Competency Plan described in Section 7.5.3.2.
- 7.2.1.3. With the exception of the Nevada Medicaid CHIP/ Operations Manager, the Chief Medical Officer, and the Medical Director for Behavioral Health who may not be assigned to any other responsibility, key personnel may be responsible for more than one area. The Contractor must ensure that all staff has appropriate training, education, and experience to fulfill the requirements of their positions.

- 7.2.1.4. Key personnel identified in Section 7.2.1.2 require physical presence in Nevada and must be responsive to the State during Pacific Time zone business hours. Key personnel positions that are vacant for significant periods may receive approval from the State to be filled by individuals residing outside of Nevada.
- 7.2.1.5. The Contractor must notify the State of vacancies for key personnel identified in Section 7.2.1.2 within seven (7) Business Days and provide the résumé of the replacement hire once the position is filled.
- 7.2.1.6. Medical Director's Office
  - 7.2.1.6.1. The Contractor must designate a Chief Medical Director to be responsible for the oversight of development, implementation and review of the Contractor's Internal Quality Assurance Program, including implementation of and adherence to any Plan of Correction. The Chief Medical Director need not serve full time or be a salaried employee of the Contractor, but the Contractor must be prepared to demonstrate it is capable of meeting all requirements using a part-time or contracted non-employee Chief Medical Director. The Contractor may also use assistant or associate medical directors to help perform the functions of this office. The Chief Medical Director and the Contractor's Utilization Management and Internal Quality Assurance Plan Committee are accountable to the Contractor's governing body. The Chief Medical Director must be licensed to practice medicine in the State of Nevada and be board-certified or board-eligible in his or her field of specialty. Assistant or associate medical directors, or the medical director of a Subcontractor responsible for the provision of Covered Services, do not need to be licensed to practice medicine in the State of Nevada but must hold a valid license in a state.
  - 7.2.1.6.2. The responsibilities of the Chief Medical Director include the following:
    - 7.2.1.6.2.1. Serves as co-chairman of the Contractor's Utilization Management and Quality Assurance Plan committee;
    - 7.2.1.6.2.2. Directs the development and implementation of the Contractor's Internal Quality Assurance Plan (IQAP) (see Section 7.9.3), utilization

management activities and monitoring the quality of care that Members receive;

- 7.2.1.6.2.3. Oversees the development and revision of the Contractor's clinical care standards and practice guidelines and protocols;
- 7.2.1.6.2.4. Reviews all potential quality of care problems and oversees the development, implementation of, and adherence to, Plans of Correction;
- 7.2.1.6.2.5. Oversees the Contractor's referral process for specialty and Out-of-Network services;
- 7.2.1.6.2.6. Oversees the Contractor's Provider recruitment and credentialing activities;
- 7.2.1.6.2.7. Serves as a liaison between the Contractor and its Providers, communicating regularly with the Contractor's Providers, including oversight of Provider education, in-service training and orientation;
- 7.2.1.6.2.8. Serves as the Contractor's consultant to medical staff with regard to Referrals, denials, Grievances and problems;
- 7.2.1.6.2.9. Ensures Member Individual Family Service Plans (IFSPs) and Individualized Education Programs (IEPs) are followed; and
- 7.2.1.6.2.10. Ensures coordination of Out-of-Network services.

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

## 7.2.2. Subcontractors

The Contractor must comply with the requirements in 42 CFR 438.230 regarding contracts with Subcontractors. The Contractor must comply with the following:

- 7.2.2.1. All subcontracts must fulfill the requirements of 42 CFR part 438 that are appropriate to the service or activity delegated under the subcontract.

- 7.2.2.2. The Contractor is responsible for oversight of all subcontracts and is accountable for any responsibilities it delegates to any Subcontractor. The Contractor must evaluate the prospective Subcontractor's ability to perform the activities to be delegated. The Contractor remains 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 Contractor of its legal responsibility under the Contract.
- 7.2.2.3. Subcontracts that must be submitted to the State for advance written approval include any subcontract between the Contractor, excluding Network Provider contracts, and any individual, firm, corporation or any other entity engaged to perform part or all of the Contractor's responsibilities under the Contract. To the extent a Network Provider is delegated administrative functions under this Contract (e.g., Utilization Management), that Network Provider is also classified as a Subcontractor and that subcontract is subject to the requirements of this section. Subcontracts submitted to the State for review and approval must include pricing information. This provision includes, but is not limited to, contracts for vision services, Behavioral Health Services, claims processing, Member services, Provider services, cost containment services such as Utilization Management, third party liability, surveillance and utilization review, and/or pharmacy services. This provision does not include, for example, purchase orders. Prior to the award of any subcontract or execution of a subcontract with a Subcontractor, the Contractor must provide written information to the State disclosing the Contractor's ownership interest of five percent (5%) or more in the Subcontractor, if applicable. All subcontracts must be submitted to the State for approval prior to their effective date. Failure to obtain advance written approval of a subcontract from the State will result in the application of a penalty of \$25,000 for each incident.
- 7.2.2.4. Within thirty-five (35) Calendar Days of the date of request, the Contractor must provide full and complete information about the ownership of any Subcontractor with whom the Contractor 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 Contractor. 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.
- 7.2.2.5. The Contractor 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.

- 7.2.2.6. The Contractor may rely on Subcontractors to perform/and or arrange for the performance of services to be provided to Members on whose behalf the State makes Capitation Payments to the Contractor. Notwithstanding the use of Subcontractor(s), the Contractor accepts and acknowledges its obligation and responsibilities under this Contract as follows:
- 7.2.2.6.1. For the provision of and/or arrangement for the services to be provided under this contract and to ensure the coordination of care between medical, behavioral and social needs is maintained;
  - 7.2.2.6.2. For the evaluation of the prospective Subcontractor's ability to perform the activities to be delegated;
  - 7.2.2.6.3. For the payment of any and all claims payment liabilities owed to Providers for services rendered to Members under this Contract, 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 Contractor. For the purposes of this section, the term "Insolvent" shall mean:
    - 7.2.2.6.3.1. 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
    - 7.2.2.6.3.2. 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.
  - 7.2.2.6.4. For the oversight and accountability for any functions and responsibilities delegated to any Subcontractor, the Contractor shall indemnify, defend and hold the State of

Nevada, the DHCFP, 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) that are related to any and all claims payment liabilities owed to Providers for services rendered to Members under this Contractor for which a Subcontractor is the primary obligor.

7.2.2.6.5. If the Contractor knowingly executes a subcontract 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 Contractor's Contract with the State or incentives or disincentives are structured to steer enrolled Members to certain Providers) the Contractor will be in default of its Contract with the State. In addition, if the Contractor 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 State.

7.2.2.7. The Contractor must maintain all agreements and subcontracts relating to the Contract in writing. The Contractor must provide copies of all agreements and subcontracts to the State within five (5) Calendar 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 Contractor has the responsibility to assure that Subcontractors are adequately insured to current insurance industry standards.

7.2.2.7.1. As part of its subcontracting, the Contractor agrees that it must comply with the procedures set forth in ***Attachment C - Contract Form***.

7.2.2.7.2. Subcontractor contracts may not be structured to provide financial or other incentives to Providers and Subcontractors for denying, reducing or limiting Medically Necessary services.

7.2.2.7.3. The use of "gag" clauses in subcontracts is prohibited.

7.2.2.8. The Contractor must monitor the Subcontractor's performance on an ongoing 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 Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractor must take corrective action.

7.2.2.9. The Contractor must notify the State, in writing, immediately upon notifying any Subcontractor of the Contractor's intention to terminate any such subcontract.

### 7.2.3. Policies and Procedures

7.2.3.1. Written policies and procedures must be developed by the Contractor to provide a clear understanding of the program and its operations to the Contractor's staff, the State, other Vendors of the State, and the Providers (Network and Out-of-Network).

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

7.2.3.3. The State must be provided with an electronic copy of the Contractor Policy and Procedure Manual, including any exhibits, attachments or other documentation included as part of the Contractor Policy and Procedure Manual. The State reserves the right to review and reject any policies or procedures believed to be in violation of federal or state law.

### 7.2.4. Contractor's Marketing Materials and Activities

7.2.4.1. All Marketing activities must be conducted in accordance with 42 CFR 438.104. The Contractor may develop Marketing Materials for distribution throughout the Contract Year. The Contractor must request and obtain permission from the State to distribute Marketing Materials or to implement an advertising campaign. The State will only review Marketing Material once per Contract Year. Marketing Materials must be submitted to the State for review and approval a minimum of sixty (60) Calendar 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 Contractor marketing materials pursuant to 42 CFR 438.104(c), the State has the sole authority to approve or disapprove Marketing Materials (including updates to existing materials), distribution and advertising campaigns.

7.2.4.2. The Contractor may not distribute, in any manner, Marketing Materials related to the managed care program without the prior written approval of the State. This includes any updates to previously approved materials. If State approval is granted, the Contractor must distribute the Marketing Materials to its entire service area to ensure that, before

enrolling, the Potential Member receives the accurate oral and written information that he/she needs to make an informed decision regarding whether to enroll with the Contractor.

- 7.2.4.3. The Contractor may not seek use of approved Marketing Materials to influence enrollment in conjunction with the sale or offering of any private insurance. The Contractor may not, directly or indirectly, engage in door-to-door, telephone, email, texting or other Cold-Call Marketing activities.
- 7.2.4.4. The Contractor must provide the methods by which it intends to assure the State that Marketing, including plans for such activities and Marketing Materials, is accurate and does not mislead, confuse, or defraud Members, Potential Members, or the State. Statements that will be considered inaccurate, false, or misleading include but are not limited to any assertion or statement that:
  - 7.2.4.4.1. The Member or Potential Member must enroll with the Contractor in order to obtain benefits or in order not to lose benefits; or
  - 7.2.4.4.2. The Contractor is endorsed by CMS, the federal or state government, or similar entity.

#### 7.2.5. Member Advisory Committee

In accordance with 42 CFR 438.110, the Contractor must establish and maintain a Member advisory committee pertaining to the provision of long term services and supports, as the Contract includes Personal Care Services and Home Health Services. The composition of the Member advisory committee must be consistent with 42 CFR 438.110(b).

#### 7.2.6. Participation in Meetings and Consortium Activities

- 7.2.6.1. The Contractor's senior staff and other key staff as identified by the Contractor must participate in all designated key meetings scheduled by the State. The purpose of these meetings includes, but is not limited to, contract compliance, the State auditing functions and responsibilities, access to care, program and service delivery, quality, and any other applicable issues concerning administration and management of the Contract. 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 State administrative offices in Carson City or a site in Las Vegas. It is the sole responsibility of the State to provide reasonable advanced notice of such meetings, including location, time, date, and agenda items for discussion.
- 7.2.6.2. The Contractor must participate in meetings with the State and county or state-level consortiums focused on mental health or other health

conditions or services. These meetings may involve presentation of managed care performance data or other programmatic aspects of the managed care program of interest to the State and the consortium. These reports include, without limitation, information on health equity, social determinants of health, and other information as specified by the State and/or the consortium.

### **7.3. ENROLLMENT AND DISENROLLMENT REQUIREMENTS AND LIMITATIONS**

#### **7.3.1. General Information and Requirements**

- 7.3.1.1. The Medicaid and Nevada Check Up eligibility determination and redetermination functions and managed care program enrollment functions are the responsibility of the DWSS and the DHCFP.
- 7.3.1.2. The Contractor must accept each individual who is enrolled in or assigned to the Contractor by the State or its fiscal agent and for whom a Capitation Payment has been made or will be made by the State to the Contractor.
- 7.3.1.3. The Contractor 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). See Section 7.3.3, Managed Care Voluntary Populations, for populations subject to voluntary enrollment in the managed care program.
- 7.3.1.4. The Contractor must accept Recipients eligible for enrollment in the order in which they apply without restriction, up to the limits set under the Contract, were such limits to be established by the State, per 42 CFR 438.3(d)(1). The Contractor will accept as enrolled all Members appearing on monthly enrollment reports.
- 7.3.1.5. The Contractor must have written policies and procedures for receiving monthly updates from the State of Members enrolled in, and disenrolled from the Contractor, and other updates pertaining to these Members or Recipients. The updates will include those newly enrolled with the Contractor. The Contractor must incorporate these updates into its management information system.
- 7.3.1.6. Per 42 CFR 438.3(d)(3)-(4) the Contractor will not, on the basis of health status or need for health services, discriminate against Recipients eligible to enroll. The Contractors will not deny the enrollment nor discriminate against any Medicaid or Nevada Check Up Recipients eligible to enroll based on race, color, national origin, sex, sexual orientation, gender identity, or disability, and will not use any policy or practice that has the effect of discrimination based on race, color, national origin, sex, sexual orientation, gender identity, or disability.
- 7.3.1.7. Change in a Member's Status

7.3.1.7.1. Within seven (7) Calendar Days of becoming aware of any change in a Member's status that may impact Medicaid or Nevada Check Up eligibility or enrollment in the managed care program, including changes in family size, change of residence, or death, the Contractor must electronically report the change(s) to the State via the Provider supplied data file.

7.3.1.7.2. The Contractor must notify a Member that any change in status, including family size and residence, must be immediately reported by the Member to their DWSS eligibility worker.

### 7.3.2. Managed Care Mandatory Populations

Enrollment in a Contractor is mandatory for FMC, NCU, and AO Recipients, when there is more than one managed care option from which to choose in a particular geographic service area.

### 7.3.3. Managed Care Voluntary Populations

The following populations are subject to voluntary enrollment in the managed care program:

7.3.3.1. Eligible Indians who are eligible as Nevada Medicaid or CHIP Recipients may choose to opt out of managed care.

7.3.3.2. Pursuant to the Medicaid State Plan, Medicaid Recipients have the option of disenrolling from managed care if determined to be a Child with Special Health Care Needs (CSHCN) or SED. The Contractor may not encourage a Member who is deemed to be a CSHCN or have SED to disenroll. However, during the Contract Term, the State may, at its sole discretion, remove the option for SED Medicaid Recipients to be voluntarily disenrolled from managed care in the future.

### 7.3.4. Managed Care Excluded Populations

The populations in this section are excluded from enrollment in the Medicaid and Nevada Check Up managed care program.

7.3.4.1. Medicaid Recipients in Child Welfare and Foster Care.

7.3.4.2. Recipients receiving services in an Intermediate Care Facility with Intellectual Disabilities.

7.3.4.3. Recipients receiving services in a Nursing Facility (NF) for more than one hundred eighty (180) Calendar Days. The Contractor must notify the State on the one hundred eighty-first (181) Calendar Day that the Member is to be disenrolled. The Recipient will be disenrolled from the

Contractor and the stay will be covered by FFS commencing on the one hundred eighty-first (181) Calendar Day of the facility stay.

7.3.4.4. Recipients admitted to a Swing Bed Stay in an Acute Care Hospital over forty-five (45) Calendar Days. The Contractor must notify the State by the fortieth (40th) Calendar Day of any swing bed stay expected to exceed forty-five (45) Calendar Days. The Member will be disenrolled from the Contractor and the stay will be covered by FFS commencing on the forty-sixth (46th) Calendar Day of the facility stay.

7.3.4.5. Recipients receiving Hospice services. Once admitted into hospice care, Members will be disenrolled immediately. Nevada Check Up Members will not be disenrolled, however payment for Nevada Check Up hospice services will be carved out and FFS should be billed.

7.3.4.6. Recipients enrolled in a 1915(c) Home and Community Based Services waiver program.

### 7.3.5. Auto-Assignment Algorithm

7.3.5.1. For Potential Members who do not select a Contractor or who are not automatically assigned to a Contractor based on family or previous history, the State will use an auto-assignment algorithm to assign the Potential Member to a Contractor based on the Contractor's capacity to accept new Members according to the algorithms described in this section. The State has the sole authority for determining the methodology and criteria used for the auto-assignment of Members and can change the algorithm at any time. The State will notify the Contractor in writing annually, through an auto-assignment methodology communication, of any changes to the methodology, quality measures, benchmarks or other elements included in the algorithm.

#### 7.3.5.2. Initial Member Auto-Assignment

Member enrollment for implementation of the initial Contract Year will prioritize equitable distribution of membership across Contractors by region. The design of the auto-assignment process for January 1, 2022, includes the following elements:

7.3.5.2.1. Enrollment in any one Contractor will be limited to no more than the following total percentage of Members residing in the region depending on the number of Contractors selected from the procurement:

Two (2) Contractors:	Sixty percent (60%)
Three (3) Contractors:	Forty percent (40%)
Four (4) Contractors:	Thirty percent (30%)

7.3.5.2.2. An incumbent Contractor with membership larger than the limit consistent with the number of Contractors selected as specified in Section 7.3.5.2.1 will have Members transferred to another Contractor.

7.3.5.2.3. Auto-assignment will prioritize the Contractor with the lowest Member enrollment until membership across Contractors is within ten percent (10%) of the enrollment for other Contractors. Once auto-assignment is within ten percent (10%), the head of household will be assigned on a rotating basis.

7.3.5.2.4. Members, regardless of whether auto-assignment resulted in a change in Contractor, will have a ninety (90) Calendar Day without cause disenrollment period.

7.3.5.3. Auto-Assignment after Initial Member Auto-Assignment through December 31, 2023

7.3.5.3.1. After initial Member auto-assignment as described in Section 7.3.5.2, the State will assign Members with a weighted preference to Contractor(s) based on level of membership. The State will follow the percentages in the following table based on number of Contractors in the managed care program and membership:

Number of Contractors	Percentage Assigned to Largest	Percentage Assigned to Second Largest	Percentage Assigned to Third Largest	Percentage Assigned to Fourth Largest
Two	34%	66%	N/A	N/A
Three	17%	33%	50%	N/A
Four	10%	10%	30%	50%

7.3.5.3.2. Once membership is within ten percent (10%) across Contractors, heads of household will be assigned on a rotating basis.

7.3.5.4. Auto-Assignment after December 31, 2023

7.3.5.4.1. Member auto-assignment after December 31, 2023, will be based on Contractor performance on selected quality measures with preference given to high performing Contractors. Measure domains intended for auto-assignment during Contract Year 2024 are Contractor performance in maternal and child health outcomes and reductions in inappropriate hospitalizations during Contract Year 2022.

7.3.5.4.2. The State will provide a written communication to Contractors on an annual basis, no later than December 31 of each calendar year that addresses the following:

7.3.5.4.2.1. The quality measures selected for use in the auto-assignment algorithm;

7.3.5.4.2.2. Any benchmarks selected to measure Contractor performance;

7.3.5.4.2.3. The Contractor's performance on the selected quality measures compared to the selected benchmarks or compared to other Contractors; and

7.3.5.4.2.4. The Contractor's associated percentage of auto-assignment for the next Contract Year.

#### 7.3.6. Enrollment for Newly Eligible Medicaid or Nevada Check Up Recipients

Newly approved Medicaid and Nevada Check Up Recipients who have never been eligible in either program who are not joining an existing case will have the opportunity to select their Contractor of choice at the time of application, or any time prior to the approval of their application. Absent a choice, the State will select a Contractor for the Recipients using the auto-assignment algorithm that applies to the Contract Year as described in Section 7.3.5, Auto-Assignment Algorithm.

#### 7.3.7. Enrollment of Newborns

7.3.7.1. The Contractor is required to report births electronically on a weekly basis to the State's fiscal agent.

##### 7.3.7.2. Medicaid Eligible Newborns

The Contractor is responsible for Medicaid newborns as of the date of birth, provided the mother was actively enrolled or retroactively enrolled at the date of birth.

##### 7.3.7.3. Nevada Check Up Newborns

7.3.7.3.1. The Head of Household/Mother must notify the DWSS of the newborn within fourteen (14) Calendar Days following the delivery in order to qualify to receive coverage from the date of birth.

7.3.7.3.2. If the family of the newborn is a Nevada Check Up family currently receiving coverage from the Contractor for a sibling of the newborn, the newborn is qualified to receive coverage from the date of birth, and is eligible for Nevada

Check Up, the Contractor will receive a Capitation Payment and provide coverage for the month of birth. The Contractor will also receive a Capitation Payment and provide coverage for all subsequent months that the child remains enrolled with the Contractor. If notification is not received as required herein, the newborn will be enrolled as of the first day of the next administrative month from the date of notification.

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

### 7.3.8. Contractor's Responsibility for Members Upon Enrollment

7.3.8.1. The Contractor will be responsible for Members as soon as they are enrolled and the Contractor is aware of the Member in treatment. The Contractor must have policies and procedures including, without limitation, the following to ensure a Member's smooth transition from FFS to the Contractor:

7.3.8.1.1. Members with medical conditions such as:

7.3.8.1.1.1. Pregnancy (especially if high risk);

7.3.8.1.1.2. Major organ or tissue transplantation services in process;

7.3.8.1.1.3. Terminal illness;

7.3.8.1.1.4. Intractable pain; and/or

7.3.8.1.1.5. Behavioral or Mental Health conditions.

7.3.8.1.2. Members who, at the time of enrollment, are receiving:

7.3.8.1.2.1. Chemotherapy and/or radiation therapy;

7.3.8.1.2.2. Significant outpatient treatment or dialysis;

7.3.8.1.2.3. Prescription medications or DME;

7.3.8.1.2.4. Behavioral Health Services;

7.3.8.1.2.5. Long Term Services and Supports, such as but not limited to, Personal Care Services and/or Home Health Services; or

7.3.8.1.2.6. Other services not included in the Medicaid State Plan but covered by Medicaid under EPSDT for children.

7.3.8.1.3. Members who, at enrollment:

7.3.8.1.3.1. Are scheduled for inpatient surgery(s);

7.3.8.1.3.2. Are currently in the hospital;

7.3.8.1.3.3. Have prior authorization approval for procedures and/or therapies for dates after their enrollment, to honor these prior authorizations; and/or

7.3.8.1.3.4. Have post-surgical follow-up visits scheduled after their enrollment.

### 7.3.9. Automatic Reenrollment

The Contractor assignment of returning Members, those who have been eligible for Medicaid or Nevada Check Up in the past but lost that eligibility, will vary depending on their length of ineligibility.

7.3.9.1. Those returning Members who were ineligible for two (2) months or less will be returned to their former Contractor except in the event that their loss of eligibility caused them to miss the Open Enrollment period.

7.3.9.2. Those returning Members who were ineligible for more than two (2) months will be treated the same as those newly approved Medicaid and Nevada Check Up Recipients who have never been eligible in either program as described as described in Section 7.3.6.

7.3.9.3. Recipients who have retained their Medicaid or Nevada Check Up eligibility, but have lost their managed care enrollment for any period of time, will be treated the same as those newly approved Medicaid and Nevada Check Up Recipients who have never been eligible in either program, as described in Section 7.3.6.

### 7.3.10. Disenrollment

Disenrollment procedures are pursuant to 42 CFR 438.56(d) as set forth in this section.

7.3.10.1. Disenrollment or Change of Contractor at the Request of the Member

- 7.3.10.1.1. The State will hold an Open Enrollment period at least once every twelve (12) months. The Open Enrollment period will occur in the month of October each Contract Year for enrollments effective January of the following Contract Year. During Open Enrollment, Members are free to change Contractors or to remain with their current Contractor. The State shall, through its fiscal agent, provide for notice to each Member of the opportunity to terminate (or change) enrollment. Such notice will be provided at least sixty (60) Calendar Days before each Open Enrollment period.
- 7.3.10.1.2. Members who are newly approved for Medicaid and Nevada Check Up, Members who lost eligibility for more than two (2) months, and Members who retained their Medicaid or Nevada Check Up eligibility, but who lost their Contractor enrollment for any period of time will be allowed to change their Contractor within the first ninety (90) Calendar Days of enrollment without cause. These Members must submit their request in writing to the State's fiscal agent to request this change.
- 7.3.10.1.3. If a Member is enrolled with a new Contractor through auto-assignment, selection during Open Enrollment, or due to an approved good cause disenrollment request (see Section 7.3.10.1.4), the Member will be allowed to change their Contractor within the first ninety (90) Calendar Days of enrollment without cause. If the Member exercises this right and returns to a Contractor of previous enrollment, the without cause change period does not apply, see 42 CFR 438.56(c)(2)(i). Members must submit this change request to the State's fiscal agent.
- 7.3.10.1.4. Any Member may request to switch Contractors for cause at any time. These Members must contact their current Contractor orally or in writing for permission to disenroll and follow up with the Disenrollment Form in ***Attachment L – Disenrollment Form***, and if approved, they will be allowed to choose from the remaining Contractors. If there is only one other Contractor, the Member will be automatically assigned to that Contractor. Should the Contractor refuse the disenrollment due to a lack of good cause, the Member can then appeal the decision first through the Contractor's Appeals process and may be escalated to the State Fair Hearing process. Switching Contractors to access a particular facility or Provider will generally not be considered good cause. Good cause for disenrollment as defined in 42 CFR 438.56(d)(2) includes:

- 7.3.10.1.4.1. The Member moves outside the Contractor's service area.
- 7.3.10.1.4.2. The Contractor does not, because of moral or religious objections cover the services the Member seeks.
- 7.3.10.1.4.3. The Member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the Member's PCP or another Provider determines that receiving the services separately would subject the Member to unnecessary risk.
- 7.3.10.1.4.4. Members that use LTSS must be allowed to request disenrollment if the Provider's change in status from a Network Provider to an Out-of-Network Provider with the Contractor would cause the Member to have to change their residential, institutional, or employment supports Provider, and, as a result, the Member would experience a disruption in their residence or employment.
- 7.3.10.1.4.5. Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the Contract, lack of access to Providers experienced in dealing with the Member's health care needs or when the State imposes intermediate sanctions, as described in 42 CFR 438.702(a)(3) and if the State has notified the Contractor it intends to terminate their Contract.
- 7.3.10.1.5. If the State receives a request directly from the Member, the Member will be directed to begin the process by requesting disenrollment through their Contractor.
- 7.3.10.1.6. If the Contractor determines that there is sufficient cause to disenroll, the Contractor will notify the State by using the form supplied. The Contractor must make a determination as expeditiously as the Member's health requires and within a timeline that may not exceed fourteen (14) Calendar Days following receipt of the request for disenrollment. The State will notify the

State's Fiscal Agent to effect the disenrollment at the first of the next administrative month.

7.3.10.1.7. If the Contractor denies the request for disenrollment for lack of good cause, the Contractor must send a Notice of Decision in writing to the Member upon the date of the decision. Appeal rights must be included with the Notice of Decision. The Contractor is required to inform the Member of their right to first Appeal through the Contractor and if the Appeal is denied to request a State Fair Hearing, how to obtain such a hearing, and representation rules must be explained to the Member and provided by the Contractor pursuant to 42 CFR 438.10(g)(1). The State ensures access to State Fair Hearing for any Member dissatisfied with a determination that there is not good cause for disenrollment.

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

7.3.10.1.9. If the Contractor approves the disenrollment through the Grievance process, the State agency is not required to make a determination. If the Contractor cannot make a determination, the Contractor may refer the request to the State. If the State determines there is not good cause for disenrollment, the Member will be given access to the State Fair Hearing process.

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

#### 7.3.10.2. Disenrollment at the Request of the Contractor

7.3.10.2.1. The Contractor may request disenrollment of a Member if the continued enrollment of the Member seriously impairs the Contractor's ability to furnish services to either the particular Member or other Members or the Member relocated his or her residence outside the Contractor's service area. In addition, the Contractor must confirm the Member has been referred to the Contractor's Member Services Department and has either refused to comply with the referral or refused to act in good faith to attempt

to resolve the problem. Prior approval by the State of a Contractor's request for the Member's disenrollment is required. The State will make a determination on such a request within ten (10) Business Days. If approval is granted, the Member will be given notice by the Contractor that disenrollment will occur effective the next administratively possible month, after the Member is given State Fair Hearing rights to Appeal the decision.

- 7.3.10.2.2. In the event the State fails to make a disenrollment determination within the timeframes specified, the disenrollment will be considered approved.
- 7.3.10.2.3. A Contractor may not request disenrollment of a Member for any of the following reasons:
  - 7.3.10.2.3.1. An adverse change in the Member's health status;
  - 7.3.10.2.3.2. The Member's Pre-existing medical condition;
  - 7.3.10.2.3.3. The Member's utilization of medical services;
  - 7.3.10.2.3.4. The Member's diminished mental capacity;
  - 7.3.10.2.3.5. Uncooperative or disruptive behavior resulting from the Member's special needs (except when continued enrollment of such a Member seriously impairs the Contractor's ability to furnish services to either the particular Member or other Members);
  - 7.3.10.2.3.6. The Member's attempt to exercise Grievance or Appeal rights; or
  - 7.3.10.2.3.7. Based on the Member's national origin, creed, color, sex, religion, or age.
- 7.3.10.2.4. If the Member was previously disenrolled from the Contractor as the result of a Grievance filed by the Contractor and has not lost their Medicaid or Nevada Check Up eligibility for more than two (2) months or maintained their eligibility, but moved out of the Geographic service area, the Member will not be re-enrolled with the Contractor unless the Member wins an appeal of the disenrollment. The Member may be

enrolled with another Contractor. Members may be enrolled with the Contractor to the extent they are treated as a newly approved Medicaid or Nevada Check Up Recipient.

#### 7.3.10.3. Timing of Disenrollment

7.3.10.3.1. Enrollment in a different Contractor due to without cause disenrollment requests is effective at the first of the next administrative month. Enrollment in a different Contractor due to for cause disenrollment requests will be effective no later than the first day of the second administrative month following the month in which the Member requests disenrollment or the Contractor refers the disenrollment to the State.

7.3.10.3.2. If a Nevada Medicaid (Title XIX) or Nevada Check Up (Title XXI) eligible Indian Member elects to disenroll from the Contractor, the disenrollment will commence no later than the first day of the second administrative month after which all covered Medically Necessary services will be reimbursed by FFS.

### **7.4. COVERED MEDICAL SERVICES AND LIMITATIONS**

#### 7.4.1. General Requirements

7.4.1.1. The Contractor must provide, either directly or through Subcontractors, the managed care benefit package, as described in this Contract, to Members to ensure all Medically Necessary services covered under the Medicaid and CHIP State Plans are available and accessible to them. The Medicaid and CHIP State Plans can be accessed on the State's website at <http://dhcftp.nv.gov/Resources/AdminSupport/Manuals/Manuals/>.

7.4.1.2. The Contractor's benefits package provided to Members, for those Covered Services covered under this Contract, shall not be less in amount, duration, and scope than those Covered Services specified in the respective State Plans for Medicaid and CHIP programs and the Nevada Medicaid Service Manual (MSM), but may be more than stated therein. Any changes in Medicaid or CHIP benefit amounts, duration, or scope will be preceded by the State's review of impact on Capitation Payments.

#### 7.4.2. Contractor's Coverage of Medicaid and CHIP State Plan Services

This section sets forth the list of Covered Services and any requirements or limitations specific to the covered service that may or may not otherwise be specified in the MSM.

- 7.4.2.1. At a minimum, the Contractor must provide directly, or through a Subcontractor, all covered Medically Necessary services, Provider types and locations, which shall include but may not be limited to the following:
- 7.4.2.1.1. Advanced Practice Registered Nurse;
  - 7.4.2.1.2. Applied Behavior Analysis;
  - 7.4.2.1.3. Alcohol and Substance Abuse Treatment, including Intensive Outpatient Treatment;
  - 7.4.2.1.4. Ambulatory Surgery Centers;
  - 7.4.2.1.5. Audiology;
  - 7.4.2.1.6. Chiropractor (for Members eligible for EPSDT);
  - 7.4.2.1.7. Certified Community Behavioral Health Centers (CCBHCs);
  - 7.4.2.1.8. Community Paramedicine;
  - 7.4.2.1.9. Dental and Dental Related Services for emergency and palliative care that is provided in an emergent or urgent care setting;
  - 7.4.2.1.10. Disposable Medical Supplies;
  - 7.4.2.1.11. Durable Medical Equipment;
  - 7.4.2.1.12. Early Periodic Screening, Diagnosis and Treatment (see Section 7.4.2.6);
  - 7.4.2.1.13. Emergency Transportation;
  - 7.4.2.1.14. End Stage Renal Disease Facilities and Hospitals;
  - 7.4.2.1.15. Family Planning Services;
  - 7.4.2.1.16. Free Standing Birth Centers/Obstetric Centers;
  - 7.4.2.1.17. Hearing Aid Dispenser and Related Supplies
  - 7.4.2.1.18. Home Health Agency;
  - 7.4.2.1.19. Hospital Inpatient;
  - 7.4.2.1.20. Hospital Outpatient;

- 7.4.2.1.21. Inpatient Medical Rehabilitation Specialty Hospital;
- 7.4.2.1.22. Long Term Acute Care Hospital;
- 7.4.2.1.23. Intravenous Therapy (TPN);
- 7.4.2.1.24. Laboratory – Pathology/Clinical;
- 7.4.2.1.25. Mental Health Services
  - 7.4.2.1.25.1. Inpatient Psychiatric Hospital;
  - 7.4.2.1.25.2. Inpatient Psychiatric Services;
  - 7.4.2.1.25.3. Mental Health Outpatient Clinic;
  - 7.4.2.1.25.4. Mental Health Rehabilitative Treatment;
  - 7.4.2.1.25.5. Psychologist;
  - 7.4.2.1.25.6. Outpatient Psychiatric;
  - 7.4.2.1.25.7. Residential Treatment Centers (RTC);
  - 7.4.2.1.25.8. Care Management;
  - 7.4.2.1.25.9. Medication Management;
- 7.4.2.1.26. Methadone Treatment;
- 7.4.2.1.27. Nursing Facilities, stays no longer than one hundred eighty (180) Calendar Days (see Section 7.4.6.10);
- 7.4.2.1.28. Certified Registered Nurse Anesthetist;
- 7.4.2.1.29. Nurse Midwife;
- 7.4.2.1.30. Opticians/Optometrists;
- 7.4.2.1.31. Outpatient Surgery;
- 7.4.2.1.32. Personal Care Aide;
- 7.4.2.1.33. Pharmacy (see Section 7.4.2.12);
- 7.4.2.1.34. Physician/Osteopath;
- 7.4.2.1.35. Physician Assistants;
- 7.4.2.1.36. Podiatrist;

- 7.4.2.1.37. Private Duty Nursing;
- 7.4.2.1.38. Prosthetics;
- 7.4.2.1.39. Radiology and Noninvasive Diagnostic Centers;
- 7.4.2.1.40. Registered Dieticians;
- 7.4.2.1.41. Residential Treatment Centers;
- 7.4.2.1.42. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs);
- 7.4.2.1.43. Special Clinics (e.g., Comprehensive Rehabilitation Facility, Genetics, Family Planning, Methadone Public Health Clinic, Community Health Clinic (State Health Division), School Based Health Centers, Special Children’s Clinic, TB Clinic, HIV, Substance Abuse Agency Model);
- 7.4.2.1.44. Swing Bed Stays, under forty-five (45) days;
- 7.4.2.1.45. Therapy
  - 7.4.2.1.45.1. Occupational;
  - 7.4.2.1.45.2. Physical;
  - 7.4.2.1.45.3. Respiratory; and
  - 7.4.2.1.45.4. Speech
- 7.4.2.1.46. Tobacco Cessation;
- 7.4.2.1.47. Transitional Rehabilitative Center;
- 7.4.2.1.48. Transplantation of Medicaid and CHIP State Plan covered organs and tissue, and related immunosuppressant drugs (see limitations at Section 7.4.2.15);
- 7.4.2.1.49. Other services as defined in the Medicaid Services Manual (MSM).

7.4.2.2. Abortions

The Contractor may only cover abortions in the following situations. No other abortions, regardless of funding, can be provided as a benefit under the Contract.

- 7.4.2.2.1. If the pregnancy is the result of an act of rape or incest;
- 7.4.2.2.2. In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

7.4.2.3. Nurse Midwife Services

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

7.4.2.4. Emergency Services

7.4.2.4.1. The Contractor must provide emergency coverage twenty-four (24) hours per day, seven (7) days per week. The Contractor must have written policies and procedures describing how Members and Providers can obtain urgent coverage and Emergency Services after business hours and on weekends. Policies and procedures must include provision of direct contact with qualified clinical staff. Urgent coverage means those problems, which, though not life threatening, could result in serious injury or disability unless medical attention is received.

7.4.2.4.2. The Contractor must cover and pay for Emergency Services both in and out of state regardless of whether the Provider who furnished the services has a contract with the Contractor. The Contractor must pay the Out-of-Network Provider for Emergency Services, applying the "prudent layperson" definition of an emergency, rendered at a rate no more than the FFS rate.

7.4.2.4.3. No prior or post-authorization can be required for emergency care provided by either Network or Out-of-Network Providers. The Contractor may not deny payment for treatment obtained when the Member has an Emergency Medical Condition and seeks Emergency Services, applying the "Prudent Layperson" definition of an emergency. This includes the prohibition against denying payment in those instances in which the absence of immediate medical

attention would have resulted in placing the health of the Member in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily part or organ. The Contractor may not deny payment for Emergency Services treatment when a representative of the Contractor instructs the Member to seek Emergency Services care.

- 7.4.2.4.4. Pursuant to 42 CFR 438.114, the Contractor may not limit what constitutes an Emergency Medical Condition as defined in this section on the basis of lists of diagnoses or symptoms, nor refuse to cover Emergency Services based on the emergency room Provider, hospital, or fiscal agency not notifying the Member's PCP, Contractor, or the State of the Member's screening and treatment within ten (10) Calendar Days of the presentation for Emergency Services.
- 7.4.2.4.5. A Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member. The Contractor is responsible for coverage and payment of services until the attending physician or the Provider actually treating the Member determines that the Member is sufficiently stabilized for transfer or discharge and that determination is binding on the Contractor.
- 7.4.2.4.6. 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.
- 7.4.2.4.7. Public Crisis Teams and Providers of Crisis Intervention services render Emergency Services to Members experiencing a Behavioral Health crisis. These services involve immediate and intensive interventions designed to help stabilize the Member and ensure stabilization, such as situational risk-of-harm assessments; follow-up and debriefing sessions to ensure stabilization and continuity of care; and identification of referral sources for ongoing community Behavioral Health Services. The Contractor must not require prior authorization for these services and must cover and pay for such services regardless of the Provider's status with the Contractor.

7.4.2.5. Post-Stabilization Services

- 7.4.2.5.1. The Contractor is financially responsible for post-stabilization services obtained within or outside the Network that are pre-approved by a Network Provider or Contractor representative.
- 7.4.2.5.2. Post-stabilization services obtained within or outside the Network that are not pre-approved by a Network Provider or other Contractor representative, but are administered to maintain, improve, or resolve the Member's stabilized condition if the Contractor does not respond to a request for pre-approval within one (1) hour, the Contractor cannot be contacted, or the Contractor and the treating physician cannot reach an agreement concerning the Member's care and a Network Provider or other Contractor representative is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a Network physician and the treating physician may continue with care of the Member until a Network Provider is reached or one of the criteria in 42 CFR 438.114(e) and 42 CFR 422.113 is met.
- 7.4.2.5.3. Pursuant to 42 CFR 438.114(e) and 42 CFR 422.113, the Contractor's financial responsibility for post-stabilization care it has not pre-approved ends when a Network physician with privileges at the treating hospital assumes responsibility for the Member's care, a Network physician assumes responsibility for the Member's care through transfer, the Contractor and the treating physician reach an agreement concerning the Member's care, or the Member is discharged.
- 7.4.2.5.4. The Contractor must pay the Out-of-Network Provider of post stabilization services rendered at a rate limited to the amount that would have been paid if the service had been provided under the State's FFS Medicaid program, unless a lower amount is mutually agreed to between the Contractor and the party(ies) rendering service. Pursuant to 42 CFR 438.114(e), 42 CFR 422.113(c), and 42 CFR 422.214, an Out-of-Network Provider of post stabilization services must accept as payment in full no more than it would receive if the services were provided under the state's FFS Medicaid program.

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

- 7.4.2.6.1. The Contractor as applicable will be required to conduct EPSDT screenings of its Members under the age of twenty-one (21) years. The screening must meet the EPSDT requirements found in the MSM Chapter 1500; as well as sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act, and 42 CFR 441.50 through 441.62. The Contractor must conduct all interperiodic screening on behalf of Members, as defined in MSM Chapter 1500.
- 7.4.2.6.2. 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 section 1905 of the Act. For Title XIX children, the Contractor is responsible for reimbursement of all Medically Necessary services under EPSDT whether or not the service is in the Medicaid State Plan. The Contractor is responsible for the oral examination component of the EPSDT physical exam and Referral to a dental Provider, as per the dental periodicity schedule or when Medically Necessary. EPSDT and Well Baby/Well Child follows recommendations set forth by the American Academy of Pediatrics and Bright Futures for preventative pediatric health care. The Contractor is responsible for the coordination of care in order to ensure all Medically Necessary coverage is provided under EPSDT. The services which need to be provided through the Contractor include, but are not limited to, the following in accordance with section 1905(r) of the Act and the MSM Chapter 1500:
- 7.4.2.6.2.1. EPSDT screens (for Nevada Medicaid Members) and Well baby/Well child screens (for Nevada Check Up Members) are basically one and the same and are billed using the same codes with the same reimbursement. The Contractors are not required to pay for any treatments outside of the CHIP State Plan for Nevada Check Up Members.
  - 7.4.2.6.2.2. Screening services which include a comprehensive health and developmental history (including assessment of both physical and mental health development);
  - 7.4.2.6.2.3. A comprehensive, unclothed physical exam;

- 7.4.2.6.2.4. Age-appropriate vaccinations (according to current American Committee on Immunization Practices (ACIP) schedule);
  - 7.4.2.6.2.5. Laboratory tests (including blood lead level assessment appropriate to age and risk as directed by current federal requirements);
  - 7.4.2.6.2.6. Health education;
  - 7.4.2.6.2.7. Vision services;
  - 7.4.2.6.2.8. Dental services Referrals;
  - 7.4.2.6.2.9. Hearing services; and
  - 7.4.2.6.2.10. Other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State Plan.
- 7.4.2.6.3. The Contractor is not required to provide any items or services determined to be unsafe or ineffective, or which are considered experimental. However, as long as there are peer reviewed studies showing the treatment to be effective in the case, this provides the basis for approval as non-experimental. Appropriate limits may be placed on EPSDT services based on Medical Necessity.
- 7.4.2.6.4. The Contractor is required to provide information and perform outreach activities to Members eligible for EPSDT services. These efforts may be reviewed and audited by the State or its designee. Refer to the MSM, federal documents cited in this section and Information Requirements of the Contract.
- 7.4.2.6.5. The Contractor must ensure Providers perform a full EPSDT visit according to the periodic schedule approved by the State and the American Academy of Pediatrics periodicity schedule. The visit must include a comprehensive history, unclothed physical examination, appropriate immunizations, lead screening and testing per CMS requirements at Sections 1902(a)(43) and 1905(a)(4)(B) of the Act and 42 CFR 441.50-441.62, and health education/anticipatory guidance. All five 95)

components must be performed for the visit to be considered an EPSDT visit.

7.4.2.6.6. The Contractor must develop an EPSDT Plan that includes written policies and procedures for conducting outreach and education, tracking and follow-up to ensure compliance with the EPSDT periodicity schedules. The EPSDT Plan must emphasize outreach and compliance monitoring taking into account the multi-lingual, multi-cultural nature of the served population, as well as other unique characteristics of this population. The EPSDT Plan must include procedures for follow-up of missed appointments, including missed Referral appointments identified through EPSDT screens and exams and follow-up on any abnormal screening exams. The EPSDT Plan must also include procedures for Referral, tracking, and follow up for annual dental examinations and visits, upon receipt of dental claim information from the State. The EPSDT Plan must consider and be consistent with current policy statements issued by the American Academy of Pediatrics and the American Academy of Pediatric Dentists to the extent that such policy statements relate to the role of the PCP in coordinating care for infants, children and adolescents. The Contractor must submit its EPSDT Plan to the State for review and approval ninety (90) Calendar Days prior to the Go-Live date and annually sixty (60) Calendar Days prior to the first day of each Contract Year.

#### 7.4.2.7. Family Planning Services

7.4.2.7.1. The Contractor is prohibited from restricting the Member's free choice of Family Planning Services, supplies, and Providers. Federal regulations grant the right to any Member of childbearing age to receive Family Planning Services from any qualified Provider, even if the Provider is not part of the Contractor's Network. The Contractor may not require family planning services to be prior authorized. Family Planning Services are provided to Members who want to control family size or prevent unwanted pregnancies. Family Planning Services may include education, counseling, physical examinations, birth control pills, intrauterine devices, implants, injections, patches, rings, diaphragms, condoms, and other birth control supplies.

7.4.2.7.2. Pursuant to MSM Chapter 600, tubal ligations and vasectomies are included for Members twenty-one (21) years of age or older. Tubal ligations and vasectomies to permanently prevent conception are not covered for any

Member under the age of twenty-one (21) or any Member who is adjudged mentally incompetent or is institutionalized. Hysterectomy is not a covered Family Planning Service.

7.4.2.7.3. At a minimum, the Contractor must reimburse qualified Out-of-Network Providers for Family Planning Services rendered to its Members at the FFS rate paid by the State. The Contractor will be responsible for coordinating and documenting Out-of-Network family planning services provided to its Members and the amounts paid for such services.

7.4.2.8. Federally Qualified Health Center and Rural Health Center (RHC)

The Contractor must pay for services provided by a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC). Contractors may enter into contracts with FQHCs or RHCs provided that payments are at least equal to the amount paid to other Providers for similar services. If the Contractor does not have a contract with an FQHC or RHC, the Contractor must pay at a rate equivalent to the FFS rate. This does not apply to Out-of-Network Providers of Emergency Services. The Contractor must report to the State payments and visits made to FQHCs and/or RHCs. Contractors will be responsible for quarterly reporting on FQHC/RHC activity. FQHCs not contracted with a Contractor must follow the Contractor's Prior Authorization Policy.

7.4.2.9. Vaccinations

7.4.2.9.1. The Contractor must require its Network Providers to enroll and participate in the Vaccines for Children (VFC) Program, which is administered by the DPBH. The Nevada State Immunization Program will review and approve Provider enrollment requests. The Contractor must require VFC enrolled Providers to cooperate with the DPBH for purposes of performing orientation and monitoring activities regarding VFC Program requirements.

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

- 7.4.2.9.3. The Contractor must reimburse the VFC Provider for the administration of vaccinations when vaccines were provided to Members.
- 7.4.2.9.4. The Contractor must ensure age-appropriate vaccinations (according to the current ACIP schedule).
- 7.4.2.9.5. The Contractor must ensure reimbursement of vaccines and vaccine administration fees to Providers that vaccinate the adult population aged nineteen (19) years and older with ACIP recommended vaccines. These vaccines are not provided by the VFC Program.
- 7.4.2.9.6. The Contractor must ensure reimbursement of travel vaccines and vaccine administration fees to Providers that vaccinate any Member of any age with appropriate travel vaccines. These vaccines are not provided by the VFC Program. ACIP also has recommendations on travel vaccines.

#### 7.4.2.10. Laboratory Service Providers

The Contractor must ensure that all laboratory testing sites providing services under this Contract have a valid Clinical Laboratory Improvement Amendments (CLIA) certificate or a waiver of certificate of registration, a CLIA identification number, and comply with CLIA regulations as specified by 42 CFR Part 493. The Contractor shall provide to the State, on request, copies of certificates of any laboratories with which it conducts business. The Contractor must ensure that if a Provider wants to conduct in-office point of care testing, the Contractor must assure the Provider has a CLIA certificate.

#### 7.4.2.11. Pharmacy Services

- 7.4.2.11.1. The State may consider carving the pharmacy benefit out of the Contract during the Contract Term specified in Section 7.1.1; however, the timing and scope of any changes related to the pharmacy benefit under the Contract is subject to legislative review and approval. Prior to implementation of any modification to pharmacy coverage under that Contract that is approved by the Nevada Legislature, the State will amend the Contract to address the Contractor's roles, responsibilities and rights in regard to pharmacy data, transitioning claims and clinical information to the pharmacy benefits manager, and ongoing coordination with the pharmacy benefits manager. The Capitation Rates will be adjusted to remove the pharmacy benefit. Until implementation of the pharmacy benefit carve out, the Contractor must

comply with all requirements pertaining to the coverage and payment of pharmacy services.

- 7.4.2.11.2. The pharmacy benefit is based on the Medicaid and CHIP State Plans and the MSM Chapter 1200. Pharmacy services are included in the Contractor's benefit package. The pharmacy benefit must be administered in a manner that is fully compliant with the federal requirements in 42 CFR 438.3(s). The Contractor is expected to offer pharmacy benefits that mirror or exceed FFS. Pharmacies that process prescription drug claims for Members must be enrolled as a Nevada Medicaid Provider and licensed in good standing by the State Board of Pharmacy.
- 7.4.2.11.3. The Contractor must adopt and adhere to the State's current FFS formulary, available at <https://www.medicaid.nv.gov/providers/rx/pdl.aspx>.
- 7.4.2.11.4. The Contractor is permitted to utilize a preferred specialty pharmacy; however, this pharmacy must be readily accessible to all of the Contractor's Members.
- 7.4.2.11.5. The Contractor must have a policy for transitioning a Member's prescriptions from FFS, or another Contractor, to the Contractor. The Contractor must not terminate a current prescription without consulting with the prescriber. The Contractor must then document the reasons a drug is not Medically Necessary if a current prescription is terminated.
- 7.4.2.11.6. The MSM Chapter 1200 stipulates the conditions with which a prescriber must comply to certify that a specific brand of medication is Medically Necessary for a particular patient. The prescriber should document in the patient's medical record the need for the brand-name product in place of the generic form. Certification must comply with the following: certification must be in the prescriber's own handwriting; certification must be written directly on the prescription blank; and a phrase indicating the need for a specific brand is required. An example would be "Brand Medically Necessary."
- 7.4.2.11.7. Contractors must have a Lock-In program for Members showing drug seeking behaviors that is consistent with the State's Lock-In program and policy for FFS Recipients. These Members are locked-in to a specific pharmacy and/or a specific physician for controlled substances only. They can use any pharmacy for their non-controlled medications. Criteria should include Members utilizing more than one pharmacy or three (3) or more physicians

for controlled substances, repeated ER visits for pain medication, cash payments for drugs or other drug seeking behaviors. Contractors must have a process where Members can change lock-in Providers and have an override policy for instances where their locked in pharmacy is out of stock or the Member is out of area and needs their controlled medication. The Contractor must provide Members appeal rights regarding assignment to the Lock-In Program.

- 7.4.2.11.8. Contractors may not use a standard for determining Medical Necessity that is more restrictive than is used in the Medicaid State Plan and MSM.
- 7.4.2.11.9. The Contractor must submit all pharmacy encounters and outpatient administered drug encounters to the State, or its vendor, and the State shall submit these encounters for rebates from manufacturers. The encounters must be submitted in the format and timeframe specified in Sections 7.12.4.7 and 7.12.4.8. The Contractor agrees to modify the pharmacy claims processing systems to accommodate additional data elements in compliance with current National Council for Prescription Drug Programs (NCPDP) transactions standards and guidelines, such that pharmacy encounters can be submitted by the State for rebates.
- 7.4.2.11.10. The Contractor's medical claims system will mandate Providers submit National Drug Code (NDC) codes and related information necessary for the State to process the claim for rebates. Covered outpatient drugs dispensed to individuals eligible for Members must be subject to the same rebate requirements as the State is subject under Section 1927 of the Act and the State shall collect such rebates from manufacturers. The Contractor must report to the State, on a timely and periodic basis specified by the U.S. Secretary of Health and Human Services (Secretary), information on the total number of units of each dosage form and strength and package size by NDC of each covered outpatient drug dispensed to Members for which the Contractor is responsible for coverage (other than outpatient drugs) and other data as the Secretary determines necessary.
- 7.4.2.11.11. The Contractor will report all claims billed for drugs that were acquired through the 340B drug pricing program using standard identifiers as defined by the State so they can be properly excluded from federal drug rebates. Entities that are identified on the Health Resources and Services Administration (HRSA) website as 340B

Providers must be excluded from rebate invoicing. The Contractor must use claim indicators to identify 340B claims and align with the State's FFS 340B policy.

- 7.4.2.11.12. The Contractor must operate a drug utilization review program for covered outpatient drugs that includes prospective drug review, retrospective drug use review, application of standards and an education program in compliance with the requirements described in Section 1927(g) of the Act and 42 CFR part 456, subpart K.
- 7.4.2.11.13. The Contractor must provide to the State a detailed description and information about its drug utilization review program activities by December 31 of each calendar year for the prior federal fiscal year (October 1 through September 30).
- 7.4.2.11.14. The Contractor must comply with the annual audit requirements specified in NRS 422.4056.
- 7.4.2.11.15. Pursuant to Sec. 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT ACT) the Contractor is required to have a constructed or designed claims review, process, or program that includes:
  - 7.4.2.11.15.1. Safety edits for subsequent fills for opioids and an automated claims review that indicates when a Medicaid Member is prescribed a subsequent fill;
  - 7.4.2.11.15.2. Safety edits on the maximum daily morphine equivalents (MME) that can be prescribed to a Medicaid Member for the treatment of chronic pain and a review process that indicates when an individual is prescribed in excess of that limitation;
  - 7.4.2.11.15.3. An automated claims review process that identifies when a Medicaid Member is concurrently prescribed opioids and benzodiazepines or antipsychotics;
  - 7.4.2.11.15.4. A program to monitor and manage the appropriate use of antipsychotic medications by children the appropriate use of antipsychotic medications by children under 18. Additionally, the Contractor must submit to the State, as part of the annual DUR reporting under Section

1927(g)(3)(D) of the Act, information on activities carried out under this program;

7.4.2.11.15.5. A process to identify potential fraud or abuse of controlled substances by Medicaid Members, Providers prescribing drugs to Members, and pharmacies dispensing drugs to Members; and

7.4.2.11.15.6. The opioid review activities outlined above do not apply with respect to Members who are receiving hospice or palliative care; receiving treatment for cancer; residents of a long-term care facility, a facility described in section 1905(d) of the Act, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy.

#### 7.4.2.12. Pharmacy Benefit Manager (PBM) Agreements

If the Contractor enters into a contract or agreement (hereinafter referred to as ‘PBM Agreement’) with a PBM for the provision and administration of pharmacy services, the PBM agreement must be developed as a pass-through pricing model as defined below. For purposes of this Contract, all requirements applicable to a PBM must also apply to any contract or agreement the Contractor has with a Pharmacy Benefit Administrator (PBA).

7.4.2.12.1. For purposes of this Contract, a pass-through pricing model is defined as a PBM Agreement where all monies related to services provided for the Contractor are passed through to the Contractor, including but not limited to, dispensing fees and ingredient cost paid to pharmacies, and all revenue received, including but not limited to pricing discounts paid to the PBM, rebates, inflationary payments, and supplemental rebates; all payment streams, including any financial benefits such as rebates, discounts, credits, claw backs, fees, grants, chargebacks, reimbursements or other payments that the PBM receives related to services provided for the Contractor are fully disclosed to the Contractor, and provided to the State upon request; and the PBM is paid an administrative fee that covers its cost of providing the PBM services as described in the PBM Agreement as well as margin.

7.4.2.12.2. The payment model for the PBM’s administrative fee must be made available to the State. If concerns are identified, the State reserves the right to request any changes be made to the payment model.

- 7.4.2.12.3. The PBM Agreement must allow for the Contractor to perform a competitive market check every three years or allow the Contractor to annually renegotiate its terms.
- 7.4.2.12.4. The following provisions must be included in any agreement between the Contractor and their PBM:
  - 7.4.2.12.4.1. At least annually, the PBM must hire an independent third party to complete a Service Organization Controls report (SOC-1) audit over the PBM's services and activities. This report must be provided to the Contractor and information from this audit must be made available to the State upon request.
  - 7.4.2.12.4.2. In addition to the SOC-1 audits, the PBM and the Contractor must cooperate with and grant full access to any independent audit entity retained by the State to perform periodic compliance audits of each PBM. These compliance audits would measure the PBM's compliance with any contractual obligations and federal and state requirements. The PBM must agree to correct any noncompliance issues discovered during these audits.
  - 7.4.2.12.4.3. The PBM must not steer or require any Providers or Members to use a specific pharmacy in which the PBM has an ownership interest or that has an ownership interest in the PBM, if for the primary purpose of reducing competition or financially benefitting the PBM's associated businesses. Arrangements between Contractors and PBMs to promote value-based reimbursement and purchasing or enhancing health outcomes are permitted.
  - 7.4.2.12.4.4. The PBM must load eligibility information into its system within twenty-four (24) hours of receipt of the 834C file from the Contractor.
  - 7.4.2.12.4.5. The PBM must report semi-annually to the Contractor its list of specialty drugs by National Drug Code, including a report on

any drugs that have moved between specialty and non-specialty designation.

7.4.2.12.4.6. The PBM must submit a report containing data from the prior calendar year to the Contractor. The report must be made available to the State upon request and contain the following information: the aggregate amount of all rebates that the PBM negotiated from all pharmaceutical manufacturers on behalf of the Contractor; and the aggregate administrative fees that the PBM negotiated from all pharmaceutical manufacturers on behalf of the Contractor.

7.4.2.12.5. The following provisions must be addressed in any PBM Agreement:

7.4.2.12.5.1. The ability for the Contractor, or its designee that has no ownership or control interest in the PBM, to audit and review contracts or agreements between the PBM and their pharmacies at least annually to ensure correct pricing has been applied. This includes, but is not limited to, prescription drug claim data, billing records, and other records to ensure the PBM's compliance with the terms and conditions of their PBM Agreement.

7.4.2.12.5.2. If there is not a provision in the PBM Agreement to restrict the PBM from selling pharmacy data, the Contractor must require a secure process to be included and followed. If any Contractor's pharmacy data is sold, aggregate total amount received by the PBM for the Contractor's data must be reported the Contractor at least semi-annually.

7.4.2.12.5.3. The ability for the Contractor to terminate the PBM Agreement for cause, including conduct that is likely to mislead, deceive, or defraud the public, as well as other unfair or deceptive business practices.

7.4.2.12.5.4. A clause that grants the State access to financial terms and arrangements that

PBMs have with pharmaceutical drug manufacturers and distributors. Reasonable confidentiality provisions can be included to protect this information if it is deemed a trade secret, subject to compliance with all laws and orders of courts and powers of investigative agencies, to protect against public disclosure.

7.4.2.12.6. The State or its designee reserves the right to review and audit the PBM or PBA Agreements between the Contractor and a PBM or PBA to ensure the PBM or PBA is fulfilling its contractual obligations and federal and state requirements. The Contractor must be responsible for ensuring that any findings from these audits are corrected within the timeframes specified by the State.

7.4.2.13. Residential Treatment Centers (RTCs), Medicaid and Nevada Check Up Members

The Contractor is responsible for reimbursement of all RTC charges including admission, bed day rate, and ancillary services.

7.4.2.14. Transplantation of Organs and Tissue, and Related Immunosuppressant Drugs

These services are covered, with limitations, when Medically Necessary. Coverage limitations for these services are defined in the Medicaid and CHIP State Plans. The State covers Corneal, Kidney, Liver and Bone Marrow transplants and associated fees for adults. For children up to age 21, any Medically Necessary transplant that is not experimental will be covered. The Contractor may claim transplant case reimbursement from the State for in-patient medical expenses above the threshold of \$500,000. Seventy-five percent (75%) of the expenses above \$500,000 are reimbursed to the Contractor as described in Section 7.13.5.

7.4.3. In Lieu of Services or Settings

7.4.3.1. Institutions for Mental Disease (IMD)

The State has determined that providing Members aged 21-64 access Services within an IMD for a limited timeframe is medically appropriate and a cost-effective substitute for services and/or settings outlined in the Medicaid State Plan.

7.4.3.1.1. The Contractor may provide access to psychiatric or substance use disorder or crisis residential services in an IMD setting as an alternative inpatient setting, such as a

hospital or subacute facility, that is licensed by the State of Nevada. These alternative inpatient settings must be lower cost than traditional inpatient settings, and the length of the stay can be no longer than 15 cumulative days during the period of monthly capitation.

7.4.3.1.2. Short-term crisis residential stabilization services are services covered under a SAPTA certified 3.5 co-occurring with enhancement facility, also licensed by the Bureau of Health Care Quality Compliance within the Division of Public and Behavioral Health. Services include community-based resources that can meet the need of an individual with an acute psychiatric crisis and provide a safe environment for care and recovery. Services do include residential services during a crisis that are short term in nature and are used to avoid inpatient hospitalization. Services provided within this type of facility must meet additional requirements as outlined in 7.4.3.1.4.

7.4.3.1.3. The Contractor must coordinate with discharge planners for transitioning to the appropriate post-hospital destination. Failure to transfer the Member to the appropriate care setting in a timely manner, within two (2) Calendar Days after the Member no longer meets an acute level of care will result in the Contractor reimbursing the acute care facility at the average skilled nursing facility (SNF) rate or the administrative day reimbursement rate, whichever is greater.

7.4.3.1.4. The Contractor may not require Members to utilize psychiatric inpatient services or substance use disorder services within an IMD setting, but services will be offered to Members at the option of the Contractor.

7.4.3.2. The Contractor, at any time, may propose to the State additional In Lieu of Services or Settings for services or settings covered under the Contract. The State will evaluate the proposed In Lieu of Services or Settings to determine if such Proposals are medically appropriate and cost effective alternatives. To the extent, the State finds the proposed In Lieu of Services or Settings appropriate, the Contractor will be permitted to offer those In Lieu of Services or Settings to Members.

#### 7.4.4. Mental Health Parity

7.4.4.1. The Contractor is required to be in compliance with 42 CFR part 438, subpart K, Parity in Mental Health and Substance Use Disorder Benefits. To the extent additional services are needed to comply with the mental health parity requirements, the State will amend the Contract

to list the specific services that are in addition to the Medicaid State Plan services that are needed for compliance.

7.4.4.2. The Contractor must not impose any financial requirements such as co-payments or aggregate or annual dollar limits on mental health or substance use disorder services.

7.4.4.3. The Contractor must not apply any treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to Members. Whether a treatment limitation is a predominant treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation.

7.4.4.4. The Contractor may not impose a nonquantitative treatment limitation for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/ surgical benefits in the classification. Nonquantitative treatment limitations include:

7.4.4.4.1. Medical management standards limiting or excluding benefits based on Medical Necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

7.4.4.4.2. Formulary design for prescription drugs;

7.4.4.4.3. Network tier design (such as preferred Providers and Network Providers);

7.4.4.4.4. Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);

7.4.4.4.5. Exclusions based on failure to complete a course of treatment;

7.4.4.4.6. Restrictions based on geographic location, facility type, Provider specialty, and other criteria that limit the scope or duration of benefits for services provided; and

7.4.4.4.7. Standards for providing access to Out-of-Network Providers.

- 7.4.4.5. The following classifications of benefits are the classifications used in applying mental health parity: inpatient services, outpatient services, emergency care, and prescription drugs.
- 7.4.4.6. The Contractor must complete analysis of its compliance with mental health parity and provide documentation to the State of this compliance prior to implementation of the program on January 1, 2022. The analysis must be supported by and include the Contractor's MHPAEA Compliance Checklist in ***Attachment M – MHPAEA Compliance Checklist***.
- 7.4.4.7. The Contractor must take affirmative steps to ensure that covered Medically Necessary mental health, substance abuse and mental health rehabilitative services are provided to Members as required in this Contract. Mental health is an integral part of holistic health care.

7.4.5. Value Added Services

Contractors are able to and encouraged to provide Value Added Services to Members in addition to Medicaid and CHIP State Plan services covered under this Contract. The State may request the Contractor to report on the use of any Value Added Services at any time. Expenditures for Value Added Services are not included in Capitation Payments.

- 7.4.5.1. To the extent the Contractor chooses to provide Value Added Services to Members, the Contractor must provide Value Added Services that address maternal and infant morbidity and mortality rates within its membership. Contractors are encouraged to engage with community partnerships to provide these types of services.
- 7.4.5.2. The Contractor is also encouraged to provide additional preventive services as Value Added Services that address tobacco cessation that are not otherwise covered under this Contract as follows:
  - 7.4.5.2.1. Tobacco Cessation Treatment;
  - 7.4.5.2.2. Screening for tobacco use at every PCP visit;
  - 7.4.5.2.3. For Members who currently use tobacco products, provision of at least two (2) quit attempts per year of which each attempt includes at a minimum:
    - 7.4.5.2.3.1. Effective counseling as defined by the U.S. Public Health Services Clinical Practice Guideline on Tobacco Dependence Treatment. These visits are in addition to any mental health coverage limits (e.g., intensive tobacco cessation counseling service through a telephone

quit-line vendor approved by DPBH; individual tobacco cessation counseling or coaching; or group tobacco cessation counseling or coaching).

- 7.4.5.2.4. The Contractor may only place “stepped therapy” requirements on tobacco cessation treatment to the extent compliant with Mental Health Parity requirements.
- 7.4.5.2.5. The Contractor must not place prior authorization requirements on tobacco cessation treatment or limit the type, duration or frequency of tobacco cessation treatments included in this section.
- 7.4.5.2.6. The Contractor should amend policies, evidences or coverage, formularies, and/or drug brochures as necessary to ensure Members are given complete information about the coverage of tobacco cessation items and services. The Contractor must gain input from the State on promotional materials provided to Members and provide reports to the State on promotional activities at least biannually.
- 7.4.5.2.7. The Contractor will partner with the DPBH to, at a minimum:
  - 7.4.5.2.7.1. Promote the full Tobacco Cessation Benefit to Members;
  - 7.4.5.2.7.2. Partner with DPBH to triage Members who call the state-run quit-line (1-800-QUIT-NOW) back to the Contractor’s quit-line.
  - 7.4.5.2.7.3. Provide aggregate North American Quitline Consortium (NAQC) Minimal Data Set (MDS) data, via the selected telephone quit-line approved vendor, to the DPBH, per data sharing agreement, at least biannually.
- 7.4.5.2.8. The approved Contractor quit-line vendor must be a member of the NAQC.
- 7.4.5.3. The Contractor is encouraged to offer additional preventive or cost-effective services to Members if the services do not increase the cost to the State.

#### 7.4.6. Excluded Services

The State has determined the following services either are excluded as a Contractor covered benefit and will be covered under FFS or have current coverage limitations. The State reserves the exclusive right to include any of the following services as a covered benefit or modify coverage limitations at any time. The State will review and may adjust the Capitation Payment to ensure an actuarial sound rate is maintained and paid to the Contractor at the time of the change to cover increased/decreased medical costs and/or expanded populations. The current service exclusions and limitations are identified as follows:

7.4.6.1. All services provided at Indian Health Service (IHS) Facilities and Tribal Clinics.

7.4.6.1.1. All eligible Indians may access and receive covered Medically Necessary services at Indian Health Service (IHS) facilities and Tribal Clinics Provider Type 47 (PT). Eligible Indians who are eligible as Nevada Title XIX or Title XXI Recipients may choose to opt out of managed care. If an eligible Indian who is enrolled in managed care seeks Covered Services from IHS, the Contractor must request and receive medical records regarding those Covered Services/treatments provided by IHS. If Covered Services are recommended by IHS and the Member seeks those services through the Contractor, the Contractor must either provide the service or must document why the service is not Medically Necessary. The documentation may be reviewed by the State or other reviewers. The Contractor is required to coordinate all services with IHS.

7.4.6.1.2. The Contractor is not responsible for payment of any service received by a Member at an IHS facility or Tribal Clinic. The IHS facility or Tribal Clinic will submit their claims directly to the State's Fiscal Agent and will be paid by the State through the FFS fee schedule.

7.4.6.2. Non-Emergency Transportation (NET)

The State contracts with a NET Broker who authorizes and arranges for all covered Medically Necessary non-emergency transportation. The Contractor and its Subcontractors shall coordinate with the NET Broker, if necessary, to ensure NET services are secured on behalf of Members. The Contractor and its Subcontractors must also verify medical appointments upon request by the State or the NET Broker.

7.4.6.3. Non-Emergency Secure Behavioral Health Transport

Non-Emergency Secure Behavioral Health Transport is available to Members; however, the services are reimbursed under FFS pursuant to MSM Chapter 1903 and are outside the scope of transportation services provided by the State's NET Broker. Providers of this service are accredited and licensed by the DPBH. The Contractor is responsible for

ensuring referral and coordination of care for Non-Emergency Secure Behavioral Health Transport services. Furthermore, the Contractor is responsible for educating Providers and Members, as appropriate, about the availability of this service.

7.4.6.4. Ground Emergency Medical Transportation (GEMT)

GEMT Services are available to Members; however, the services are reimbursed under FFS pursuant to MSM Chapter 1900. The Contractor is not responsible for payment of any GEMT service received by a Member. The GEMT Provider will submit their claims directly to the State's Fiscal Agent and will be paid by the State through the Medicaid FFS fee schedule. The Contractor is responsible for ensuring referral and coordination of care for GEMT services pursuant to this RFP.

7.4.6.5. School Health Services (SHS) (EPSDT)

The State has provider contracts with several school districts to provide EPSDT Medically Necessary Covered Services to eligible Title XIX Medicaid and Title XXI Nevada Check Up Members. School-Based Health Centers are separate and distinct from SHS.

7.4.6.5.1. The school districts can provide, through school district employees or contract personnel, Medically Necessary Covered Services. Nevada Medicaid reimburses the school districts for these services in accordance with the school districts' provider contract. The current school district contracts will be maintained by the State; the Contractor will not contract directly with the school district.

7.4.6.5.2. The Contractors will provide covered Medically Necessary services beyond those available through the school districts, or document why the services are not Medically Necessary. The documentation may be reviewed by the State or its designees. Medicaid and NCU-eligible children are not limited to receiving health services through the school districts. Services may be obtained through the Contractor rather than the school district if requested by the parent/legal guardian.

7.4.6.5.3. The Contractor will stay up-to-date on efforts to promote State standards for SHS. The Contractor will ensure their delivery systems support the integration of SHS with Medicaid managed care services.

7.4.6.6. Adult Day Health Care

Adult Day Health Care (ADHC) services for eligible Members are

Covered under FFS pursuant to MSM Chapter 1800. The Contractor is responsible for ensuring referral and coordination of care for AHDC services. The Contractor must ensure that Members who are receiving ADHC services are receiving all Medically Necessary services covered in the managed care benefit package.

7.4.6.7. Home and Community Based Waiver Services (1915(c)).

7.4.6.8. Pre-Admission Screening and Resident Review (PASRR) and Level of Care (LOC) Assessments. All PASRR and LOC are performed by the State's fiscal agent.

7.4.6.9. Targeted Case Management (TCM)

TCM, as defined by Chapter 2500 in the MSM, is carved out of this Contract. Care Management, which differs from TCM, is required from the Contractors and described in Section 7.5.6.

7.4.6.10. Day Habilitation and Residential Habilitation Services

7.4.6.11. All Nursing Facility Stays Over One Hundred Eighty (180) Days

Pursuant to the MSM 3603.4c, the Contractor is required to track and cover the first One Hundred Eighty (180) Calendar Days of a nursing facility admission. The Contractor is also required to collect any patient liability (PL) for each month a Capitation Payment is received, see 42 CFR 435.725. The amount of PL is determined by the DWSS. The Contractor shall notify the State on the 181st day that the Member is to be disenrolled. The Member will be disenrolled from the Contractor and the stay will be covered by FFS commencing on the 181st Calendar Day of the nursing facility stay.

7.4.6.12. Swing Bed Stays in Acute Hospitals Over Forty-Five (45) Days

Pursuant to the MSM, the Contractor is required to cover the first forty-five (45) Calendar Days of a swing bed admission. The Contractor is also required to collect any PL for each month a Capitation Payment is received. The Contractor shall notify the State by the fortieth (40th) Calendar Day of any swing bed stay expected to exceed forty-five (45) Calendar Days. The Member will be disenrolled from the Contractor and the stay will be covered by FFS commencing on the forty-sixth (46th) day of the facility stay.

7.4.6.13. Hospice

Once admitted into hospice care, Medicaid Members will be disenrolled immediately. Nevada Check Up Members will not be disenrolled, however payment for Nevada Check Up hospice services will be carved out and FFS should be billed.

#### 7.4.6.14. Dental Services Not Covered under Medical Benefits

The following services are covered by the State's dental vendor: covered diagnostic, preventive or corrective services or procedures that include treatment of the teeth and associated structures of the oral cavity for disease, injury or impairment that may affect the oral or general health of the eligible Medicaid Member up to age 21 years and eligible Nevada Check Up Members up to the birth month of their 19th year; dentures; follow up for emergent and urgent dental care; pregnancy-related dental services; adult emergency care except when provided on an emergency basis in the emergency room, hospital, or ambulatory surgical center.

#### 7.4.6.15. Orthodontic Services

Orthodontic services for Members are covered under FFS pursuant to MSM Chapter 1000. The Contractor is responsible for ensuring referral and the coordination of care for orthodontic services, pursuant to this Contract.

#### 7.4.6.16. Pharmacy Drug Limitations

Zolgensma®, a high-cost gene therapy drug used to treat children less than two (2) years old with spinal muscular atrophy (SMA), is carved out and FFS should be billed. Members receiving this drug will not be disenrolled from managed care.

### 7.4.7. Coverage and Authorization of Services

#### 7.4.7.1. General Requirements

The Contractor must furnish services in the same amount, duration and scope as services furnished to Recipients under FFS Medicaid as set forth in 42 CFR 440.230, which provides the Contractor:

- 7.4.7.1.1. Must ensure the services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished;
- 7.4.7.1.2. May not arbitrarily deny or reduce the amount, duration, or scope of the required services solely because of the diagnosis, type or illness, or condition of the Member;
- 7.4.7.1.3. May place appropriate limits on a service on the basis of criteria applied under the Medicaid and CHIP State Plans, such as Medical Necessity, or for the purpose of Utilization Management, provided the services can reasonably be expected to achieve their purpose. This includes authorizing services for individuals with ongoing or chronic conditions or who require Long-Term Services

and Supports (LTSS). Such services must be authorized in a manner that reflects the Member’s ongoing need for such services and supports; and

7.4.7.1.4. Must specify what constitutes “Medically Necessary Services” to the extent to which the Contractor is responsible for covering services related to the prevention, diagnosis and treatment of health impairments; covering services related to the opportunity for a Member receiving LTSS to have access to benefits of community living to achieve person-centered goals, and live and work in the setting of their choice; 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 Medicaid and CHIP State Plans, and other State policy and procedures, including the Medicaid Services Manual (MSM).

#### 7.4.7.2. Authorization of Services Generally

7.4.7.2.1. The Contractor must, for itself and its Subcontractors, have in place and follow, written policies and procedures for the processing of requests for initial and continuing authorization of services. The Contractor must also 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. See additional requirements for Utilization Management programs, including policies and procedures, at Section 7.9.13.

7.4.7.2.2. The Contractor must use InterQual or MCG criteria for making Medical Necessity and utilization decisions.

7.4.7.2.3. The Contractor can utilize different authorization requirements than what is used by the State under FFS, as long as they are not more restrictive. Prior authorization requirements cannot be so restrictive that the application of such requirements results in Medically Necessary services being denied, reduced, or terminated inappropriately, or strictly to manage costs. Refer to MSM Chapter 100, Section 103.2 and appropriate service chapters for the State’s coverage policies.

7.4.7.2.4. The Contractor shall coordinate prior authorizations and clinical edit patterns, based on evidence-based and peer-reviewed clinical criteria, with those used in the fee-for-

service program to support administrative simplification for Providers.

- 7.4.7.2.5. The Contractor must implement the following prior authorization and concurrent review standards:
  - 7.4.7.2.5.1. Prior authorization and concurrent review decisions must be supervised by qualified medical professionals;
  - 7.4.7.2.5.2. Efforts must be made to obtain all necessary information, including pertinent clinical information and consult with the treating physician, as necessary;
  - 7.4.7.2.5.3. The reasons for the decision must be clearly documented and available to the Member in easily understandable terminology and in accordance with reading level requirements for Member communications;
  - 7.4.7.2.5.4. There must be mechanisms to evaluate the effects of the program, including using data on Member satisfaction, Provider satisfaction, or other measures; and
  - 7.4.7.2.5.5. Consistent with 42 CFR 438.210(e), the Contractor must ensure that compensation to individuals or entities that conduct Utilization Management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member.
- 7.4.7.2.6. The Contractor must monitor prior authorization requests. The State, at its sole discretion, may require removal of the prior authorization requirement based on reported approval percentage rates, to align prior authorization procedures across Contractors, and if determined necessary for the proper administration of the Medicaid program. In making such a determination, the State may conduct data analysis based on current or historical trends, consult national standards, or consider quality initiatives under the program.
- 7.4.7.2.7. Any decision made by the Contractor to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested,

must be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease.

7.4.7.2.8. All services prescribed by a PCP or requested by a Member that are denied by the Contractor must be reviewed by a physician, physician assistant, advanced nurse practitioner, or staff pharmacist (for medication denials) with the reason for the denial being documented and logged.

7.4.7.2.9. The State, at its discretion, may require removal of the prior authorization requirement for various procedures based on reported approval data and any other relevant information. The Contractor is required to provide written notification to all affected Network Providers within thirty (30) Calendar Days of the end of the reported quarter regarding the elimination of the prior authorization requirement.

#### 7.4.7.3. Authorization of Behavioral Health Services

7.4.7.3.1. The Contractor must not require Members to obtain a Referral or Prior Authorization for the first mental health or substance use disorder assessment completed in a twelve (12) month period.

7.4.7.3.2. The Contractor must make available to all Members a complete listing of its Network Behavioral Health Providers. The listing must specify which Provider groups or practitioners specialize in pediatric mental health services.

7.4.7.3.3. The Contractor must require Providers to use the following Behavioral Health screening tools as part of the Contractor's Utilization Management Program:

7.4.7.3.3.1. The American Society for Addiction Medicine (ASAM) for substance abuse services for Medical Necessity review for all populations except children ages zero (0) through (6);

7.4.7.3.3.2. ESPDT criteria when evaluating service requests for children;

7.4.7.3.3.3. Level of Care Utilization System (LOCUS) scores for Mental Health Services for Medical Necessity reviews for Members age eighteen (18) and older;

- 7.4.7.3.3.4. Child and Adolescent Level of Care Utilization System (CALOCUS) scores for Mental Health services for Medical Necessity reviews for children and adolescents age six (6) through seventeen (17); and
- 7.4.7.3.3.5. Either the Early Childhood Services Intensity Instrument (ECSII) or Children and Adolescents Needs and Strengths (CANS) for infants, toddlers and preschoolers to determine Medical Necessity for children ages zero (0) through five (5) or another validated assessment tool with prior approval by the State.

#### 7.4.7.4. Service Authorization Determinations

- 7.4.7.4.1. For standard service authorization decisions, the Contractor must provide notice as expeditiously as the Member's health condition requires and within fourteen (14) Calendar Days following the receipt of the request for service, with a possible extension of up to an additional fourteen (14) Calendar Days if:
  - 7.4.7.4.1.1. The Member, or the Provider, requests the extension, or
  - 7.4.7.4.1.2. The Contractor justifies (to the State upon request) a need for additional information and how the extension was in the Member's interest.
  - 7.4.7.4.1.3. If the Contractor extends the timeframe, the Contractor must give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if the Member disagrees with that decision.
- 7.4.7.4.2. For cases in which a Provider indicates, in making the request on the Member's behalf or supporting the Member's request, or the Contractor determines upon request of the Member that the standard service authorization decision timeframe could seriously jeopardize the Member's life, health or ability to attain, maintain, or regain maximum function, the Contractor

must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than seventy-two (72) hours after receipt of request for the service.

7.4.7.4.2.1. The Contractor may extend the seventy-two (72) hour time period by up to fourteen (14) Calendar Days if the Member requests the extension, or if the Contractor justifies (to the State upon request) a need for additional information and how the extension is in the Member's interest.

7.4.7.4.2.2. If the Contractor extends the timeframe, the Contractor must give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if the Member disagrees with the decision. The Contractor must issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.

7.4.7.4.3. For all covered outpatient drugs authorization decisions, the Contractor must provide notice as described in section 1927(d)(5) of the Act.

7.4.7.4.4. Untimely service authorizations constitute a denial and are an Adverse Benefit Determination. This includes situations in which the Contractor gives notice of its intent to extend the timeframe and the date for the original timeframe expires.

7.4.7.5. Seriously Emotionally Disturbed (SED)/Severely Mentally Ill (SMI) Members

7.4.7.5.1. The Contractor must ensure that Members who are referred for evaluation for SED/SMI, or who have been determined SED/SMI, are obtaining the Medically Necessary evaluations by a Network PCP, and that the Member is receiving covered Medically Necessary medical, mental health and mental health rehabilitation services.

7.4.7.5.2. The Contractor or its identified Subcontractors or Network Providers must ensure that the parent/guardian of a minor Member who is referred for SED assessment, or

an adult who is referred for SMI assessment, is fully informed of the reason why the assessment is necessary, and must obtain authorization from the minor Member's parent/guardian or from the adult Member or his/her personal representative to conduct the assessment and to release the determination to the State and/or its designee. Policy regarding whom the State recognizes as a "personal representative" is defined in the State's HIPAA Privacy Rule Manual, as well as a sample personal representative designation form, and is available upon request.

- 7.4.7.5.3. The Contractor and its identified Subcontractors or Network Providers are the only entities that have the authority to make the SED or SMI determination for its Members. If any entity other than the Contractor's identified Subcontractors or Network Providers makes a determination on behalf of a Medicaid Member, the determination will be rejected and the entity will be directed to refer the Member to the Contractor for a determination and services. SED or SMI determinations made by authorized entities referenced in Chapter 400 of the MSM will be considered valid for Recipients who transition from FFS to managed care. Likewise, determinations made by the Contractor or its identified Subcontractors or Network Providers will be considered valid for Members who transition from managed care to FFS. SED or SMI determinations made by appropriately licensed mental health practitioners within the twelve (12) month period preceding initial Medicaid eligibility will be considered valid for either FFS Recipients or Members.
- 7.4.7.5.4. If a Member is determined to be either SED or SMI, the Contractor must ensure that the State's requirements for data collection are met.
- 7.4.7.5.5. Members who receive either an SED or SMI determination must be redetermined at least annually. For SED Members who have the option to and have voluntarily elected to remain enrolled in managed care, the process for these redeterminations is the same as for the initial SED determination as stated above.
- 7.4.7.5.6. Forms to obtain consent for an SED/SMI evaluation, to document the determination, and to disenroll from Medicaid managed care, as applicable, are located in the State's electronic MoveIt reporting repository, or any successor repository.

- 7.4.7.6. Children with Special Health Care Needs (CSHCN) and Mental Health Services for Adults
  - 7.4.7.6.1. The Contractor’s benefit package must include certain services for Members with special health care needs, including CSHCN, Early Intervention, and mental health services for adults. The Contractor must reimburse certain types of Providers with whom formal contracts may not be in place and coordinate these services with other services in the benefit package. Examples of these Providers include DHHS Divisions, such as DPBH, ADSD, DCFS, and counties, Out-of-Network or Out-of-State Providers.
  - 7.4.7.6.2. The Contractor must create and implement a treatment plan for Members with special health care needs who are determined through an assessment by appropriately qualified health care professionals to need a course of treatment or regular care monitoring. The treatment plan must be a required component of the request for services. The treatment plan must be:
    - 7.4.7.6.2.1. Developed by the Member’s PCP or Case Manager if the Member is receiving Care Management services, with Member participation, and in consultation with any specialists caring for the Member;
    - 7.4.7.6.2.2. Approved by the Contractor as part of the utilization management process in a timely manner, if approval is required by the Contractor; and
    - 7.4.7.6.2.3. In accordance with any applicable State quality assurance and utilization review standards.
  - 7.4.7.6.3. The Contractor must have a mechanism in place to allow these Members direct access to a specialist through a standing Referral or an approved number of visits, as deemed appropriate for the Member’s condition and identified needs.
  - 7.4.7.6.4. The Contractor is required to adhere to MSM Chapter 400 and relevant requirements and forms in the State’s electronic MoveIt reporting repository, or any successor repository, for all SED and SMI referrals and determinations, and must reimburse Providers of these services pursuant to the referenced Nevada Medicaid policies and procedures.

#### 7.4.8. Coordination with Other State Vendors and Other Services

- 7.4.8.1. Pursuant to 42 CFR 438.208(b)(2), (3), and (4), the Contractor is required to implement procedures to coordinate services it may provide to the Member with the services the Member may receive from any other vendor or entity, including dental, pharmacy (if carved out of the Contract as described in Section 7.4.2.11.1), or through FFS. Upon request or notification of need, the Contractor is required to communicate with other vendors or entities serving the Member the results of its identification and assessment of any special health care needs to ensure that services are not duplicated, and to ensure continuity of care. The Contractor's procedures must ensure that, in the process of coordinating care, each Member's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164 (the Health Insurance Portability and Accountability Act (HIPAA)).
- 7.4.8.2. The Contractor's Case Managers will be responsible for coordinating services with other appropriate Nevada Medicaid and non-Medicaid programs. This coordination includes referral of eligible Members to appropriate community resources and social service programs, including supportive housing.
- 7.4.8.3. In addition to routine Care Coordination with other vendors or entities, the Contractor is responsible for designating a specific clinician or case manager to ensure continuity of services for Members with special needs. These Members may include, but are not limited to juveniles temporarily detained by a state or county agency; children with SED; adults with SMI and individuals with SUD; Children with Special Health Care Needs; homeless Members; Members with chronic conditions; the correction-involved population; and women with high-risk pregnancies). Care Coordination must address critical issues such as out-of-home placement, specialized mental health services and therapies, and needs that may typically be filled by community resources and social service programs.

#### 7.4.9. Prohibited Practices in the Provision of Covered Services

The Contractor shall take affirmative action so that Members 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:

- 7.4.9.1. Denying or not providing a Member a Covered Service or available facility placement;
- 7.4.9.2. Providing a Member a covered service which is different, or provided in a different manner, or at a different time from that provided to other Member, other public or private patients, or the public at large;

- 7.4.9.3. Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any covered Medically Necessary services, except where medically indicated;
- 7.4.9.4. The assignment of times or places for the provision of services on the basis of race, national origin, creed, color, gender, gender identify, sexual preference, religion, age, physical or mental disability, or health status of the Member to be served;
- 7.4.9.5. The Contractor may not prohibit or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient:
  - 7.4.9.5.1. For the Member's health status, medical care or treatment options, including any alternative treatment that may be self-administered;
  - 7.4.9.5.2. For any information the Member needs in order to decide among all relevant treatment options;
  - 7.4.9.5.3. For the risks, benefits, and consequences of treatment or non-treatment; and
  - 7.4.9.5.4. For the Member's right to participate in decision regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions.
- 7.4.9.6. Charging a fee for a Medically Necessary covered service or attempting to collect a co-payment.

7.4.10. Transitions of Care

- 7.4.10.1. It may be necessary to transfer a Member from one Contractor to another or to FFS for a variety of reasons. When notified that a Member has been transferred to another Contractor or to FFS, the Contractor must have written policies and procedures for transferring/receiving relevant patient information, medical records and other pertinent materials to the other Contractor or current FFS Provider. This includes any Care Management Organizations (CMOs) providing services to the FFS population.
- 7.4.10.2. Prior to transferring a Member, the Contractor (or via their Subcontractors when requested by the Contractor) within five (5) Calendar Days or as medical needs dictate must send the receiving Contractor or Provider information regarding the Member's condition. This information shall include the name of the assigned PCP, as well as the following information, without limitation, as to whether the Member is:

- 7.4.10.2.1. Hospitalized;
- 7.4.10.2.2. Pregnant;
- 7.4.10.2.3. Receiving Dialysis;
- 7.4.10.2.4. Chronically ill (e.g., diabetic, hemophilic, etc.)
- 7.4.10.2.5. Receiving significant outpatient treatment and/or medications, and/or pending prior authorization request for evaluation or treatment;
- 7.4.10.2.6. On an apnea monitor;
- 7.4.10.2.7. Receiving Behavioral or Mental Health services;
- 7.4.10.2.8. Receiving Nevada Early Intervention Services (NEIS) in accordance with an Individualized Family Service Plan (IFSP), which provides a case manager who assists in developing a plan to transition the child to the next service delivery system. For most children, this would be the school district and services are provided for the child through an Individual Education Program (IEP);
- 7.4.10.2.9. Involved in, or pending authorization for, major organ or tissue transplantation;
- 7.4.10.2.10. Scheduled for surgery or post-surgical follow-up on a date subsequent to transition;
- 7.4.10.2.11. Scheduled for prior authorized procedures and/or therapies on a date subsequent to transition;
- 7.4.10.2.12. Referred to a Specialist(s);
- 7.4.10.2.13. Receiving substance use disorder treatment;
- 7.4.10.2.14. Receiving prescription medications;
- 7.4.10.2.15. Receiving DME or currently using rental equipment;
- 7.4.10.2.16. Currently experiencing health problems;
- 7.4.10.2.17. Receiving Care Management (Referral must include the Case Manager's name and phone number); and
- 7.4.10.2.18. Receiving Long Term Services and Supports, such as but not limited to, Personal Care Services and/or Home Health.

7.4.10.3. When a Member changes Contractors or reverts to FFS while hospitalized, the transferring Contractor shall notify the receiving Contractor (if the Member changes Contractors), the receiving Provider(s) providing direct care (if the Member changes Contractors or transitions to FFS), or the State's Quality Improvement Organization (QIO)-like vendor (if the Member transitions to FFS). The notification process must occur as soon as the transition is known to the Contractor.

7.4.10.4. Transitions of Child Welfare Involved Children from FFS to a Contractor

For children that received Medicaid benefits through the FFS system while in the custody of the Child Welfare system (e.g., foster care, juvenile justice) that become eligible for and enroll in the managed care program, the following requirements for continuity of care apply:

7.4.10.4.1. For a period of no less than twelve (12) months from the date of enrollment with a Contractor, the Member must maintain full access to the Providers and level of services that were received while in FFS.

7.4.10.4.2. The State and County Child Welfare Network Providers in Section 7.6.2.8.2.9 of the Contract must be reimbursed in accordance with 7.7.5.4. If such Providers are not part of the Contractor's Network, the same reimbursement requirements apply.

7.4.10.4.3. Any service Providers affiliated with or employed by the State or County Child Welfare system that treated the Member prior to the transition to managed care must be under a single case agreement or part of the Contractor's Network. Regardless of such Provider's status with the Contractor, such Providers must be reimbursed no less than FFS reimbursement under the Medicaid State Plan.

7.4.10.5. Transitions of Members between the Contractor and the State Designated Insurance Exchange (HIX) or other Insurance Product

A person may change eligibility status during a care episode. That person may then be eligible for HIX coverage or other non-exchange coverage to include individual and employer based coverage or Medicare. The Contractor must have a procedure in place to notify any insurance carrier or plan of relevant patient information. This must be done in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other privacy laws.

## **7.5. POPULATION HEALTH AND CARE MANAGEMENT**

### 7.5.1. Population Health Program

- 7.5.1.1. The Contractor must establish a Population Health program that establishes population health goals and targeted annual improvements that are aligned with the State's Quality Strategy.
- 7.5.1.2. Population Health management involves an overarching emphasis on health promotion and disease prevention and incorporates community-based health and wellness strategies with a strong focus on social determinants of health, creating health equity, and supporting efforts to build more resilient communities.
- 7.5.1.3. The Contractor's Population Health program must align the efforts and resources of the Contractor's Care Management programs (i.e., disease management, Care Coordination, Case Management, and programs that address social determinants of health and racial and ethnic disparities in health care), Quality Management, and the Contractor's value based contracting strategies to achieve population health improvements.
- 7.5.1.4. At a minimum, the Contractor must provide interventions to address the following:
  - 7.5.1.4.1. Keeping Members healthy through a spectrum of primary and preventive care;
  - 7.5.1.4.2. Use of the principles of population health management to prevent chronic disease and identify and manage Members with emerging risk for chronic conditions;
  - 7.5.1.4.3. Coordination of care along the continuum of health and well-being and assurance of safety and access to services across settings;
  - 7.5.1.4.4. Managing Members that are high-utilizers of services and with multiple chronic conditions; and
  - 7.5.1.4.5. Effective utilization of these principles to maintain or improve the physical and psychosocial well-being of Members through cost-effective and tailored health solutions, incorporating all risk levels across the care continuum.

### 7.5.2. Population Health Annual Strategy

Within ninety (90) Calendar Days of Contract execution and by January 31 of each Contract Year thereafter, the Contractor must submit a Population Health Annual Strategy to the State for approval that addresses the following:

- 7.5.2.1. A summary description of the Contractor's Population Health program.

- 7.5.2.1.1. The Population Health strategy and program goals;
  - 7.5.2.1.2. The Contractor’s staffing structure that supports the Population Health program. The Contractor must identify a staff person, title, or position responsible for oversight of the Population Health program. If there is a change in the staff person responsible for the Population Health program, the Contractor must notify the State;
  - 7.5.2.1.3. The Committee structure that supports the Population Health program and interface with the quality management committee(s);
  - 7.5.2.1.4. A description of the population health data and reporting tools; and
  - 7.5.2.1.5. A description of how the Contractor’s Population Health strategy is aligned with the State’s Quality Strategy goals and priority populations.
- 7.5.2.2. A description of how the information derived from the Health Needs Screening Assessment, supported by evidence-based tool(s) in Section 7.5.5, is used in the stratification model.
- 7.5.2.3. An overview of the stratification algorithm used to risk-stratify the membership, including the following: the data sources utilized; how socio-economic and social determinants of health factors are considered in the algorithm; how cultural, ethnic and racial factors are considered with the algorithm; and the levels or types of risk categories that result in a Care Management Referral or any type of outreach by the Contractor.
- 7.5.2.4. Overview of the Cultural Competency Plan (CCP) required in Section 7.5.3.2, including how cultural preferences are identified within the membership and a description of how information on culture is used to build a culturally sensitive delivery system.
- 7.5.2.5. A description of how social determinants of health are integrated into the Population Health program, including:
- 7.5.2.5.1. The Contractor’s screening process for Member social determinant of health needs, including the screening tool(s) used, the frequency of screening, and how the Contractor obtains the Provider’s social determinant of health screening results for incorporation in the Member’s plan of care;
  - 7.5.2.5.2. The process for supporting Members who screen positive for a social determinant of health need and “closing the

loop” to ensure the Member accessed the needed community resource to resolve the need; and

- 7.5.2.5.3. A description of how social determinant of health data is used to inform the stratification algorithm.
- 7.5.2.6. A description of the approach to identify and address racial and ethnic disparities in health care, including:
  - 7.5.2.6.1. The process to identify racial and ethnic disparities within the membership;
  - 7.5.2.6.2. A summary of the racial and ethnic membership distribution and summary of all identified racial and ethnic disparities within the membership;
  - 7.5.2.6.3. A description of how information is used to design targeted clinical programs to improve health care disparities based on race and/or ethnicity;
  - 7.5.2.6.4. A description of training provided to all Contractor staff related to addressing racial and ethnic disparities, diversity, and inclusion; and
  - 7.5.2.6.5. A description of reporting and/or training provided to Network Providers specifically related to addressing racial and ethnic disparities in health care.
- 7.5.2.7. A detailed description of the role Quality Improvement has in supporting Population Health outcomes.
- 7.5.2.8. A detailed description of the role all clinical Care Management programs (including Care Coordination and Case Management) and Member engagement strategies have in supporting Population Health outcomes.
- 7.5.2.9. A detailed description of the role Value Based Payments (also referred to as alternative payment methodologies) with Network Providers has in supporting and incentivizing Population Health outcomes. The required level of detail for Value Based Payment reporting is provided at Section 7.7.6.
- 7.5.2.10. After the first Contract Year, the Contractor will include an annual evaluation of the Population Health program’s achievement of goals and objectives, any planned activities to accelerate achievement of goals and objectives, and how the Population Health program is aligned with the State’s Quality Strategy.

### 7.5.3. Cultural Competency Program

### 7.5.3.1. General Requirements

- 7.5.3.1.1. The Contractor must participate in State and federal efforts to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds pursuant to MSM Chapter 100. For the purposes of the Contract, the State has identified Spanish as the prevalent non-English language Federal regulation at 438.206(c)(2) and the State requires that the Contractor offer accessible and high quality services in a culturally competent manner.
- 7.5.3.1.2. The Contractor must provide effective, equitable, understandable and respectful quality care and services that are responsive to the diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs of the membership.
- 7.5.3.1.3. The Contractor must recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsible to the population in the service area.
- 7.5.3.1.4. The Contractor must educate and train governance, leadership and workforce on culturally and linguistically appropriate policies and practices on an ongoing basis.
- 7.5.3.1.5. Multicultural Health Care Distinction from NCQA is encouraged as a way to build a strong cultural competency program, reduce health disparities, and develop culturally and linguistically appropriate Member communication strategies.
- 7.5.3.1.6. The Contractor, at the point of contact, must make Members aware that translation services are available. The services that are offered must be provided by someone who is proficient and skilled in translating language(s).
- 7.5.3.1.7. The availability and accessibility of translation services should not be predicated upon the non-availability of a friend or family member who is bilingual. Members may elect to use a friend or relative for this purpose, but they must not be encouraged to substitute a friend or relative for a translation service.

### 7.5.3.2. Cultural Competency Plan

- 7.5.3.2.1. The Contractor must have a comprehensive cultural competency program, which is described in a written plan. The Cultural Competency Plan (CCP) must describe how care and services will be delivered in a culturally competent manner.
- 7.5.3.2.2. The CCP must identify the goals and objectives of the Contractor's cultural competency program and encompass the goals and objectives described in the State's Quality Strategy.
- 7.5.3.2.3. The CCP must be reviewed and updated annually and submitted to the State in the second quarter of each calendar year.
- 7.5.3.2.4. The Contractor must identify a staff person, title or position responsible for the CCP. If there is a change in the staff member responsible for the CCP, the Contractor must notify the State.
- 7.5.3.2.5. The Contractor must demonstrate how it plans to recruit and retain staff who can meet the cultural needs of the Contractor's membership and cultural competence must be included as part of job descriptions.
- 7.5.3.2.6. The CCP must include a process to obtain Member and stakeholder feedback that will be used to improve the cultural competency program and cultural support provided by clinical and member services programs.
- 7.5.3.2.7. The Contractor must describe in the CCP the method for the ongoing evaluation of the cultural diversity of its membership, including maintaining an up-to-date demographic and cultural profile of the Contractor's Members. A regular assessment of needs and/or disparities is performed, which is used to plan for and implement services that respond to the distinct cultural and linguistic characteristics of the Contractor's membership.
- 7.5.3.2.8. Culturally competent care requires that the Contractor regularly evaluate its Network, outreach services and other programs to improve accessibility and quality of care for its membership. The CCP must also describe the provision and coordination needed for linguistic and disability-related services.

### 7.5.3.3. Cultural Competency Education and Training

- 7.5.3.3.1. The training program must include the methods the Contractor will use to ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery to Members of all cultures. The Contractor must regularly assesses the training needs of the staff and update the training programs, when appropriate.
- 7.5.3.3.2. Training must be customized to staff based on the nature of the contacts they have with Providers and/or Members.
- 7.5.3.3.3. The education program must include methods the Contractor will use for Providers and other Subcontractors with direct Member contact. The education program must be designed to make Providers and Subcontractors aware of the importance of providing services in a culturally competent manner. The Contractor must make sufficient efforts to train Providers and Subcontractors or assist Providers and Subcontractors in receiving training on how to provide culturally competent services.

7.5.3.4. Culturally Competent Services and Translation/Interpretation Services

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

- 7.5.3.4.1. All materials shall be translated when the Contractor is aware that a language is spoken by 3,000 or 10% (whichever is less) of the Contractor's Members who also have Limited English Proficiency (LEP) in that language.
- 7.5.3.4.2. All vital materials shall be translated when the Contractor is aware that a language is spoken by 1,000 or 5% (whichever is less) of the Contractor's Members who also have LEP in that language. Vital materials must include, at a minimum, notices for denial, reduction, suspension or termination of services, and vital information from the Member Handbook.
- 7.5.3.4.3. All written notices informing Members of their right to interpretation and translation services must be translated into the appropriate language when the Contractor's caseload consists of 1,000 Members that speak that language and have LEP.

7.5.3.5. Evaluation and Assessment of the CCP

The Contractor must evaluate the CCP annually to determine its effectiveness and identify opportunities for improvement. A summary report of the evaluation must be sent to the State. The evaluation may, for example, focus on comparative Member satisfaction surveys, outcomes for certain cultural groups, Member Grievances, Provider feedback, and/or Contractor employee surveys. If issues are identified, they must be tracked and trended, and actions must be taken to resolve the issue(s).

#### 7.5.4. Health Promotion and Education Programs

The Contractor must identify relevant community issues and health promotion and education needs of its Members, and implement plans that are culturally appropriate to meet those identified needs and issues relevant to each of the target population groups of Members served. The Contractor 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 Members. The Contractors must comply with all applicable State and federal statutes, regulations, and protocols on health wellness programs.

7.5.4.1. Health promotion and education topics must include early intervention and risk reduction strategies to avoid complications of disability and chronic illness to include the following preventative cancer screenings:

7.5.4.1.1. Colonoscopy, Fecal Occult Blood Test, and Fecal Immunochemical Test for Colorectal Cancer;

7.5.4.1.2. Mammography and Clinical Breast Exams for Breast Cancer; and

7.5.4.1.3. Pap Testing for Cervical Cancer.

7.5.4.2. Health promotion and topics must include early intervention and risk reduction strategies to mitigate poor health outcomes associated with delayed screening or receipt of services for the following:

7.5.4.2.1. Substance use, including alcohol;

7.5.4.2.2. Sexually transmitted infections; and

7.5.4.2.3. Adult and child vaccinations.

7.5.4.3. The Contractor must submit a written description of all planned health promotion and education activities and targeted implementation dates to Nevada Division of Public and Behavioral Health (DPBH), 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.

#### 7.5.5. Health Needs Assessment

The Contractor must conduct a Health Needs Assessment Screening for all new Members with the following timeframes from the date of enrollment with the Contractor:

- 7.5.5.1. The Contractor must arrange for or conduct an initial screening assessment of new Members, to confirm the results of a positive identification and to determine the need for Care Coordination and/or Case Management services within sixty (60) Calendar Days of enrollment. Screening assessment for pregnant women, children with special health care needs, adults with special health care needs must be conducted within thirty (30) Calendar Days; and
- 7.5.5.2. The MCO shall document at least three (3) attempts to conduct the screen using a variety of methods beyond telephonic. If unsuccessful, the Contractor must document the barrier(s) to completion and how the barriers will be overcome so that the Health Needs Assessment can be accomplished within the first one hundred and twenty (120) Calendar Days.
- 7.5.5.3. Face-to-face health needs assessments must be conducted, as necessary. The goal of the health needs assessment is to identify the Member's existing and/or potential health care needs and assess the Member's need for Care Management services, including Care Coordination and/or Case Management.
- 7.5.5.4. The Contractor will submit its Health Needs Assessment Screening form and screening-related data for the State upon request. The State reserves the right to standardize the Health Needs Assessment Screening form across Contractors. The Health Needs Assessment tool must, at a minimum, address the following:
  - 7.5.5.4.1. Behavioral Health screen, including SUD;
  - 7.5.5.4.2. Medical conditions screen;
  - 7.5.5.4.3. Social determinants of health screen; and
  - 7.5.5.4.4. Pregnancy screen, as applicable.
- 7.5.5.5. Promotion of Care Management and early intervention services shall be accomplished by completing welcome calls and/or visits to new Members. This method ensures that an orientation with emphasis on access to care, choice of PCP, and completion of an initial health needs assessment occurs proactively with each Member early upon enrollment

with the Contractor. If a screening risk level determines need for further Care Management, a Referral will be completed.

#### 7.5.6. Care Management

- 7.5.6.1. Care Management comprises the Contractor's clinical programs that must include, at a minimum, Level 1 Care Coordination and Level 2 Case Management as described in this section.
- 7.5.6.2. The Contractor must put a system in place that promotes continuity of care and Care Management. The Contractor must take a comprehensive and collaborative approach to coordinate care for the populations and conditions as specified by the State through effective Care Coordination and Case Management programs, partnerships with PCPs and Specialists, other Providers, Members, Member/family outreach and education, and the ability to holistically address Member health care needs. Care Coordination or Case Management must include not only the specific diagnosis, but also the complexities of multiple co-morbid conditions, including Behavioral Health and related issues, such as lack of social or family support.
- 7.5.6.3. The Contractor will have a geographically based Case Manager for in-person assistance. Upon request of the State, Case Managers must be available to conduct home visits of Members within forty-eight (48) hours of identification as high-risk for serious health, safety and welfare issues.

#### 7.5.6.4. Care Management Program Description

Within ninety (90) Calendar Days of Contract execution and by March 30 annually thereafter, the Contractor must submit a Care Management Program Description to the State for approval that includes all of the requirements within Section 7.5.6. The Contractor must provide an overview of the Contractor's Care Management Program that includes, at a minimum:

##### 7.5.6.4.1. Member Identification

- 7.5.6.4.1.1. Inclusion and exclusion criteria for eligible Members for Care Management (criteria to identify Members);
- 7.5.6.4.1.2. Process and timeframe for case identification from sources, including the stratification model, UM process, Provider referrals, etc.;
- 7.5.6.4.1.3. A Description of the stratification model and frequency of data refresh and model reporting.

- 7.5.6.4.2. A description of delivery model.
- 7.5.6.4.3. Care Management Staffing Structure
  - 7.5.6.4.3.1. Staffing structure and qualifications for all required positions, staffing ratios, and the location of Care Management operations;
  - 7.5.6.4.3.2. Role and function of the non-clinical support team members in the Care Management process;
  - 7.5.6.4.3.3. Role and function of Care Coordinators;
  - 7.5.6.4.3.4. Role and function of the clinical Case Managers, including Behavioral Health Case Managers;
  - 7.5.6.4.3.5. A description of the process for assigning Members to clinical Case Managers;
  - 7.5.6.4.3.6. A description of the process for assigning a primary Case Manager for Members with comorbid (medical and behavioral) conditions;
- 7.5.6.4.4. Care Management Staff Training Requirements
  - 7.5.6.4.4.1. Training for Care Coordination, Utilization Management, and Care Management staff on the Care Management program;
  - 7.5.6.4.4.2. Training for Care Coordinators and Case Managers on recruitment and engagement techniques; and
  - 7.5.6.4.4.3. Training for Case Managers on engagement, activation and behavior change to maximize the Member's engagement in a whole person approach, encourage goal setting and achievement of goals by the Member;
- 7.5.6.4.5. Member Enrollment and Engagement
  - 7.5.6.4.5.1. Tools and resources used to conduct outreach to targeted Members for

engagement in Care Coordination and Case Management;

7.5.6.4.5.2. Process for obtaining missing telephone numbers, email address(es), and other contacts for potential complex Case Management candidates; and

7.5.6.4.5.3. Process and timeframe from initial Member contact to obtaining consent for Care Coordination or Case Management.

#### 7.5.6.4.6. Care Coordination Process

7.5.6.4.6.1. Description of the screening tools and other resources used in the Care Coordination process, including the processes and tools to identify and address social determinants of health;

7.5.6.4.6.2. Description of the ability to perform face-to-face Member contacts in the community;

7.5.6.4.6.3. Integration of the Care Coordination program with the Case Management program (if applicable);

7.5.6.4.6.4. Process for referrals to community resources and ensuring Members actually access needed resources; and

7.5.6.4.6.5. The Care Coordination documentation process, including a description of the clinical documentation platform.

#### 7.5.6.4.7. Case Management Process

7.5.6.4.7.1. Description of assessment tools and other resources used in the Case Management process;

7.5.6.4.7.2. Process and timeframe for developing and distributing the Case Management care plan, including Member/family, Providers, and others as appropriate;

7.5.6.4.7.3. Processes and tools to identify and address social determinants of health;

- 7.5.6.4.7.4. Tools and resources available to Case Managers for activating Member behavior change, service coordination and monitoring Member progress toward goals and activation;
- 7.5.6.4.7.5. Processes for transition care management;
- 7.5.6.4.7.6. Interface with specialty resources for Behavioral Health and pharmacy;
- 7.5.6.4.7.7. Description of ability to perform on-site visits and accommodate embedded Case Managers with larger healthcare delivery systems;
- 7.5.6.4.7.8. Tools and processes used for transitions of care, from discharge planning to post-discharge follow up processes;
- 7.5.6.4.7.9. Integration with other health management programs and process for referrals to other services, such as wellness programs; and
- 7.5.6.4.7.10. Case Management closing criteria and processes, including notifications to the Member, family, Providers, and others (as appropriate).

7.5.6.4.8. The Care Management Program Evaluation Plan, which addresses processes to measure the program’s effectiveness, process to revise and update elements of the Care Management Program as needed based on evaluation finds, and the process for handling complaints related to Care Management services.

7.5.6.5. Member Stratification

7.5.6.5.1. Consistent with Section 7.5.2.3, the Contractor must utilize predictive modeling tools to stratify Members by risk and identify Members who are appropriate for Care Coordination and/or Case Management supports. The stratification model must consider physical, behavioral, and social determinant of health needs identified through a variety of data sources, including but not limited to, claims, pharmacy, utilization data, laboratory results, health needs assessments and other Contractor screenings and/or assessments, referral information, census or other geographic data, and should include methods to identify racial and ethnic health disparities.

7.5.6.5.2. The Contractor is encouraged to incorporate a broad array of data sources such as the American Community Survey (provides population, race, gender, age, income by zip code), Public Health Registries, CDC Chronic Disease Indicators, CDC National Environment Public Health Tracking, Public Safety Reports, School Performance Reports, USDA Food Atlas, and CDC Behavioral Risk Factor Surveillance System (BRFSS).

7.5.6.6. Level 1 – Lower Risk: Care Coordination

7.5.6.6.1. Level 1- Care Coordination is designed to assist Members with social determinant of health needs, challenges in accessing health and community resources, or other Member needs that fragment the Member’s care or lead to poor health outcomes. The Contractor must offer and provide Care Coordination to reduce fragmentation, improve Member’s access to necessary services and address social determinant of health needs for eligible Members.

7.5.6.6.2. The Contractor’s Care Coordination services are provided to Members who have short-term or intermittent needs for coordination of care, to limit Member and Provider confusion, the State requires Contractors to use the title “Care Coordinator” for staff who perform Care Coordination supports for Members as defined in this Contract.

7.5.6.6.3. A Care Coordinator for purposes of this Contract is a para-professional, whose background is most frequently anchored in the disciplines of social work or community health systems to improve health outcomes. Care Coordination services may be provided by non-licensed staff, including Community Health Workers, Promotores or Peer Support Specialists, and Doulas for Contractors who may offer this service as a Value Added Service.

7.5.6.6.4. The type of interventions provided to Members under the Care Coordination program may include, but are not limited to:

7.5.6.6.4.1. Coordinating the authorization of needed services such as timely approval of durable medical equipment, pharmacy, and medical supplies;

7.5.6.6.4.2. Ensuring access to Medically Necessary physical health or Behavioral Health

through assisting with appointments and transportation services;

- 7.5.6.6.4.3. Providing coaching and social support;
- 7.5.6.6.4.4. Providing coordination of Member's care with treating Providers such as primary care and Behavioral Health Services;
- 7.5.6.6.4.5. Ensuring access to community based services and resources to address identified social or economic factors impacting the Member's health outcomes;
- 7.5.6.6.4.6. Ensuring appropriate referrals are made and services are delivered, including any follow-up action;
- 7.5.6.6.4.7. Providing Member education and resources to support Member shared decision-making;
- 7.5.6.6.4.8. Screening for and addressing social determinants of health, including identification of community resources and actively linking Members to those resources;
- 7.5.6.6.4.9. Following up after an emergency department visit to assist the Member in reengagement with primary care treating Providers;
- 7.5.6.6.4.10. Providing culturally appropriate health education and information; and
- 7.5.6.6.4.11. Provision of face-to-face Care Coordination and in the communities where Members reside.

#### 7.5.6.6.5. Care Coordination Reporting

On a quarterly and annual basis, the Contractor must, at a minimum, report the number of unique identified Members eligible for Care Coordination, outreach attempts, number of Members with an outreach success (reached a Member), number of Members for at least one (1) successful outreach with the Care Coordinator, volume of Members served who have a Behavioral Health condition, and social determinant

of health issues identified and addressed within the population. The report template will be provided by the State.

7.5.6.7. Level 2 – High: Case Management

- 7.5.6.7.1. A comprehensive Case Management program must be designed and implemented to support Members, regardless of age, based on an individualized assessment of health and social determinant of health needs.
- 7.5.6.7.2. The Contractor must offer a Case Management program for all Members identified as eligible within the Nevada Medicaid population that includes Case Management support for Members identified as high-risk. These populations include Members with SED/SMI and Members with comorbid medical and Behavioral Health conditions, including substance use disorders, and Members experiencing a high-risk pregnancy.
- 7.5.6.7.3. Eligible Members for Case Management include Members identified as high-risk through Referrals, Contractor stratification or other methods, Members for whom Care Coordination alone is not sufficient to meet their complex needs and Members whose needs require clinical expertise, clinical assessment and/or a plan of care. Eligible Members also include adults involved in the criminal justice system or recently released from jail or prison. The State reserves the right to identify additional priority populations for Case Management.
- 7.5.6.7.4. The Contractor’s Case Management program must include, at a minimum, the following:
  - 7.5.6.7.4.1. Identification of Members who potentially meet the criteria for Case Management through health needs assessments and stratification as outlined in Section 7.5.2.3;
  - 7.5.6.7.4.2. Tailoring Case Management programs to the Member’s needs, respecting the role of the Member to be a decision-maker in the care planning process;
  - 7.5.6.7.4.3. Assessment of the health condition for Member’s with a positive screen;
  - 7.5.6.7.4.4. Notification to the Member’s PCP of the Member’s eligibility for enrollment and

enrollment status in the Contractor's Case Management program;

- 7.5.6.7.4.5. Development and implementation of a care treatment plan that incorporates person centered planning and system of care principles for Members is Case Management based on the assessment. System of care principles are provided in ***Attachment N – System of Care Principles***;
- 7.5.6.7.4.6. The care treatment plan must include the Member, family, caregiver(s), formal and informal supports, other service Providers, and PCP participation in both development and implementation phases of the care treatment plan in the least restrictive environment; and
- 7.5.6.7.4.7. The care treatment plan must also include coordination with State and county agencies, such as ADSD, DCFS, Governor's Office of Consumer Health Assistance (GovCHA), DPBH; DWSS, and SAPTA as well as other public assistance programs, such as the Women, Infant, Children (WIC) program; teen pregnancy programs; parenting programs; and Child Welfare programs.
- 7.5.6.7.5. The Contractor's stratification algorithm must be designed to identify emerging risk, at-risk, and high-risk populations, including Members who are experiencing racial and ethnic disparities in health care.
- 7.5.6.7.6. The Contractor's stratification algorithm should incorporate data sources beyond cost and utilization, such as the American Community Survey (provides population, rate, gender, age, and income by zip code), Public Health Registries, CDC Chronic Disease Indicators, CDC National Environment Public Health tracking, Public Safety Reports, School Performance Reports, USDA Food Atlas, and CDC BRFSS.
- 7.5.6.7.7. Members are identified for Case Management through an array of methods including risk stratification, health needs assessment or other physical or Behavioral Health screenings, Provider referral, State agency referral, Member self-referral, or health event that triggers Case

Management such as: hospitalization (Inpatient or Psychiatric) with transition to home after a facility admission, including IMD and RTC admissions; readmission within thirty (30) Calendar Days; identification as a high-risk population; being at-risk for or experiencing racial and/or ethnic health disparities; complex health and/or social factors that adversely influence health outcomes; screening positive social determinants of health, Behavioral Health screening; presence of multiple co-morbidities; high risk pregnancy; frequent use of emergency room services (greater than two (2) emergency room visits in three (3) months or four (4) or more visits in twelve (12) months); children diagnosed with a psychotic disorder or SED until eligible for TCM services (if applicable); individuals on long-acting psychotic injectable medications; and pregnant women with a Behavioral Health disorder, especially a substance use disorder.

7.5.6.7.8. Face-to-face assessments must be conducted for Members stratified at the highest tier for Case Management where telephonic outreach has failed to reach the Member.

7.5.6.7.9. The goals of the assessment are to identify the Member's existing and/or potential health care needs and should include Behavioral Health screening questions to identify potential mental health and/or substance use disorder issues, identify social determinant of health issues, and assess the Member's need for Case Management services.

7.5.6.7.10. High Risk Maternal Case Management

7.5.6.7.10.1. The Contractor will make a good faith effort to screen Medicaid and CHIP pregnant Members for maternal high risk factors.

7.5.6.7.10.2. Case Management services for Members with high risk pregnancies are defined as preventive and/or curative services and may include, but are not limited to, patient education, nutritional services, Personal Care Services or Home Health care, substance abuse services, and Care Coordination services, in addition to maternity care.

7.5.6.7.10.3. All Case Management requirements and standards outlined within Section 7.5.6.7

apply to the Contractor's High Risk Maternal Care Management program.

7.5.6.7.10.4. Any identification of high-risk factors will require the PCP, OB/GYN Provider, Case Manager or other health care professional to refer the woman who is determined to be at risk for preterm birth or poor pregnancy outcome to the Contractor's High Risk Maternal Case Management Program.

7.5.6.7.10.5. The Contractor must demonstrate ongoing and active efforts to educate Providers on how to make referrals to the Contractor's High Risk Maternal Case Management Program for Members identified as pregnant for screening.

7.5.6.7.10.6. As appropriate, the Contractor must assist the Member in contacting appropriate agencies for Care Coordination of non-covered/carved-out plan services or community health information. The Contractor's Case Manager will begin medical Case Management services for those risk factors identified.

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

7.5.6.7.11. Engagement in Case Management

7.5.6.7.11.1. Members identified as potentially eligible for Case Management must be actively outreached for engagement.

7.5.6.7.11.2. The Contractor must make reasonable attempts to outreach and engage Members. A reasonable attempt involves at least six (6) telephonic other attempts at various times/days; an additional six (6) attempts by text messaging, email or other electronic methods; and the use of face-to-face community visits for high-risk

Members who are difficult to engage or may not have a telephone.

7.5.6.7.11.3. On a quarterly basis, Contractors must report the number of Members identified as eligible for Case Management counts, outreach attempts by method (phone, letter, text email, etc.); outreach successes (reached a Member) and engagement counts (reached Member and Member opted into Case Management supports for at least one (1) successful outreach with the Case Manager). The State will issue a report template for these Member engagement metrics.

7.5.6.7.12. Comprehensive Assessment

For those identified through the Health Needs Assessment Screening to potentially need Case Management services, a comprehensive assessment must be completed for Members consenting to case management within thirty (30) Calendar Days of consent. The assessment must be completed by a physician, physician assistant, RN, LPN, licensed social worker, or a graduate of a two or four-year allied health program. If the assessment is completed by another medical professional, there should be oversight and monitoring by either a registered nurse or physician. The Contractor must provide information to the Member and the Member's PCP and/or other key treating Providers (such as Behavioral Health) that they have been identified as meeting the criteria for Care Management, including their enrollment into Case Management services. The comprehensive assessment must identify the Member's:

7.5.6.7.12.1. Immediate care needs and current services, including other state and local services currently used, and any medication (prescribed and taken);

7.5.6.7.12.2. Physical health conditions, including dental conditions;

7.5.6.7.12.3. Current and past mental health and substance use status and/or disorders;

7.5.6.7.12.4. Physical, intellectual, or developmental disabilities;

- 7.5.6.7.12.5. Cultural preferences and considerations for treatment;
  - 7.5.6.7.12.6. Community resource needs identified through a social determinant of health screen;
  - 7.5.6.7.12.7. Available informal, caregiver, or social supports, including peer support, and any caregiving-related needs of an unpaid caregiver;
  - 7.5.6.7.12.8. Any other ongoing special conditions that require a course of treatment or regular care monitoring; and
  - 7.5.6.7.12.9. Exposure to adverse childhood experiences (ACEs) or other trauma.
- 7.5.6.7.13. Person Centered Care Treatment Plan
- 7.5.6.7.13.1. The Contractor must develop methods to synthesize assessment information to prioritize care needs and develop person centered treatment plans. The Contractor must assure and coordinate the placement of the Member into Care Management and development of a treatment plan within sixty (60) Calendar Days of enrollment with the Contractor. In active collaboration with the Member, designated informal and formal supports and the Member's PCP, the Contractor must develop the person centered treatment plan comprised on the following:
    - 7.5.6.7.13.1.1. Establish measurable and achievable goals and identify appropriate interventions with timeframes;
    - 7.5.6.7.13.1.2. Establish a check-in schedule with the Member to monitor the Member's progress;

7.5.6.7.13.1.3 Provide Referrals with appointment support for services of community resource supports need by the Member, including all Behavioral Health Services and supports;

7.5.6.7.13.1.4 Identify the Member's PCP and other key treating Providers, such as Behavioral Health Providers. For Members with Case Management needs, the PCP is the Provider who will manage and coordinate the overall care for the Member. In addition, the Contractor will facilitate the coordination of the Member's care and ensure communication between the Member, PCP, and Providers and Case Managers (if applicable); and

7.5.6.7.13.1.5 Reflect the Member's primary medical diagnosis and health condition; any comorbidity; and behavioral health, LTSS and community support needs.

7.5.6.7.13.2. At least every ninety (90) Calendar Days, the care treatment plan must be re-evaluated and the level of Care Management services adjusted accordingly. Ongoing communication regarding the status of the treatment plan may be accomplished between the Contractor and the PCP's designee (i.e., qualified health care professional). Revisions to the clinical portion of the

care treatment plan should be completed in consultation with the PCP.

- 7.5.6.7.13.3. The Member's care treatment plan must address collaboration with other Care Coordinator(s) or Case Manager(s) involved in the Member's care, including Behavioral Health Care Management provided by a Behavioral Health Provider with a clear communication plan to avoid duplication of efforts.
- 7.5.6.7.13.4. The Contractor must demonstrate that Case Management is conducted collaboratively with the Member, the Member's designated formal and informal supports, and the Member's treatment team (which may include physicians, physician assistants, nurses, specialists, pediatricians, pharmacists, therapists (PT, OT, etc.), Behavior Health specialists, TCM managers, and/or social workers) appropriate for the Member's condition and health care needs.
- 7.5.6.7.13.5. The Contractor must honor ongoing person centered care treatment plans, as Medically Necessary, for Members transferred into the Contractor's plan from another Contractor, a State-designated HIX plan, or any other existing care treatment plans.
- 7.5.6.7.13.6. For Members who require LTSS and/or Members with special conditions, the care treatment plan must be developed by a person trained in person centered planning using a person-centered planning process as defined in 42 CFR 441.301(c)(1), to the extent such federal requirements were not otherwise explicitly addressed in this section. All requirements of 42 CFR 438.208(c) must be followed.

#### 7.5.6.7.14. Case Management Program Staffing

- 7.5.6.7.14.1. The Contractor must identify the staff that will be involved in the operations of the Care Management program, including but not limited to: Case Manager supervisors,

Case Managers, Care Coordinators, social workers, Behavioral Health professionals, community health workers, peer support specialists, pharmacy consult support, physician consult support and administrative support staff.

- 7.5.6.7.14.2. The Contractor must identify the role/functions of each Case Management staff person as well as the required educational requirements, clinical licensure standards, certification and relevant experience with Case Management standards and/or activities.
- 7.5.6.7.14.3. The Contractor must provide case manager staff/Member ratios based on the risk stratification and different levels of care being provided to Members.
- 7.5.6.7.14.4. Behavioral Health Case Management must be available 24 hours a day, 7 days a week.
- 7.5.6.7.14.5. The Contractor is required to contract with the State of Nevada's designated Behavioral Health Crisis Line which will provide Members with a service that is available twenty-four (24) hours a day, seven (7) days a week, every day of the year through a is confidential, toll free number with immediate access to trained, skilled, licensed Behavioral Health professionals who provide assistance for any type of Behavioral Health distress the Member may be experiencing, and offers assistance in linking Members to supportive available community resources.
- 7.5.6.7.14.6. To limit Member and Provider confusion, the State requires the Contractor to use the title "Case Manager" for staff who perform Case Management supports for Members as defined in the Contract.

7.5.6.7.15. Case Management Priority Conditions

The Contractor must, at a minimum, provide Case Management to Members with the following conditions or

status. The priority list is not exhaustive and Case Management should be offered to Members whose health conditions warrant Case Management services.

- 7.5.6.7.15.1. Congestive Heart Failure (CHF);
- 7.5.6.7.15.2. Coronary Arterial Disease (CAD);
- 7.5.6.7.15.3. Hypertension (excluding Mild Hypertension);
- 7.5.6.7.15.4. Diabetes;
- 7.5.6.7.15.5. Chronic Obstructive Pulmonary Disease (COPD);
- 7.5.6.7.15.6. Asthma;
- 7.5.6.7.15.7. High-Risk or High-Cost Substance Abuse Disorders; including Opioid Use Disorders;
- 7.5.6.7.15.8. Members with Co-Morbid (PH and BH) Conditions;
- 7.5.6.7.15.9. Children with SED and Adults with SMI;
- 7.5.6.7.15.10. Children with Special Health Care Needs;
- 7.5.6.7.15.11. High Risk Pregnancy including Members who are pregnant and have a SUD or history of a SUD;
- 7.5.6.7.15.12. Severe Cognitive and/or Developmental Limitation;
- 7.5.6.7.15.13. HIV;
- 7.5.6.7.15.14. Members with Complex Conditions such as cystic fibrosis, cerebral palsy, sickle cell anemia, etc.;
- 7.5.6.7.15.15. Justice involved populations;
- 7.5.6.7.15.16. Members in Supportive Housing; and
- 7.5.6.7.15.17. Homeless/Transient status

7.5.6.7.16. Case Management Reporting

On a quarterly basis and annual basis, the Contractor must report the number of unique identified Members eligible for Case Management, outreach attempts, number of Members with an outreach success (reached a member), and number of Members with successful enrollment in the program (reached Member and Member opted into Case Management supports for at least one (1) successful outreach with the Case Manager). The report template will be provided by the State.

7.5.6.7.17. Coordination with Other Care Management Resources

7.5.6.7.17.1. The Contractor must identify if other entities are providing Care Coordination or Case Management-like services for any Member enrolled in Case Management to avoid duplication of effort, this includes Members enrolled in TCM.

7.5.6.7.17.2. The Contractor must coordinate the services the Contractor furnishes its Members with the Care Coordination or Case Management services the Member receives from another vendor of the State, Provider or service entity to avoid duplication of services.

7.5.6.7.17.3. The Contractor must coordinate with residential Behavioral Health Services Providers, including Providers outside of Contractor's Service Area, for Member receiving both Medicaid funded and non-Medicaid-funded residential addiction and mental health services. The Contractor must actively participate in discharge planning for Members and ensure continuity of care upon discharge.

7.5.6.7.17.4. The Contractor must promote communication and coordination with state and local government agencies and culturally diverse community social and support services organizations, including early child education, special education, Behavioral Health and public health, as critical partners for the development and operation of an effective delivery system.

7.5.6.7.17.5. In accordance with 42 CFR 438.208(b)(2)(i), the Contractor must

coordinate services furnished to the Member, including between settings of care and appropriate discharge planning for short term and long term hospital and institutional stays. A Member transfer from a facility to an inpatient facility must be completed within twenty-four (24) hours of the facility's determination that the Member is to be discharged to an inpatient facility.

#### 7.5.6.8. Information Technology System for Care Management Programs

- 7.5.6.8.1. The Contractor's information technology system for its Care Management program must maximize the opportunity for communication between the Contractor, PCP, the Member, other service Providers and Case Managers.
- 7.5.6.8.2. The Contractor must have an integrated database that allows Contractor staff that may be contacted by a Member in Case Management to have immediate access to and review of the most recent information within the Contractor's information systems relevant to the case, including the Contractor's 24-hour Nurse Line.
- 7.5.6.8.3. At the direction of the State, the Contractor will be required to contract with and collaborate with a State-identified Crisis Now program once developed.
- 7.5.6.8.4. The integrated database must include the following: administrative data, call center communications (contact tracking), service authorizations, HL7 inpatient and ER notifications, person centered care treatment plans, patient assessments and case management notes. For example, Contractor Member services staff must have access to a Member's case management notes and recent inpatient or emergency department utilization if contacted by that Member.
- 7.5.6.8.5. The information technology system must also have the capability to share relevant information (i.e., utilization reports, person centered care treatment plans, etc.) with the Member, the PCP, and other service Providers and Case Managers.

## 7.6. PROVIDER NETWORK

### 7.6.1. Geographic Service Area

- 7.6.1.1. The mandatory geographic service areas under this Contract are urban Clark and Washoe Counties, see *Attachment H – Geographic Service Area*.
- 7.6.1.2. As used in this Contract, “urban area” means not rural or frontier and it is determined by zip code. Both Washoe and Clark County have urban and rural areas; the Contractors are not required to establish a Provider Network in any rural / frontier areas unless necessary to provide access to care, nor are they required to serve any Members who live in rural / frontier areas unless necessary to provide appropriate access to care.
- 7.6.1.3. Medicaid and Nevada Check Up has catchment areas in California, Arizona, Idaho and Utah, which are treated the same as in state. Out of state treatment for a Member is required when there is not a Provider in Nevada who is able to provide services to the Member. The Contractor must permit Members to obtain services from Out of Network Providers in the following catchment areas:

Catchment Areas	
State	Cities/Zip Codes
Arizona	<b>Bullhead City:</b> 86426, 86427, 86429, 86430, 86439, 86442, 86446 <b>Kingman:</b> 86401, 86402, 86411, 86412, 86413, 86437, 86445 <b>Littlefield:</b> 86432
California	<b>Bishop:</b> 93512, 93514, 93515 <b>Bridgeport:</b> 93517 <b>Davis:</b> 95616, 95617, 95618 <b>Loyalton:</b> 96118 <b>Markleeville:</b> 96120 <b>Needles:</b> 92363 <b>Sacramento:</b> 94203, 94204, 94205, 94206, 94207, 94208, 94209, 94211, 94229, 94230, 94232, 94234, 94235, 94236, 94237, 94239, 94240, 94244, 94245, 94246, 94247, 94248, 94249, 94250, 94252, 94254, 94256, 94257, 94258, 94259, 94261, 94262, 94263, 94267, 94268, 94269, 94271, 94273, 94274, 94277, 94278, 94279, 94280, 94282, 94283, 94284, 94285, 94286, 94287, 94288, 94289, 94290, 94291, 94293, 94294, 94295, 94296, 94297, 94298, 94299, 95811, 95812, 95813, 95814, 95815, 95816, 95817, 95818, 95819, 95820, 95821, 95822, 95823, 95824, 94825, 95826, 95827, 95828, 95829, 95830, 95831, 95832, 95833, 95834, 95835, 95836, 95837, 95838, 95840, 95841, 95842, 95843, 95851, 95852, 95853, 95860, 95864, 95865, 95866, 95867, 95887, 95894, 95899 <b>South Lake Tahoe:</b> 96150, 96151, 96152, 96154, 96155, 96156, 96157, 96158 <b>Susanville:</b> 96127, 96130 <b>Truckee:</b> 96160, 96161, 96162
Idaho	<b>Boise:</b> 83701, 83702, 83703, 83704, 83705, 83706, 83707, 83708, 83709, 83711, 83712, 83713, 83714, 83715, 83716, 83717, 83719, 83720, 83721, 83722, 83724, 83725, 83726, 83727, 83728, 83729, 83730, 83731, 83732, 83733, 83735, 83756, 83757, 83799 <b>Mountain Home:</b> 83647 <b>Twin Falls:</b> 83301, 83302, 83303
Utah	<b>Cedar City:</b> 84720, 84721 <b>Enterprise:</b> 84725 <b>Orem:</b> 84057, 84058, 84059, 84097 <b>Provo:</b> 84601, 84602, 84603, 84604, 84605, 84606 <b>Salt Lake City:</b> 84101, 84102, 84103, 84104, 84105, 84106, 84107, 84108, 84109, 84110, 84111, 84112, 84113, 84114, 84115, 84116, 84117, 84118, 84119, 84120, 84121, 84122, 84123, 84124, 84125, 84126, 84127, 84128, 84130, 84131, 84132, 84133, 84134, 84136, 84138, 84139, 84141, 84143, 84144, 84145, 84147, 84148, 84150, 84151, 84152, 84153, 84157, 84158, 84165, 84170, 84171, 84180, 84184, 84189, 84190, 84199 <b>St. George:</b> 84770, 84771, 84790, 84791 <b>Tooele:</b> 84074 <b>Wendover:</b> 84083 <b>West Jordan:</b> 84084

7.6.2. Network Development Requirements

- 7.6.2.1. The Contractor 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 Members enrolled with the Contractor. The Contractor must implement written policies and procedures for selection and retention of Network Providers consistent with the requirements in Section 7.6. The timing and other events associated with Provider recruitment must occur in a manner that will ensure meeting the Network Adequacy and Timely Access standards in the Contract. These efforts must include outreach to Providers who are not currently participating in the State’s medical assistance programs or have signed provider contracts but do not

actively accept Members. In establishing and maintaining the Network, the Contractor must consider the following:

- 7.6.2.1.1. The anticipated enrollment;
- 7.6.2.1.2. The numbers of Network Providers who currently are and are not accepting new Medicaid and Nevada Check Up Members;
- 7.6.2.1.3. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid and Nevada Check Up populations;
- 7.6.2.1.4. The numbers and types of Network Providers (in terms of training, experience, experience, and specialization) required to furnish the contracted Medicaid and Nevada Check Up Covered Services;
- 7.6.2.1.5. The geographic location of Network Providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members;
- 7.6.2.1.6. The ability of Network Providers to communicate with limited English proficient Members in their preferred language;
- 7.6.2.1.7. The ability of Network Providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Members with physical or mental disabilities;
- 7.6.2.1.8. The availability of triage lines or screening systems, as well as the use of telehealth, e-visits, and/or other evolving and innovative technological solutions appropriate for the delivery of Covered Services; and
- 7.6.2.1.9. The Network adequacy standards established by the State in accordance with 42 CFR 438.68 (refer to Section 7.6.3.1 Time and Distance Standards), Provider-to-Member ratios (refer to Section 7.6.3.4), and timely access standards (refer to Section 7.6.3.9) for the Contractor's geographic service area(s).

7.6.2.2. Provider Status

- 7.6.2.2.1. The Contractor must comply with federal requirements, including the Patient Protection and Affordable Care Act (PPACA) for Medicaid enrollments.

- 7.6.2.2.2. The Contractor may not employ or contract with Providers excluded from participation in the federal health care programs under Section 1128 of the Act.
- 7.6.2.2.3. Prior to becoming a Network Provider, a Provider who is a non-Medicaid enrolled Provider must be referred to the State's fiscal agent for completion of the Medicaid Provider enrollment process. The Provider is not required to see FFS Recipients.
- 7.6.2.2.4. The Contractor may execute Network Provider contracts, pending the outcome of the screening, enrollment, and revalidation process of up to one hundred twenty (120) Calendar Days but must terminate a Network Provider immediately upon notification from the State that the Network Provider cannot be enrolled, or the expiration of one hundred twenty (120) day period without Medicaid enrollment of the Provider, and notify affected Members.
- 7.6.2.2.5. The Contractor must 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 Contractor must not discriminate against particular Providers who serve high-risk populations or specialized conditions that require costly treatment. If the Contractor 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.
- 7.6.2.2.6. Federal regulation at 42 CFR 438.12(a) may not be construed to require the Contractor to contract with Providers beyond the number necessary to meet the needs of its Members; preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Members.
- 7.6.2.2.7. A Provider must be credentialed in accordance with the requirements in Section 7.5.2.3 in order to become a Network Provider.

### 7.6.2.3. Credentialing

Providers seeking Network Provider status with the Contractor must be credentialed and recertified as required by 42 CFR 438.214 and the

requirements of the Contract (see also Section 7.9.6). The Contractor's credentialing process must comply with 42 CFR 1002.3 and be supported by written policies and procedures as set forth in Section 7.9.6. The Contractor will comply with NAC 679B.0405 which requires the use of Form NDOI-901 for use in credentialing Providers. In the event State regulations or provider licensure laws conflict with NCQA standards, State regulations and provider licensure laws control for purposes of the credentialing process.

- 7.6.2.3.1. The initial credentialing process must obtain and review primary source verification of the following information, at a minimum:
  - 7.6.2.3.1.1. The practitioner holds a current valid license to practice in the state where the practitioner practices;
  - 7.6.2.3.1.2. Valid Drug Enforcement Administration (DEA) certificate for all practitioners authorized by the scope of their license to prescribe drugs;
  - 7.6.2.3.1.3. Graduation from a medical school and completion of a residency, or other post-graduate training, as applicable;
  - 7.6.2.3.1.4. For psychiatrists and psychologists that treat child and adolescent populations, the specific age bands served by the Provider. The age bands are 0-6, 6-12, 12-17, and 17-24;
  - 7.6.2.3.1.5. Work history;
  - 7.6.2.3.1.6. Professional liability and claims history;
  - 7.6.2.3.1.7. The practitioner holds current, adequacy malpractice insurance according to the Contractor's policy;
  - 7.6.2.3.1.8. Any revocation or suspension of a State license or DEA number;
  - 7.6.2.3.1.9. Any curtailment or suspension of medical staff privileges (other than for incomplete medical records);
  - 7.6.2.3.1.10. Any sanctions imposed by the OIG or the State;

- 7.6.2.3.1.11. Any censure by any state or county Medical Association or any other applicable licensing or credentialing entity; and
- 7.6.2.3.1.12. The Contractor obtains information from the National Practitioner Data Bank, the Nevada Board of Medical Examiners, the State Board of Osteopathic Medicine, any equivalent licensing boards for Out-of-State Providers, and any other applicable licensing entities for all other practitioners seeking Network status with the Contractor.
- 7.6.2.3.1.13. The application process includes a statement by the Provider applicant regarding the following that should be used to evaluate the practitioner’s current ability to practice:
  - 7.6.2.3.1.12.1 Any physical or Behavioral Health Providers that may affect current ability to provide health care;
  - 7.6.2.3.1.12.2 Any history of chemical dependency or substance abuse;
  - 7.6.2.3.1.12.3 History of loss or license and/or felony convictions;
  - 7.6.2.3.1.12.4 History or loss or limitation of privileges or disciplinary activity; and
  - 7.6.2.3.1.12.5 An attestation to the correctness and completeness of the application.

- 7.6.2.3.2. There is an initial visit to each potential Primary Care Provider’s office, including documentation of a structured review of the site and medical record keeping practices to ensure conformance with the Contractor’s standards. If the Contractor’s credentialing process complies with the

current NCQA standards, it is not required to conduct initial site visits.

7.6.2.3.3. If the Contractor has denied credentialing or not extended a provider contract to a Provider where the denial is due to Contractor's concerns about Provider fraud, integrity, or quality, the Contractor is required to report this to the State's Provider Enrollment Unit within fifteen (15) Calendar Days.

7.6.2.3.4. Recredentialing

The recredentialing process must adhere to the requirements of this section and comply with 42 CFR 1003.3. The Contractor must maintain evidence that the procedure is conducted at least every sixty (60) months.

7.6.2.3.4.1. The Contractor must conduct 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 provider contract. At a minimum, the recredentialing, recertification or reappointment process is organized to verify the Provider's current standing in required areas.

7.6.2.3.4.2. The recredentialing, recertification, or reappointment process also includes review of data from:

7.6.2.3.4.2.1 Member Grievances and Appeals;

7.6.2.3.4.2.2 Results of quality reviews;

7.6.2.3.4.2.3 Utilization management;

7.6.2.3.4.2.4 Member satisfaction surveys; and

7.6.2.3.4.2.5 Re-verification of hospital privileges and current licensure, if applicable.

- 7.6.2.3.5. Credentials for Network Providers or a Subcontractor's Network Providers must be provided by the Contractor and furnished to the State and/or MFCU upon request, at no cost.
- 7.6.2.3.6. The Contractor must provide credentialing criteria for review and approval by the State's Provider Enrollment unit ninety (90) Calendar Days prior to the start of the Contract and ensure that all Network Providers meet the criteria. The written policies and procedures for credentialing and recredentialing must be in accordance with Section 7.9.6 Changes to the credentialing process will need to be provided in writing to the State's Provider Enrollment Unit thirty (30) Calendar Days prior to the change. If the change is unanticipated, the Contractor will notify the State's Provider Enrollment unit within five (5) Calendar Days of the change.
- 7.6.2.3.7. Delegation of Credentialing Activities
- If the Contractor 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 Contractor must monitor the effectiveness of the delegate's credentialing and reappointment or recertification process.
- 7.6.2.3.8. Retention of Credentialing Authority
- The Contractor retains the right to approve new practitioners and sites, and to terminate or suspend individual practitioners.
- 7.6.2.3.9. The State reserves the right to contract with a single Centralized Credentialing Vendor if in the best interest of the State, Providers, and the managed care program.

7.6.2.4. Provider Contract Requirements

- 7.6.2.4.1. The Contractor must execute and maintain, for the term of the Contract, written provider agreements (hereinafter "provider contract(s)") with a sufficient number of appropriately credentialed, licensed or otherwise qualified Providers to provider Members al all Medically Necessary Covered Services.

- 7.6.2.4.2. The Contractor must provide, for the State’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 Contractor must submit drafts of standard language for any such provider contract to the State for review. Provider contracts must meet all state and federal requirements. Contractors are expected to submit all necessary information to demonstrate provider contracts are complete. The Contractor must submit any of its provider contracts to the State and/or the MFCU upon request within five (5) Business Days.
- 7.6.2.4.3. The State retains the right to review contracts between the Contractors and Network Providers and/or Out-of-Network Providers. The State agrees to protect the terms of Contractor-Provider contracts, if the Contractor clearly labels individual documents as a "trade secret" or "confidential" as per Section 22 of ***Attachment C - Contract Form***.
- 7.6.2.4.4. 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 Member.
- 7.6.2.4.5. The use of “gag” clauses in provider contracts is prohibited.
- 7.6.2.4.6. If the Contractor knowingly executes a provider contract with the intent of allowing, encouraging, or permitting the Network Provider to implement unreasonable barriers or segregate (i.e., the terms of the provider contract are more restrictive than the Contractor’s Contract with the State or incentives or disincentives are structured to steer enrolled Members to certain Providers) the Contractor will be in default of its Contract with the State. In addition, if the Contractor 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 State.

7.6.2.5. Network Maintenance and Availability of Services

- 7.6.2.5.1. Maintenance of the Network includes but is not limited to initial and ongoing credentialing; adding, deleting, and period provider contract renewal, monitoring of adherence to the Network Adequacy and Timely access standards under this Contract and remediation of any deficiencies; provider education; and discipline, termination, etc. The

Contractor must have mechanisms in place to regularly monitor the Network's compliance with the requirements of this Contract and take corrective action if there is a failure to comply by Network Providers.

- 7.6.2.5.2. The Contractor must ensure its Network Providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS, if the Provider serves only Medicaid Recipients.
- 7.6.2.5.3. The Contractor must allow each Member to choose his or her Provider, including the PCP, to the extent possible and appropriate.
- 7.6.2.5.4. The Contractor must allow for continued use of a Member's Provider(s) until the Member can be transferred to an appropriate Network Provider(s).
- 7.6.2.5.5. The Contractor must allow for a pregnant Member's continued use of her OB/GYN, if at all possible.
- 7.6.2.5.6. The Contractor must provide for a second opinion from a qualified Network Provider, or arrange for a Member to obtain one outside the Network, at no cost to the Member.
- 7.6.2.5.7. The Contractor must provide female Members with direct access to a women's health specialist within the Network for Covered Services necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated PCP if that source is not a women's health specialist.
- 7.6.2.5.8. The Contractor will assure access to health screenings, reproductive services, and vaccinations through county and state public health clinics. The Contractor must maintain a Network with a sufficient number of family planning providers to ensure timely access to services.
- 7.6.2.5.9. The Contractor will notify the State's designated staff within one (1) Business Day of any unexpected change that would impair the Provider Network. This notification must include:
  - 7.6.2.5.9.1. Information about the nature of the change and how the change will affect the delivery of Covered Services; and
  - 7.6.2.5.9.2. Plans for maintaining the quality of Member care if the Provider Network

change is likely to result in deficient delivery of Covered Services.

7.6.2.5.10. The Contractor must notify the State of any change in its Provider Network that will substantially affect the ability of Members to access services as soon as the change is known or not later than fifteen (15) Calendar Days prior to the change.

7.6.2.5.11. The Contractor must partner actively with the State, community providers, and stakeholders to identify and address issues and opportunities to improve health care access and availability of services for Medicaid and Nevada Check Up Members.

7.6.2.5.12. Provider Termination

7.6.2.5.12.1. If the Contractor decredentials, terminates, or disenrolls a Provider from the Network, the Contractor must inform the State's Provider Enrollment Unit within five (5) Business Days. At a minimum, the Contractor must provide the State the basis, reasons or causes for such action and any and all documentation, data, or records obtained, reviewed, or relied on by the Contractor, including but not limited to: Provider/patient files, audit reports and findings, Medical Necessity reviews.

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

7.6.2.5.12.3. On a monthly basis, no later than the tenth (10th) Calendar Day of the month, the Contractor will submit to the State 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.

7.6.2.5.12.4. The Contractor must give written notice of termination of a Network Provider, by the later of thirty (30) Calendar days prior

to the effective date of the termination or fifteen (15) Calendar Days after receipt of issuance of the termination notice, to each Member who received his/her primary care from, or was seen on a regular basis by the terminated Network Provider.

7.6.3. Network Adequacy Standards

7.6.3.1. Per 42 CFR 438.68, at a minimum, the Contractor must develop and maintain a Network that adheres to the following time and distance standards for the following provider types and any additional provider types as may be determined by CMS or the State. A description of Provider types is at *Attachment I – Provider Types*.

<b>Specialty Area</b>	<b>Maximum Time and Distance Standards (Minutes/Miles)</b>
Primary Care (adult)	15/10
Pediatrics	15/10
Hospitals	45/30
Obstetrics/Gynecology	15/10
Endocrinology (adult and pediatric)	60/40
Infectious Diseases (adult and pediatric)	60/40
Oncology - Medical/Surgical (adult and pediatric)	45/30
Oncology – Radiation/Radiology (adult and pediatric)	60/40
Rheumatology (adult and pediatric)	60/40
Psychiatrist (adult)	45/30
Board Certified Child and Adolescent Psychiatrist	45/30
Psychologist (adult and pediatric)	45/30
Qualified Mental Health Professional (QMHP) (adult and pediatric)	45/30
Outpatient Dialysis	45/30
Pharmacy	15/10

### 7.6.3.2. Exception Process to the Time and Distance Standards

Although the Time and Distance Standards developed by the Nevada Department of Insurance and the State are generally attainable across the geographic service area, there may be unique instances where a supply of Providers is such that the Contractor will not be able to meet the standards specified in Section 7.6.3.1. If a Contractor, through regular monitoring of their Network, discovers it is unable to meet a standard, justification for an exception that includes an alternative standard that is equal to or better than the usual and customary community standard for accessing care must be provided to the State. The State will review such requests for an exception against the Medicaid providers available through FFS and in other Contractor's Networks to determine if the alternative proposed standard will be accepted. To the extent the State determines the Contractor should be able to meet the Time and Distance standard for which an exception was requested, the Contractor will be required to develop a Plan of Correction plan in order to come into compliance that will be subject to the State's review and approval. If the State does accept the alternative standard, the Contractor must include additional reporting in its quarterly Network adequacy reporting to demonstrate how this alternative standard does not negatively impact Member Access to care.

### 7.6.3.3. Network Adequacy Reporting

7.6.3.3.1. The Contractor must provide supporting documentation to the State, in a format specified by the State, which demonstrates it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care. Such documentation must demonstrate the Contractor offers and appropriate range for preventive, primary care, and specialty services and maintains a Network that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of Members in the service area. Such documentation must be provided at the time the Contractor enters into a Contract with the State and any time there is a significant change in the Contractor's operations that would affect adequacy capacity and services, and as requested by the State, to conduct an access to care analysis. A significant change includes, but may not be limited to:

7.6.3.3.1.1. Changes in the Contractor's services, benefits, geographic service area, or payments; or

7.6.3.3.1.2. Enrollment of a new population in the managed care program.

- 7.6.3.3.2. On a quarterly basis, use geo-access mapping and data-driven analysis to ensure compliance with these access standards and take appropriate corrective action, if necessary to comply with such access standards. This report must be submitted to the State within thirty (30) Calendar Days after the end of the quarter, in a format specified by the State, and include the following:
  - 7.6.3.3.2.1. Documented compliance with the access standards of the Contract;
  - 7.6.3.3.2.2. The number and types of Providers that are new to the Network for the quarter;
  - 7.6.3.3.2.3. The number and types of Providers that were terminated in the quarter; and
  - 7.6.3.3.2.4. Identified areas of deficiency and planned corrective action to address the identified deficiencies.

7.6.3.4. Provider-to-Member Ratios and PCP Participation Requirements

- 7.6.3.4.1. The Contractor must have at least one (1) full-time equivalent (FTE) Primary Care Provider, considering all lines of business for that Provider, for every one thousand five hundred (1,500) Members per service area. However, if the PCP practices in conjunction with a health care professional, the ratio is increased to one (1) FTE PCP for every one thousand eight hundred (1,800) Members per service area. The Contractor must demonstrate that the capacity of the PCP Network meets the FTE requirements for accepting eligible Members per service area. This ratio cannot exceed the FTE requirement. In no case may a single provider accept more Members than allowed by the FTE requirement.
- 7.6.3.4.2. Per geographic service area, at least fifty percent (50%) of all of the Network PCPs must contractually agree to accept Members. At least fifty percent (50%) of the aforementioned PCPs must accept Members at all times. If the Contractor has a provider contract with a Federally Qualified Health Center (FQHC) and/or the University of Nevada Medical Schools, the physicians of the FQHC can be counted to meet the fifty percent (50%) participation and fifty percent (50%) acceptance requirement.
- 7.6.3.4.3. The Contractor must provide access to all types of physician specialists for PCP referrals, and it must employ

or contract with specialists in sufficient numbers to ensure specialty services are available in a timely manner. The Contractor should provide access to at least two (two) specialists/subspecialists in their service areas. The minimum ratio for specialists (i.e., those who are not PCPs) is one (1) specialist per one thousand five hundred Members per service area (1:1,500).

7.6.3.4.4. These ratios may be adjusted by the State for under-served areas, upon the analysis of PCP or Specialist availability by specific service area.

7.6.3.4.5. The State reserves the right to add Member-to-Provider ratios for other Provider types.

7.6.3.5. Primary Care Provider or Primary Care Site Responsibilities

7.6.3.5.1. The PCP or physician in a Primary Care Site serves as the Member's initial point of contact with the Contractor. Although the PCP must be given responsibility for the following tasks, the Contractor must agree to retain responsibility for monitoring PCP and Primary Care site activities to ensure compliance with the Contractor's and the State's requirements. The Contractor is prohibited from imposing restrictions on the tasks in this section. As such, the PCP or the physician at the Primary Care Site is responsible for the following:

7.6.3.5.1.1. Delivery of covered Medically Necessary primary care services and preventive services, including EPSDT screening services and Well Baby/Child Services;

7.6.3.5.1.2. Provider of twenty-four (24) hour, seven (7) days per week coverage;

7.6.3.5.1.3. Referrals for specialty care and other covered Medically Necessary services in the managed care benefit package;

7.6.3.5.1.4. Members must be allowed to self-refer for family planning (in or Out-of-Network), and obstetrical, gynecological, mental health and substance abuse services within the Contractor's Network;

7.6.3.5.1.5. Continuity and coordination of Member's health care; and

7.6.3.5.1.6. Maintenance of a current medical record for the Member, including documentation of all services provided by the PCP, specialty or Referral services, or Out-of-Network services such as Family Planning and Emergency Services.

7.6.3.5.2. Use of Medical Homes and Accountable Care Organizations

The Contractor is encouraged to use existing patient-centered medical homes, when available and appropriate. The Contractor should use supportive Provider services and contracting to support the expansion of patient-centered medical homes. The Contractor is encouraged to use Accountable Care Organizations (ACOs) and other innovative models, when available and appropriate.

7.6.3.6. Election and Assignment of a PCP or Primary Care Site

7.6.3.6.1. The Contractor must allow each Member the freedom to choose among its Network PCPs and change PCPs as requested. The Contractor must implement procedures to ensure each Member has an ongoing source of primary care appropriate to his or her needs.

7.6.3.6.1.1. Each Member must elect or be assigned to a PCP or Primary Care Site within five (5) Business Days of the effective date or enrollment. However, Members with disabilities must be given an additional thirty (30) Calendar Days to select a PCP.

7.6.3.6.1.2. Members with disabilities, chronic conditions, or complex conditions must be allowed to select a Specialist as their PCP and any Specialist can be a PCP based on Medically Necessary conditions. These Members must also be allowed to select a State-operated clinic as their PCP. If a Specialist is chosen as a PCP, the Provider should be reported as a Specialist. The Specialist does not count as both a PCP and Specialist for reporting purposes.

7.6.3.6.1.3. If the Member desires, the Contractor must allow him or her to remain with his or her existing PCP if the PCP is part of the Contractor's Network.

7.6.3.6.2. The Contractor must ensure that Members receive information about where they can receive care during the time period between enrollment and PCP selection/assignment. The Contractor must notify the Member in writing of his or her assigned PCP within five (5) Business Days of assignment. If a Member does not choose a PCP, the Contractor must match Members with PCPs by one or more of the following criteria:

7.6.3.6.2.1. Assigning a Member to a Provider from whom they have previously received services, if the information is available;

7.6.3.6.2.2. Designating a PCP or Primary Care Site who is geographically accessible to the Member per 42 CFR 438.68 and the Time and Distance requirements for PCPs in Section 7.6.3.1.

7.6.3.6.2.3. Assigning all children within a single family to the same PCP;

7.6.3.6.2.4. Assigning and Child with Special Health Care Needs (CSHCN) to a practitioner experienced in treating that condition, if the Contractor knows of the condition; and/or

7.6.3.6.2.5. Assigning a Member to a PCP upon receipt of a Claim for services rendered by a PCP to the Member.

#### 7.6.3.7. Changing a PCP or Primary Care Site

7.6.3.7.1. A Member may change a PCP or PCS for any reason. The Contractor shall notify Members of the procedures for changing PCPs or PCSs.

7.6.3.7.2. In cases where a PCP has been terminated from the Network, the Contractor must notify Members in writing and allow Members to select another PCP, or make a re-assignment within fifteen (15) Calendar Days of the termination effective date, and must provide for urgent care for Members until re-assignment.

7.6.3.7.3. The Contractor may initiate a PCP or PCS change for a Member under the following circumstances:

7.6.3.7.3.1. Specialized care is required for an acute or chronic condition;

- 7.6.3.7.3.2. The Member's residence has changed such that distance to the PCP is greater than fifteen (15) miles. Such change will be made only with the consent of the Member;
- 7.6.3.7.3.3. The PCP ceases to participate in the Contractor's Network;
- 7.6.3.7.3.4. Legal action has been taken against the PCP, which excludes participation; or
- 7.6.3.7.3.5. The Member will be given the right to select another PCP or PCS within the Contractor's Network.

7.6.3.7.4. The Contractor must track the number of requests to change PCPs and the reasons for such requests.

#### 7.6.3.8. Essential Community Providers

- 7.6.3.8.1. 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 State that the restriction of patient base from this Provider would cause access problems for either Medicaid or low-income patients. In addition, the State has identified Essential Community Providers that may not meet the aforementioned requirements but are critical to ensuring access to Covered Services in the Contractor's Provider Network.
- 7.6.3.8.2. The Contractor is required to negotiate in good faith with all of the following Essential Community Providers who are located in the Contractor's geographic service area(s). Negotiating in good faith requires, at a minimum, offering Provider Contracts that are at least as beneficial to the Provider as contracts with other Providers in the same geographic area for similar services. Contracts with Providers who work through one of the Essential Community Providers must be negotiated in good faith.
  - 7.6.3.8.2.1. A Federally Qualified Health Center (FQHC) or Rural Health Center to provide health care services. The Contractor must demonstrate a good faith effort to negotiate a contract with FQHCs and RHCs, see Section 7.6.3.8.2, and include

all licensed and qualified FQHC and RHC providers in the Network. Contracting with just one provider at each FQHC or RHC does not constitute a good faith effort to include the FQHC or RHC in the Network (see *Attachment J – Essential Community Providers*);

- 7.6.3.8.2.2. The University Medical Center of Southern Nevada to provide inpatient and ambulatory services;
- 7.6.3.8.2.3. The University of Nevada School of Medicine (UNSOM) System, including Mojave Mental Health clinics, to provider health care and Behavioral Health care services;
- 7.6.3.8.2.4. Southern Nevada Adult Mental Health Services (SNAMHS) and Northern Nevada Adult Mental Health Services (NNAMHS);
- 7.6.3.8.2.5. School Health Services;
- 7.6.3.8.2.6. Aging and Disability Services Division (ADSD);
- 7.6.3.8.2.7. Division of Public and Behavioral Health (DPBH);
- 7.6.3.8.2.8. Substance Abuse Prevention and Treatment Agency (SAPTA);
- 7.6.3.8.2.9. Division of Child and Family Services (DCFS);
- 7.6.3.8.2.10. County Child Welfare Agencies, there may be times when DCFS and County Child Welfare Providers have provided services to a FFS Recipient who then moves into managed care. Contracting with these Providers will help ensure continuity of care for these Members;
- 7.6.3.8.2.11. Crisis Stabilization Centers;
- 7.6.3.8.2.12. Public Mobile Crisis Teams operated by public agencies;

- 7.6.3.8.2.13. Nurse Midwives;
- 7.6.3.8.2.14. Certified Community Behavioral Health Centers (CCBHCs);
- 7.6.3.8.2.15. Free Standing Birth Centers (FBCs)/Obstetric Centers;
- 7.6.3.8.2.16. Indian Health Care Providers (see ***Attachment J – Essential Community Providers***);
- 7.6.3.8.2.17. Any health provider designated by the State as an Essential Community Provider. The State will notify the Contractor of Providers designated by the State as Essential Community Providers.
- 7.6.3.8.2.18. At the States option, the Contractor may be required to contract with other agencies within the DHHS, the Juvenile Justice system, Disproportionate Share Hospitals (DSH), or various County entities in providing Medically Necessary services, including Behavioral Health. If this option is exercised and there is any resulting additional expense incurred by the Contractor, the State will adjust the Capitation Rate so that it remains Actuarially Sound.

7.6.3.9. Timely Access Requirements

The Contractor must make services included in the Contract available twenty-four (24) hours per day, seven (7) days a week, when Medically Necessary. The Contractor must ensure Member access to Covered Services is consistent with the degree of urgency, and require its Network Providers to meet State standards for timely access to care and services, as follows:

7.6.3.9.1. Emergency Services

Emergency Services shall be provided immediately on a twenty-four (24) hour basis, seven (7) days a week, with unrestricted access, to Members who present at any qualified Provider, with a Network or Out-of-Network Provider.

7.6.3.9.2. PCP Appointments:

- 7.6.3.9.2.1. Medically Necessary PCP appointments must be available within two (2) Calendar Days;
- 7.6.3.9.2.2. Same day urgent care PCP appointments; and
- 7.6.3.9.2.3. Routine care PCP appointments are available within two (2) weeks. The two (2) week standards does not apply to regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every two weeks.

7.6.3.9.3. Specialist Appointments

For specialty Referrals to physicians, therapists, Behavioral Health Services, vision services, and other diagnostic and treatment Providers, the Contractor must provide:

- 7.6.3.9.3.1. Same day emergency appointments within twenty-four (24) hours of Referral;
- 7.6.3.9.3.2. Urgent appointments within three (3) Calendar Days of Referral;
- 7.6.3.9.3.3. Routine Appointments within thirty (30) Calendar Days of Referral; and
- 7.6.3.9.3.4. Access to a child/adolescent Specialist(s) if requested by the parent(s).

7.6.3.9.4. Prenatal Care Appointments

Initial prenatal care appointments must be provided for pregnant Members as follows:

- 7.6.3.9.4.1. First trimester within seven (7) Calendar Days of the first request;
- 7.6.3.9.4.2. Second trimester within seven (7) Calendar Days of the first request;
- 7.6.3.9.4.3. Third trimester within three (3) Calendar Days of the first request; and
- 7.6.3.9.4.4. High-risk pregnancies within three (3) Calendar Days of identification of high-

risk by the Contractor or maternity care Provider, or immediately if an emergency exists.

7.6.3.9.5. Home Health, Private Duty Nursing, and Personal Care Services

Initiation of ongoing services according to the Member's identified needs must be provided as follows:

7.6.3.9.5.1. Same day for Members with urgent needs;

7.6.3.9.5.2. Non-urgent care within fourteen (14) Calendar Days.

7.6.3.9.6. Appointments to Maintain Efficacy of Treatment

For conditions that are not urgent or emergent, but where treatments are more medically effective when delivered sooner than routine care (for example, physical therapy), services must be provided to Members as follows:

7.6.3.9.6.1. Within fourteen (14) Calendar Days of the first request; or

7.6.3.9.6.2. Within the timeframe recommended by the referring Provider.

7.6.3.9.7. Office Waiting Times

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

7.6.3.9.8. Oversight of Appointment Standards

7.6.3.9.8.1. The Contractor must have established written policies and procedures to disseminate 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.

7.6.3.9.8.2. The Contractor must have established written policies and procedures concerning the education of its Network regarding appointment time requirements, monitor the adequacy of the appointment process and Network compliance, and implement a Plan of Correction (POC) when appointment standards are not met.

7.6.3.10. Annual Secret Shopper Survey

7.6.3.10.1. The Contractor must conduct an annual secret shopper survey across its Network as part of the Access to Care Monitoring Plan to identify appointment standards and access to services for PCPs, Physician Specialists, Behavioral Health, Applied Behavioral Analysis (ABA) Providers, Prenatal Obstetric, and Home Health/Private Duty Nursing/Personal Care Service providers consistent with the appointment standards in this Contract.

7.6.3.10.2. The State will assign each Contractor a calendar year quarter to conduct the survey and provide each Contractor with a list of at least thirty (30) unique Medicaid IDs to use in the survey. Medicaid IDs will be provided to the Contractor in the quarter in which their survey is to be conducted. The Contractor must use the provided Medicaid IDs to call a random sample of each of the provider types in Section 7.6.3.11.1 to determine when the next available and the third next available appointment times are for PCP routine care, specialist urgent and routine care including Behavioral Health providers, and Prenatal care in the first, second and third trimesters.

7.6.3.10.3. The Contractor must provide a call script to the State at least seven (7) Calendar Days prior to conducting any calls for the secret shopper survey.

7.6.3.10.4. A report is due to the State thirty (30) Calendar Days after the end of the quarter that the secret shopper survey was conducted that addresses:

7.6.3.10.4.1. The number of calls made by provider type by urgency of appointment including the provider IDs of the providers called;

7.6.3.10.4.2. The compliance percentage with the appointment standards in the Contract;

- 7.6.3.10.5. A description of any actions taken by the Contractor to address compliance issues;
- 7.6.3.10.6. A description of planned oversight activities in other Calendar quarters; and
- 7.6.3.10.7. Any other Appointment Standard oversight elements as requested by the State.

7.6.4. Out-of-Network Services

- 7.6.4.1. If the Contractor's Provider Network is unable to provide Medically Necessary services covered under the Contract to a particular Member, the Contractor must adequately and timely cover these services Out-of-Network for the Member for as long as the Contractor is unable to provide them. The Contractor's benefit package includes covered Medically Necessary services for which the Contractor must reimburse certain types of Providers with whom formal contracts may not be in place. The Contractor must also coordinate these services with other services in the Contractor's benefit package.
- 7.6.4.2. When it is necessary for Members to obtain services from Out-of-Network Providers, the Contractor must:
  - 7.6.4.2.1. Exhaust all Out-of-Network Providers located within twenty-five (25) miles of the Member's address as a source for that Member's care before contracting with Out-of-Network Providers located over twenty-five (25) miles from Member's address;
  - 7.6.4.2.2. Offer the opportunity to the Out-of-Network Provider to become a Network Provider;
  - 7.6.4.2.3. Validate that the Out-of-Network Provider, if not a Medicaid-enrolled Provider, is licensed in the home state of practice in order to enter into a single case agreement with the Contractor;
  - 7.6.4.2.4. Negotiate a single case agreement to determine the rate prior to services being rendered or pay no more than the Medicaid FFS rate, unless otherwise specified in the Contract for the particular Provider type; and
  - 7.6.4.2.5. Coordinate the care of Out-of-Network Providers.
- 7.6.4.3. Single case agreements must be reported to the State.
- 7.6.4.4. Requirements for Pregnant Members

7.6.4.4.1. The Contractor may reimburse an Out-of-Network Provider at a negotiated rate less than the FFS rates established for pregnancy-related CPT codes.

7.6.4.4.2. A Members newly enrolled with the Contractor within the last trimester of pregnancy must be allowed to remain in the care of an Out-of-Network Provider if she so chooses. The Contractor must have policies and procedures for this allowance.

#### 7.6.5. Out-of-State Providers

When it is necessary for Members to obtain services from an Out-of-State Provider, the Contractor must negotiate a contract to determine the rate prior to services being rendered. The Contractor must inform the Provider to accept the Contractor's reimbursement as payment in full. The only exception is for Third Party Liability (TPL). The Out-of-State Provider must not bill, accept or retain payments from Medicaid or Nevada Check Up Members.

#### 7.6.6. Provider Call Center

##### 7.6.6.1. General Requirements

7.6.6.1.1. The Contractor must provide assistance to Providers through a toll-free call center. The Provider Call Center must allow Providers to obtain real time information regarding the status of prior authorization requests, Utilization Management decisions, Claims payment, and direction to available resources to address questions or concerns.

7.6.6.1.2. The Contractor must have the capability to capture "audio signatures" for any required forms or request that require the Provider's signature.

7.6.6.1.3. The Contractor must use the information from Provider Call Center interactions to inform improvements in the Contractor's operations, Provider training and outreach strategies, and service delivery operations.

7.6.6.1.4. The Contractor must ensure provider services staff are available to provide assistance to Providers through the toll-free call center at all times during the hours of 8:00 am to 6:00 pm Pacific Time, Monday through Friday, except for the following major holidays: New Year's Day, Martin Luther King Day, Memorial Day, and Independence Day. Labor Day, Thanksgiving Day, and Christmas Day.

7.6.6.1.5. The Contractor must specify Provider Call Center closure days in the Provider Manual, provider portal, and website at least thirty (30) Calendar Days in advance of the closure.

7.6.6.2. Provider Call Center Performance Standards

7.6.6.2.1. The Contractor must meet or exceed the following Provider Call Center standards:

7.6.6.2.1.1. Ninety percent (90%) of calls answered within thirty (30) seconds;

7.6.6.2.1.2. Capture rate of ninety-five percent (95%);

7.6.6.2.1.3. Hold time not to exceed thirty (30) seconds;

7.6.6.2.1.4. All inquiries that require a call back must be returned within one (1) Business Day of receipt; and

7.6.6.2.1.5. A minimum of seventy percent (70%) of all calls to the Provider Call Center are resolved during the first call.

7.6.6.2.1.6. The Contractor must resolve ninety percent (90%) of written, telephone or personal contacts within thirty (30) Calendar Days of the date of receipt with appropriate follow up to the Provider.

7.6.6.2.2. The Contractor must self-report its compliance with these standards to the State via a monthly affidavit that swears to compliance and/or identifies any areas of non-compliance and the planned resolution.

7.6.6.2.3. The Contractor must report performance standards by provider type, frequency, and nature of contact if required by the State.

7.6.7. Provider Policy and Procedure Manual

7.6.7.1. The Contractor must prepare a Provider Policy and Procedure Manual (hereinafter “Provider Manual”) for each distinct class of Provider which must be approved by the State. The Contractor must document the approval of the Provider Manual by the Contractor’s Medical Director, and must maintain documentation verifying that the provider manual is reviewed and updated at least annually. The Contractor will provide policy and procedure updates to the State within five (5)

Business Days of the contract implementation, any significant changes in the manual or upon request. One (1) electronic copy of the Provider Manual must be provided to the State and an email notification directing to the website when changes are made.

7.6.7.2. Upon approval by the State, the Contractor may publish the manual material related to more than one category of Provider in a single volume. The Contractor must direct each Provider upon recruitment into the Network, to their website location of the electronic Provider Manual and must update all electronic copies of the Provider Manual when changes are made by the Contractor. Provider update notices sent via facsimile, mail, and e-mail may be utilized to update the Provider Manual when changes are made by the Contractor. The Contractor can meet this requirement by providing the website location of the Provider Manual to each provider practice where several Providers within the practice are participants in the Network.

7.6.7.3. The Provider Manual must include, at a minimum:

7.6.7.3.1. The policies and procedures to be implemented by the Contractor to ensure Provider Contract compliance;

7.6.7.3.2. The procedures governing verification of Member eligibility and the process for receiving and disseminating Member enrollment data to Network Providers;

7.6.7.3.3. Prior authorization procedures and requirements including the Appeals process for denied, reduced or terminated services;

7.6.7.3.4. The procedures for claims administration including the Appeals process for denied claims and adverse payment and Provider Contract decisions;

7.6.7.3.5. Provider credentialing criteria;

7.6.7.3.6. Provider Network management;

7.6.7.3.7. The benefits and limitations available to Members under the program, including any restrictions on Members' freedom of choice imposed by the program and any/all payment obligations;

7.6.7.3.8. 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; and

7.6.7.3.9. Policies and procedures to be implemented by the Contractor to manage quality improvement and Member service utilization.

#### 7.6.8. Provider Training

- 7.6.8.1. The Contractor must ensure Providers receive training on applicable program requirements and all relevant Contractor operational requirements. In addition to presenting education and training materials of interest to all providers, the workshops must provide sessions for each discrete class of providers whenever the volume of recent changes in policy or procedures in a provider area warrants such a session. All sessions should reinforce the need for Providers to verify Member eligibility and enrollment prior to rendering services in order to ensure that the Member is Medicaid or Nevada Check Up eligible and that claims are submitted to the responsible entity.
- 7.6.8.2. The Contractor must submit its calendar of provider required training for the State's review.
- 7.6.8.3. The Contractor must ensure that individuals who oversee and delivery training must have demonstrable experience and expertise in the topic for which they are providing training.
- 7.6.8.4. The Contractor must certify to the State that such training has occurred. Upon the State's request, the Contractor must provide evidence of Provider completion of Contractor-required training.
- 7.6.8.5. The Contractor must employ strategies in the timing and platform for required training to maximize Provider participation.
- 7.6.8.6. The Contractor must require Providers to attend State-delivered provider training, as mandated by the State.

#### 7.6.9. Provider Feedback and Education

The Contractor must have the administrative capacity to offer feedback to individual Network Providers on adherence to evidence-based practice guidelines and positive and negative care variances from standard clinical pathways that may impact outcomes or costs. The Contractor must use this information to guide Contractor activities, such as performance improvement projects for Network Providers.

#### 7.6.10. Provider Newsletter

The Contractor must publish a semi-annual newsletter for Network Providers. Topics may include practice guidelines, policy updates, quality management strategies, and other topics of Provider interest.

#### 7.6.11. Provider Enrollment Roster Notification

The Contractor must either notify or provide the means for Providers to verify Members' PCP selection. The Contractor must establish and implement a mechanism to inform each PCP about any newly enrolled Members assigned to the PCP on at least a monthly basis. This information must be made available to each PCP within five (5) Business Days of the Contractor receiving the Benefit Enrollment and maintenance (834) file from the State. The State's Fiscal Agent will pass the 834 file through the MMIS for verification of eligibility prior to distribution to the Contractor, who will in turn be responsible for keeping individual Network Providers informed. The Contractor may elect to update its Membership File more frequently to keep PCPs informed of the enrollment activity.

#### 7.6.12. Practice Guidelines

- 7.6.12.1. The Contractor must adopt practice guidelines and protocols that meet the requirements below and as set forth in Section 7.9.4.6.
  - 7.6.12.1.1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
  - 7.6.12.1.2. Consider the needs of the Contractor's Members;
  - 7.6.12.1.3. Are adopted in consultation with Network Providers;
  - 7.6.12.1.4. Are reviewed and updated periodically as needed to reflect the current practice standards; and
  - 7.6.12.1.5. Include prior authorization requirements that are documented and applied in a manner than complies with requirements for parity in mental health and substance use disorder benefits in accordance with 42 CFR 438.901(d).
- 7.6.12.2. The Contractor must disseminate its practice guidelines to all affected Providers prior to the Contract start date and, upon request, to Members and Potential Members, including prior authorization policies and procedures.
- 7.6.12.3. The Contractor must ensure that decisions for Utilization Management, Member education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines.
- 7.6.12.4. Network Providers must be required to use designated practice guidelines and protocols.
- 7.6.12.5. Prior to the Contract start date, the Contractor must identify the practice guidelines it intends to use for acceptance by the State. Submission must occur after the date of the awarded Contract but before the

Contract start date. The State shall accept or reject, in writing, within ten (10) Business Days.

7.6.12.6. At the State's request, the Contractor must coordinate the development of specialized clinical practice guidelines with the State to avoid Network Providers receiving conflicting practice guidelines.

#### 7.6.13. Medical Records

7.6.13.1. Complete medical records must be maintained by the Contractor's Network Providers for each Member. The Contractor must take steps to promote maintenance of medical records in legible, current, detailed, organized and comprehensive manner that permits effective Member care and quality review and in accordance with the requirements of Section 7.6.14. The medical records must be available for review by duly authorized representatives of the State and CMS upon request.

7.6.13.2. The Member's medical record is the property of the Provider who generates the medical record. The Contractor must assist the Member or the parent/legal guardian of the Member in obtaining a copy of the Member's medical records, upon written request, from the Provider. Medical records must be furnished in a timely manner upon receipt of such a request but not more than thirty (30) Calendar Days from the state of request. Upon request, each Member or parent/legal guardian of the Member shall receive of one (1) free copy of the medical records. The fee for additional copies shall not exceed the actual cost of time and materials to comply the copy and furnish such records.

7.6.13.3. When a Member changes PCPs and or Contractors, the Contractor's Network Providers must forward all medical records in their possession to the new Provider within ten (10) Business Days from receipt of the request.

7.6.13.4. The Contractor must have standards for medical records, which must reflect all aspects of Member care, including ancillary services. These standards must, at a minimum, include requirements for:

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

7.6.13.4.2. 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;

7.6.13.4.3. 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;

- 7.6.13.4.4. Past Medical History [for patients seen three (3) or more times] – Past medical history is easily identified including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth;
- 7.6.13.4.5. Vaccinations for Pediatric Records [ages twenty (20) and under] – There is a completed immunization record or a notation that vaccinations are up to date with documentation of specific vaccines administered and those received previously (by history);
- 7.6.13.4.6. Diagnostic information;
- 7.6.13.4.7. Medication information;
- 7.6.13.4.8. Identification of Current Problems – Significant illnesses, medical conditions and health maintenance concerns are identified in the medical record;
- 7.6.13.4.9. 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;
- 7.6.13.4.10. Consultations, Referrals, and Specialist Reports – Notes from any consultations are in the record. Consultation, lab, and x-ray reports filed in the chart have the ordering physician’s initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans;
- 7.6.13.4.11. Emergency care;
- 7.6.13.4.12. Hospitals and Mental Hospitals:
  - 7.6.13.4.12.1. Identification of the Member;
  - 7.6.13.4.12.2. Physician name;
  - 7.6.13.4.12.3. Date of admission;
  - 7.6.13.4.12.4. Initial and subsequent stay review dates;
  - 7.6.13.4.12.5. Reasons and plan for continued stay if applicable;
  - 7.6.13.4.12.6. Date of operating room reservation if applicable;

- 7.6.13.4.12.7. Justification for emergency admission if applicable; and
- 7.6.13.4.12.8. Hospital Discharge Summaries – Discharge summaries are included as part of the medical record for all hospital admissions that occur while the Member is enrolled with the Contractor and prior admissions as necessary.
- 7.6.13.4.13. Advance Directive – For medical records of adults age eighteen (18) and over, the medical record documents whether or not the individual has executed an Advance Directive and documents the receipt of information about Advance Directives by the Member and confirms acknowledgment of the option to execute an Advance Directive. An Advance Directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated;
- 7.6.13.4.14. Patient Visit Data – Documentation of individual encounters must provide at a minimum adequate evidence of:
  - 7.6.13.4.14.1. History and Physical Examination – Comprehensive subjective and objective information obtained for the presenting complaints;
  - 7.6.13.4.14.2. Plan of treatment;
  - 7.6.13.4.14.3. Diagnostic tests;
  - 7.6.13.4.14.4. Therapies and other prescribed regimens;
  - 7.6.13.4.14.5. 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;
  - 7.6.13.4.14.6. Referrals and results thereof; and
  - 7.6.13.4.14.7. All other aspects of patient care, including ancillary services.

- 7.6.13.4.15. Entry Date – All entries must have date and time noted;
  - 7.6.13.4.16. Provider Identification – All entries are identified as to author;
  - 7.6.13.4.17. Legibility – The record is legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.
- 7.6.13.5. The Contractor must participate financially in the HealthIE Nevada statewide health information exchange (HIE) as of the effective date of the Contract. At a minimum, the participation level must be based upon all Member lives covered under the Contract. Additionally, the Contractor will fund the PMPM connections for its Medicaid and Nevada Check Up Members.
- 7.6.13.6. The Contractor must, consistent with the intention of NRS 439.581 through 439.595 and applicable federal law, incorporate measures to ensure Network Providers either initiate measures to, or continue to, contribute Members clinical data to the HIE according to policies and standards set forth by the HIE.
- 7.6.13.7. Medicaid and Nevada Checkup Members may not opt out of having their individually identifiable health information disclosed electronically.
- 7.6.14. Provider Grievance and Appeals
- 7.6.14.1. The Contractor 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 Members. Written grievance and appeals procedures must be included, for review and approval, at the time the Contractor’s policies and procedures are submitted to the State and at any time thereafter when the Contractor’s Provider grievance and appeals policies and procedures have been revised or updated. The Contractor may not implement any policies and procedures concerning its Provider grievance and appeal system without first obtaining the written approval of the State.
  - 7.6.14.2. The following provisions reflect minimum requirements and are not intended to limit the scope of the Contractor’s grievance and appeals process for Providers.
    - 7.6.14.2.1. The Contractor 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 State.
    - 7.6.14.2.2. The Contractor’s appeal process must address payment disputes and instances when the Contractor chooses to

deny, reduce, suspend or terminate a Provider's privileges with the Contractor.

7.6.14.2.3. The Contractor must issue a final decision, in writing, no later than ninety (90) Calendar Days after a grievance is filed and thirty (30) Calendar Days after an appeal is filed.

7.6.14.3. Pursuant to NRS 422.306, when a Provider has exhausted the Contractor's internal appeals process, the Provider has the right to submit a written request to the State for a State Fair Hearing. The Contractor must notify the Provider of the right to request a State Fair hearing at the time the Provider enters into a provider contract with the Contractor and when the outcome of the appeal is not wholly in favor of the Provider. Disputes eligible for the State Fair Hearing process include:

7.6.14.3.1. Denial or limited authorization of a requested service;

7.6.14.3.2. Reduction, suspension or termination of a previously authorized service;

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

7.6.14.3.4. Demand for recoupment; and

7.6.14.3.5. Failure of the Contractor to meet specified timeframes (e.g., authorization, claims processing, appeal resolution);

7.6.14.4. A written record in the form of a file or log (paper-based or electronic) is to be maintained by the Contractor for each provider grievance or appeal to include the Provider's name and National Provider Identifier (NPI), name of the covered person, a description of the issue, the date filed, dates and nature of actions taken, and final resolution.

## **7.7. PAYMENT TO PROVIDERS**

### **7.7.1. Payment of Claims**

7.7.1.1. The Contractor shall be responsible for paying all claims for properly accessed and, if necessary, authorized Covered Services provided to Members on dates of service when they were eligible for coverage unless the services are excluded under the contract or the Nevada Medicaid or CHIP State Plan. The Contractor 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.

- 7.7.1.2. In cases where third party liability is known, the Contractor must ensure that third party liability has been billed and processed prior to paying the claim.
- 7.7.1.3. The Contractor 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 Contractor shall have the capability to electronically accept and adjudicate claims. The Contractor's claims processing system must use standard claim forms.
- 7.7.1.4. The Contractor must allow Network and Out-of-Network Providers to submit an initial claim for Covered Services. The Contractor must allow all in-state Network Providers to submit claims for reimbursement up to one hundred eighty (180) Calendar Days from the last date of service and Out-of-State Providers three hundred sixty-five (365) Calendar Days from the last date of service unless a shorter period is negotiated.
- 7.7.1.5. The Contractor must meet the requirements for timely claims payment in 42 CFR 447.45(d)(2) and (d)(3) and abide by the specifications of 42 CFR 447.45(d)(5) and (d)(6) and NRS 695C.185. The Contractor must pay ninety percent (90%) of all Clean Claims from Providers, 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 Contractor 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 Contractor 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.
- 7.7.1.6. The Contractor must have written policies and procedures for processing claims submitted for payment from any source and shall monitor its compliance with these procedures.
- 7.7.1.7. The Contractor'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 (e.g., counties or other DHHS divisions, such as DPBH, ADSD, or DCFS)
- 7.7.1.8. The Contractor agrees for valuable consideration that NRS 695C.185 and NRS 695C.128 applies to the terms of this Contract. NRS 695C.128 requires the Contractor to pay interest to a Provider of health care services on a Claim that is not paid within the time provided in the Contract 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) Calendar Days after the date on which the Claim is approved until the date on which the Claim is paid.

- 7.7.1.9. The Contractor and its Network Providers may, by mutual agreement, establish an alternative payment schedule but such a schedule must be stipulated in the provider contract. If the Contractor does not pay claims in accordance with 42 CFR 447.45(d), the State may assess a financial penalty for each day the Contractor is out of compliance.
- 7.7.1.10. The Contractor must verify that reimbursed services were actually provided to Members by Providers and Subcontractors.
- 7.7.1.11. The Contractor must provide the State with information prior to implementation of any material changes to the software system to be used to support the claims processing function as described in the Contractor's Proposal in response to the RFP and incorporated by reference in the Contract.
- 7.7.1.12. A medical review of Claims will be conducted when the appropriateness of service, procedure, or payment is in question. Medical reviews must be conducted by a licensed medical clinician(s).

#### 7.7.2. Third Party Liability

- 7.7.2.1. 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 Act, the State 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 Member.
- 7.7.2.2. Nevada Medicaid shall be the payer of last resort of all Covered Services in accordance with federal regulations. The Contractor acts 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 Contractor's Capitation Payments include an offset for these collections. The Contractor must vigorously pursue billing Prior Resources as these amounts are considered part of the risk based Capitation Payment. The Contractor is required to secure signed acknowledgements from Members or their Authorized Representative confirming any Prior Resources (e.g., Medicare, worker's compensation, private insurance, etc.) and share that information with the State. TPL is a self-reporting element. The Contractor is responsible for developing and distributing communication forms to Members.

- 7.7.2.3. The Contractor must identify potential TPL, including Medicare, and deny the claim if it is for a service covered by other insurance based on the Member's type of TPL coverage and type of service (e.g., medical service claim with medical service coverage, pharmacy service claim with pharmacy coverage). The Contractor must 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.
- 7.7.2.4. The Contractor is required to vigorously pursue billing Prior Resources. The Contractor is required to obtain TPL information independently of the State 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 State (including circumstances under which the third party refuses to pay) on the Third Party Monthly Report. TPL collections should also be reported to the State through Encounter Data and other required reports.
- 7.7.2.5. The Contractor is responsible not only for pursuing third-party resources that it identifies but also for using third-party resources identified and communicated to the Contractor by the State.
- 7.7.2.6. TPL recoveries made by either the Contractor or the State will be incorporated into the Capitation Rate development by the State and its Actuary. The Contractor has three hundred sixty-five (365) Calendar Days from claim paid date to recover TPL payment; after three hundred sixty-five (365) Calendar Days, the Contractor forfeits the right to recovery to the State unless the Contractor can provide evidence that the recovery effort is active and/or in dispute. The Contractor will be responsible to pay for the cost incurred to complete the recovery of the TPL payment to the State.
- 7.7.2.7. The Contractor 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.
- 7.7.2.8. Exceptions to the TPL rule are Indian/Tribal Health Services (IHS); Children with Special Health Care Needs (CSHCN); and State Victims of Crime.
- 7.7.2.9. The Contractor must 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.
- 7.7.2.10. All requirements of 42 CFR 438.3(t) must be met; to the extent they are applicable.

### 7.7.3. Subrogation

- 7.7.3.1. 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.
- 7.7.3.2. The Contractor must also determine if casualty claims are filed and recover costs through subrogation on behalf of both Medicaid and CHIP Members. The Contractor must utilize the EVS eligibility system and TPL data provided to the Contractor by the State to assist in accomplishing this objective.
- 7.7.3.3. The State will monitor and evaluate the Contractor's TPL and subrogation collection reports to validate collection activities and results. The Contractor is expected to meet or exceed baseline target collections as determined by the State and its Actuary. The baseline target amount will be built into future rates. If the Contractor does not meet or exceed baseline TPL and subrogation collections, the State will conduct a review to determine if there is a legitimate reason. If there is no legitimate reason as determined by the State, the difference between baseline and actual collections will be deducted from the Contractor's costs before the data is used to set future Capitation Rates. The State will prospectively adjust Capitation Rates to account for expected TPL collections.

7.7.4. Provider Preventable Conditions

- 7.7.4.1. The Contractor must comply with 42 CFR 447.26, regarding Medicaid's payment policy on Provider Preventable Conditions (PPCs). The Contractor must 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:
  - 7.7.4.1.1. Is identified in the Medicaid State Plan;
  - 7.7.4.1.2. Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonable preventable through the application of procedures supported by evidence-based guidelines;
  - 7.7.4.1.3. Has a negative consequence for the Member;
  - 7.7.4.1.4. Is auditable;
  - 7.7.4.1.5. Includes, at minimum, wrong surgical or other invasive procedure performed on a patient;
  - 7.7.4.1.6. Surgical or other invasive procedure performed on the wrong body part; and



- 7.7.6.2. The Contractor must focus its APM contracting strategies to support the Population Health goals and plan as provided in Section 7.5.2.9, in particular, the APM contracting strategies should focus on incentivizing Providers to address the social determinant health needs of Members, improving health equity in access to and delivery of health care services, improvements in maternal and child health outcomes, diversions from emergency rooms, and psychiatric hospital placement into outpatient clinics, when appropriate.
- 7.7.6.3. The Contractor's APM contracting strategies must also consider and implement approaches to reduce Provider administrative burden associated with APM contracting and support Providers with data analytics and technical assistance to ensure the successful transition to APM-based reimbursement and progression along the LAN framework.
- 7.7.6.4. Reporting Requirements

As part of the Population Health program reporting specified in Section 7.5.2 of the Contract, and upon request of the State, the Contractor must provide the following information related to its APM contracting strategies:

- 7.7.6.4.1. A detailed description of the role APMs with Network Providers has in supporting and incentivizing Population Health outcomes;
  - 7.7.6.4.2. Using the LAN framework, a detailed description of the types of APM contracting models used by Network Provider type and the volume of Provider participation by Provider type;
  - 7.7.6.4.3. An estimate of Members served by Providers under an APM reimbursement model;
  - 7.7.6.4.4. A description of the strategies employed to reduce Provider administrative burden;
  - 7.7.6.4.5. A description of the evaluation metrics used by the Contractor to evaluate the success of the APM contracting strategies and any findings associated with those evaluation metrics, plan for evaluating the success of the APM contracting strategies, and approach to evaluate if a Provider has the capacity to advance along the LAN framework.
- 7.7.6.5. The State reserves the right to implement a requirement that the Contractor achieve provider contracting at specified percentages across the LAN framework per Contract Year. Failure to achieve the specified thresholds for APM provider contracting may result in financial penalties.

#### 7.7.7. Physician Incentive Plans

If the Contractor has a physician incentive plan, it must comply with section 1876 of the Social Security Act and the reporting requirements outlined in 42 CFR 422.208 and 422.210, pursuant to 42 CFR 438.3(i). The Contractor must provide information regarding its physician incentive plan(s) to the State, CMS, and any Medicaid and Nevada Check Up Member, upon request. The rules and guidelines for physician incentive plans also apply to Subcontractors.

#### 7.7.8. Obstetrical Global Payment

7.7.8.1. The length of time that the pregnant woman is enrolled with the Contractor is not a determining factor in payment to the obstetrician/nurse midwife. Payment to the delivering obstetrician/nurse midwife for normal routine pregnancy will be based upon the services and number of visits provided by the obstetrician/nurse midwife to the pregnant woman through the course of pregnancy. Payments are determined by Current Procedural Terminology (CPT) codes submitted by the Provider. The Contractor must provide separate payment for covered Medically Necessary services required as a result of a non-routine pregnancy.

7.7.8.2. A global payment will be paid to the delivering obstetrician, regardless of Network affiliation, when the Member has been seen seven (7) or more times. If the obstetrician has seen the Member less than seven (7) times, the obstetrician may be paid according to a negotiated rate of no less than the FFS rates established for pregnancy-related CPT codes.

#### 7.7.9. Contractor Responsibility for Provider Payment Due to Retroactive Enrollment

The Contractor 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 Contractor. In such cases, the Contractor shall only be obligated to pay for such services that would have been authorized by the Contractor had the individual been enrolled at the time of such services. For in-state Providers in these circumstances, the Contractor shall pay the providers for such services only in the amounts that would have been paid to a Network Provider in the applicable specialty. Out-of-State Providers in these circumstances will be paid according to a negotiated rate between the Contractor and the Out-of-State Provider. The timeframe to make such corrections will be limited to one hundred eighty (180) Calendar Days from the incorrect enrollment date. The State is responsible for payment of applicable Capitation for the retroactive coverage.

#### 7.7.10. Prohibition on Payments to Institutions or Entities Located Outside of the United States

7.7.10.1. Pursuant to Section 6505 of the ACA, which amends Section 1902(a) of the Social Security Act (the Act), the Contractor must 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.).

- 7.7.10.2. 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, the Contractor is prohibited from making payments to telemedicine providers located outside of the U.S. Additionally, payments to pharmacies located outside of the U.S. are not permitted.
- 7.7.10.3. 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 Contractor.
- 7.7.10.4. 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.
- 7.7.10.5. 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.

#### 7.7.11. Prohibited Provider Payments

The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):

- 7.7.11.1. Furnished by any individual or entity that is excluded from participation under title V, XVIII, XIX or XX of the Act;
- 7.7.11.2. Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation and when the person furnishing such item or service knew, or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person);
- 7.7.11.3. Furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or

entity, unless the state determines there is good cause not to suspend such payments;

- 7.7.11.4. With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997;
- 7.7.11.5. With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan; or
- 7.7.11.6. For Home Health care services provided by an agency or organization, unless the agency provides the state with a surety bond as specified in Section 1861(o)(7) of the Act.

## **7.8. MEMBER RIGHTS, MATERIALS AND SERVICES**

### **7.8.1. Member Rights**

The Contractor must ensure the following Member rights are protected and maintain written policies and procedures for such rights as specified in Section 7.9.7.

- 7.8.1.1. To be treated with respect, and recognition of their dignity and need for privacy;
- 7.8.1.2. To be provided with information about the Contractor, its services, the practitioners providing care, and Members' rights and responsibilities in accordance with 42 CFR 438.10;
- 7.8.1.3. To be able to choose primary care practitioners, including specialists as their PCP if the Member has a chronic condition, within the limits of the Network, including the right to refuse care from specific practitioners;
- 7.8.1.4. To participate in decision-making regarding their health care, including the right to refuse treatment;
- 7.8.1.5. To pursue resolution of Grievances and Appeals about the Contractor or care provided;
- 7.8.1.6. To formulate Advance Directives;
- 7.8.1.7. To have access to his/her medical records in accordance with applicable federal and state laws and to request that they be amended or corrected as specified in 45 CFR Part 164;
- 7.8.1.8. To guarantee the Member's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

7.8.1.9. To receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand; and

7.8.1.10. To ensure the Member is free to exercise his or her rights without the Contractor or Network Provider treating the Member adversely.

## 7.8.2. Member Protection from Contractor Liability

The Contractor and any Subcontractor must ensure that its Members are not held liable for any of the following:

7.8.2.1. The Contractor's debts, in the event of the Contractor's insolvency;

7.8.2.2. For services provided to the Member in the event of the Contractor failing to receive payment from the State for such services;

7.8.2.3. For services provided to a Member in the event a Provider with a contractual, referral, or other arrangement with the Contractor fails to receive payment from the State or the Contractor for such services; or

7.8.2.4. Payments to a Provider who furnishes Covered Services under a contractual, referral, or other arrangement with the Contractor or Subcontractor in excess of the amount that would be owed by the Member if the Contractor had directly provided the services.

7.8.2.5. The Contractor must ensure continuation of services to Members during insolvency pursuant to the CMS State Medicaid Manual (SMM) 2086.6.B.

## 7.8.3. Advance Directives Requirements

Pursuant to Section 1902(w)(1) of the Act, the Patients' Self-Determination Act, including Advance Directives, Contractors must have written policies and procedures with respect to all emancipated adult Members receiving medical care through the Contractor. Specifically, this Act requires the Contractor:

7.8.3.1. To provide written information to each Member at the time of enrollment concerning:

7.8.3.1.1. The Member's rights, under State law, to make decisions concerning medical care, including the right to accept or refuse medical treatment and the right to formulate Advance Directives; and

7.8.3.1.2. The Contractor's policies with regard to a Member's right to execute an Advance Directive, including a requirement that the Network Provider present a statement of any limitation in the event the Network Provider cannot implement an Advance Directive on the basis of

conscience. At a minimum, the Network Provider's statement of limitation, if any, must clarify any difference between institution-wide conscience objections and those that may be raised by individual Network Providers; identify the State legal authority pursuant to NRS 449.628 permitting each objective; and describe the range of medical conditions or procedures affected by the conscience objection.

- 7.8.3.2. Educate the Member to inform his/her Network Provider to document in the Member's medical record whether the Member has executed an Advance Directive;
  - 7.8.3.3. Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an Advance Directive;
  - 7.8.3.4. Ensure compliance with requirements of State laws regarding Advance Directives, including informing Members that any complaints concerning the Advance Directives requirements may be filed with the appropriate State agency, which regulates the Contractor. The Contractor must reflect any changes in state law in this information as soon as possible, but no later than ninety (90) Calendar Days after the effective date of the change. Sample advance directives policies, procedures and forms, as well as patient information concerning Nevada law, are available on the State's website: <http://dhcfnv.gov/Resources/PI/AdvanceDirectives/>; and
  - 7.8.3.5. Educate Contractor staff and Network Providers on issues concerning Advance Directives, at least annually.
- 7.8.4. Member Services Department/Concierge Services
- 7.8.4.1. The Contractor shall maintain a Member Services Department (that also includes a Concierge Service) that personally assists Members to find a Provider. This department must be adequately staffed with qualified individuals who shall also assist Members, Member's family members, or other interested parties (consistent with laws on confidentiality and privacy) in obtaining information and services from the Contractor.
  - 7.8.4.2. The Member Services Department is to operate, at a minimum, traditional business hours of Monday through Friday, 8:00 a.m. through 5:00 p.m. PST, and not less than what is provided to the Contractor's commercial clients, if applicable.
  - 7.8.4.3. The Contractor must 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. PST for Member access.

- 7.8.4.4. At a minimum, Member Services Department staff must be responsible for the following:
  - 7.8.4.4.1. Explaining the operation of the Contractor;
  - 7.8.4.4.2. Explaining covered benefits;
  - 7.8.4.4.3. Resolving, recording and tracking Member Grievances and Appeals in a prompt and timely manner. The Member Services Department should serve as a single point of contact on Grievances and Appeals and the Member may be transferred to the dedicated work unit that handles Member Grievances and Appeals;
  - 7.8.4.4.4. Responding to Member inquiries; and
  - 7.8.4.4.5. Providing Concierge Services. If the Member requires assistance with accessing care, including finding a Provider, the Member Services Department will transfer the Member to the in-person Concierge Services. The in-person Concierge Service staff will assist the Member to find a Provider. This assistance is over and above providing a list of Network Providers or directing the Member to the web. The Concierge will provide the following assistance:
    - 7.8.4.4.5.1. Assisting Members in selecting and/or changing PCPs or Primary Care Sites. The Contractor must report any PCP and/or Primary Care Sites changes electronically to the State.
    - 7.8.4.4.5.2. Assisting the Member to make appointments and obtain services. The Contractor is required to find and schedule an appointment if the Member reports they are unable to access or find a provider or make an appointment.
    - 7.8.4.4.5.3. Assisting the Member in obtaining out-of-area and Out-of-Network care.
- 7.8.4.5. Member Services Department Performance Standards
  - 7.8.4.5.1. The Contractor must meet or exceed the following standards:
    - 7.8.4.5.1.1. Ninety percent (90%) of calls answered within thirty (30) seconds;

- 7.8.4.5.1.2. Capture rate of ninety-five percent (95%);
- 7.8.4.5.1.3. Hold time not to exceed thirty (30) seconds;
- 7.8.4.5.1.4. All inquiries that require a call back must be returned within one (1) Business Day of receipt: and
- 7.8.4.5.1.5. A minimum of seventy percent (70%) of all calls to the Member Services Department must be resolved during the first call.

7.8.4.5.2. The Contractor must self-report its compliance with these standards via a monthly affidavit that swears to compliance and/or identifies any areas of non-compliance and the planned resolution. This requirement applies to Member Services and the 24/7 toll-free call-in systems to the State. The Contractor must provide evidence of compliance in addition to the monthly affidavit if requested by the State.

7.8.4.5.3. The Contractor must have a separate telephone line and phone number for this Contract.

7.8.4.5.4. The Contractor must measure and monitor the accuracy of responses provided by the Member Services Department staff and take corrective action as necessary to ensure the accuracy of responses by staff.

## 7.8.5. Member Information Requirements

- 7.8.5.1. All information provided to Members or Potential Members must be provided in a manner and format that is easily understood and readily accessible. The Contractor must have mechanisms in place, as set forth in the Contract, to help Members and Potential Members understand the requirements and benefits offered by the Contractor.

The Contractor must have written information available on all areas deemed critical to obtaining services, which includes information about its services, access to services, and a Member Services phone number available to Members and Potential Members. This written information must be available in a font size no smaller than twelve (12) points and also be available in the prevalent non-English languages of the population groups served, as determined by the State, in its particular geographic service area taking into consideration the special needs of Members or Potential Members with disabilities or limited English proficiency. For the purposes of the Contract, the State has identified Spanish as the prevalent non-English language. The Contractor must

make free oral interpretation services available to each Member and Potential Member. This applies to all non-English languages, not just those that the State identifies as prevalent.

- 7.8.5.2. The Contractor's written material must include conspicuously visible taglines, as defined in 45 CFR 92.8(f)(1) and in the prevalent non-English language(s) in the State, that explains:
  - 7.8.5.2.1. The availability of written translation or oral interpretation to understand the information provided;
  - 7.8.5.2.2. The availability of the toll-free and Teletypewriter Telephone/Text Telephone (TTY/TDY) telephone number of the MCO member/customer service unit;
  - 7.8.5.2.3. The availability of interpretation services, including American Sign Language; and
  - 7.8.5.2.4. How to request auxiliary aids and services, including materials in alternative formats at no additional cost.
- 7.8.5.3. The Contractor's written material must use an easily understandable format and language and written in no higher than an eighth (8th) grade level. The Contractor must also develop appropriate alternative methods for communicating with visually and hearing-impaired Members, and accommodating physically disabled Members in accordance with the requirements of the Americans with Disabilities Act of 1990. All Members and Potential Members must be informed that this information is available in alternative formats and how to access those formats at no cost to the Member or Potential Member. All Member Materials must use the standard terminology and definitions as defined by the State and provided in ***Attachment K – Standard Member Material Definitions*** when such terminology or concepts are used in the Member Materials.
- 7.8.5.4. The State must approve initial mass letter mailings and brochures or any subsequent change in content for Members, exclusive of medical educational and disease management information, prior to release. If the State does not respond within ten (10) Business Days, the Contractor may consider the communication approved. This provision does not pertain to communications on specific topics to individual Members.
- 7.8.5.5. If the Contractor chooses to provide required Member information electronically, the information must meet the following requirements:
  - 7.8.5.5.1. The information must be in a format that is readily accessible, as defined in 42 CFR 438.10(a), and placed in a location on the Contractor's website that is prominent.

- 7.8.5.5.2. The information must be provided in an electronic form that can be electronically retained and printed.
- 7.8.5.5.3. The electronic information must be drafted and published in a manner consistent with the content and language requirements in Section 7.8.5.
- 7.8.5.5.4. The Contractor must notify Members that electronic information is available in paper form without charge and upon request. Such requests must be fulfilled within five (5) Business Days.

7.8.5.6. The Contractor must use any State-developed Member notices.

#### 7.8.6. Member Handbook

- 7.8.6.1. The Contractor must provide all Members with a Member Handbook using the State developed model handbook The Contractor can meet this requirement by sending the Member Handbook to the head of the household. The Member Handbook 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 CONTRACTOR AND THE MEMBER.”**

- 7.8.6.2. The Contractor must submit the Member Handbook to the State before it is published and/or distributed. The State will review the handbook and has the sole authority to approve or disapprove the handbook, in consultation with the Medical Care Advisory Committee (MCAC). Prior to the contract start date, the initial handbook must be submitted to the State for its MCAC review. Thereafter, annual updates must be submitted to the State for approval before publication and/or distribution. The Contractor must agree to make modifications in handbook language if requested by the State, in order to comply with the requirements of the Contract or as required by federal or State law. In addition, the Contractor must maintain documentation that the Member Handbook is updated at least once per year.
- 7.8.6.3. The Contractor must mail the Member Handbook to all Members within five (5) Business Days of receiving notice of the Member’s enrollment and must notify all Members of their right to request and obtain this information at least once per year or upon request. The Contractor will also publish the Member Handbook on the Contractor’s Internet website upon contract implementation and will update the website, as needed, to keep the Member Handbook current. The Contractor must give each Member written notice of any significant change, as defined by the State, in any of the required information in Section 7.8.6.4. The Contractor must issue updates to the Member Handbook thirty (30)

Calendar 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 managed care program. The Contractor will provide notification with a change directly affects the ongoing care of Members. The Contractor must also provide such notices in its semi-annual Member Newsletter (see Section 7.8.7) and must maintain documentation verifying Member Handbook updates.

- 7.8.6.4. At a minimum, the information enumerated below must be included in the Member Handbook and information on how to access the Member Handbook in alternative formats and languages:
- 7.8.6.4.1. Information that enables the Member to effectively use the program.
  - 7.8.6.4.2. An explanation of the Member's right to obtain available and accessible health care services covered under this contract; how to obtain health care services, including out-of-plan services; how to access them; the address and toll-free telephone number of the Contractor's member services, medical management or any other office or facility providing services directly to Members; and the days the office or facility is open and services are available.
  - 7.8.6.4.3. The role of the PCP and a description of how the Member will receive confirmation of their selection of a PCP, if a PCP was designated at the time of enrollment. Confirmation of the Member's PCP selection may be via an ID card and not printed directly in the Member Handbook.
  - 7.8.6.4.4. Any restrictions on the Member's freedom of choice among Network Providers.
  - 7.8.6.4.5. Procedures for changing a PCP as well as their right to select a PCP that meets their cultural and/or racial preferences.
  - 7.8.6.4.6. Member rights and protections as specified in 42 CFR 438.100.
  - 7.8.6.4.7. The amount, duration and scope of benefits available under the Contract in sufficient detail to ensure that Members understand the benefits to which they are entitled.
  - 7.8.6.4.8. Procedures for obtaining benefits, including authorization requirements.

- 7.8.6.4.9. The extent to which, and how, Members may obtain benefits, including family planning services, from Out-of-Network Providers.
- 7.8.6.4.10. Procedures for disenrollment without cause during the ninety (90) Calendar Day period beginning on the date the Member receives notice of enrollment and the annual open enrollment period. The Member Handbook must also describe procedures for disenrolling with cause and auto-assignment due to temporary loss of eligibility.
- 7.8.6.4.11. The extent to which, and how, after-hours and emergency coverage are provided including: what constitutes an Emergency Medical Condition; emergency and post stabilization services with reference to the definitions in 42 CFR 438.114; the fact that prior authorization is not required for Emergency Services; the process and procedures for obtaining Emergency Services, including the 911-telephone system or its local equivalent; the locations of any emergency settings and other locations that Providers and hospitals furnish emergency and post stabilization services under the contract; and emergency transportation; the fact that, subject to regulatory limitations, the Member has a right to use any hospital or other setting for emergency care and clarification of the appropriate use of Emergency Services.
- 7.8.6.4.12. Explanation of procedures for urgent medical situations and how to utilize services, including the Member services telephone number; clear definitions of urgent care; and how to use non-emergency transportation.
- 7.8.6.4.13. Policy on Referrals for specialty care and for other benefits not furnished by the Member's PCP, including explanation of authorization procedures and information that a Referral is not required in choosing a family planning Provider.
- 7.8.6.4.14. How and where to access any benefits that are available under the Medicaid and CHIP State Plans but are not covered under the contract, including any cost sharing, and how transportation is provided. For a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor need not provide the information on how or where to obtain the service. The Contractor must notify Members when it adopts a policy to discontinue coverage of a counseling or referral service based on moral or religious objectives at least thirty (30) Calendar Days prior to the effective date of the policy for any particular service.

- 7.8.6.4.15. Procedures for accessing emergency and non-emergency services when the Member is in and out of the Contractor service area.
- 7.8.6.4.16. Information on Grievance, Appeal, and State Fair Hearing procedures, as specified in 42 CFR 438.10(g) and Section 7.8.10.
- 7.8.6.4.17. Information on procedures for recommending changes in policies and services.
- 7.8.6.4.18. Information for adult Members on Advance Directives' policies and include a description of applicable State law as set forth in Section 7.8.3.
- 7.8.6.4.19. To the extent available, quality and performance indicators, including Member satisfaction.
- 7.8.6.4.20. The Member Handbook must include a distinct section for Members that explains the EPSDT program and includes a list of all the services available to children; a statement that services are provided to the Member at no costs and a telephone number that the Member can call to receive assistance in scheduling an appointment.
- 7.8.6.4.21. Information regarding prescription coverage, to the extent covered by the Contractor, or the phone number for the State's Pharmacy Benefit Manager.
- 7.8.6.4.22. Notification of the Member's responsibility to report any on-going care corresponding to a plan of care at the time of enrollment, and their right to continue that treatment under the Contractor on a transitional basis.
- 7.8.6.4.23. Notification of the Member's responsibility to report any third-party payment service to the Contractor and the importance of doing so.
- 7.8.6.4.24. Explanation of fraud and abuse and how to report suspected causes of fraud and abuse, including hotlines, e-mail addresses and the address and telephone number of the Contractor's fraud and abuse unit.
- 7.8.6.4.25. The transition of care policy and instructions on how to access continued services upon transition to FFS or another Contractor.

#### 7.8.7. Member Newsletter

The Contractor must publish a newsletter for Members at least twice per year. The newsletter will focus on topics of interest to Members and must adhere to the requirements for written Member materials in Section 7.8.5. The Contractor must provide a copy of all newsletters to the State. Additionally, these newsletters must be published on the Contractor's website.

#### 7.8.8. Provider Directory

7.8.8.1. The Contractor will publish its provider directory for all geographic service areas in machine readable, online, and paper formats which includes all providers including FQHCs, and any Subcontractors' provider directory upon contract implementation, update the paper directory quarterly (if a mobile-enabled provider directory is available) or otherwise monthly, and update the electronic directory on the website no later than thirty (30) Calendar Days after the Contractor receives updated provider information. Paper copies of the provider directories must be provided upon request of the Member. Listed providers in the Contractor's Network must be active, currently providing care or accepting new patients on behalf of the Contractor and the Provider's demographic data must be accurate. The Contractor will provide the State with the most current provider directory upon contract award for each geographic service area. Upon request by the State, the Contractor must confirm the Network adequacy and accessibility of its Provider Network and any Subcontractor's Provider Network. When queried, at least ninety percent (90%) of listed providers will confirm participation in the Contractor's Network.

7.8.8.2. The Contractor's Provider Directory must include the following:

- 7.8.8.2.1. A list of current Network Providers, including group affiliation and specialties for all PCPs and Specialists, hospitals, pharmacies, Behavioral Health and LTSS Providers, as appropriate.
- 7.8.8.2.2. The specific age bands served by psychologists and psychiatrists that treat child and adolescent Members; the age bands are 0-6, 6-12, 12-17, and 17-24.
- 7.8.8.2.3. The Provider's website URL, as appropriate;
- 7.8.8.2.4. If the Provider is accepting new patients in the Member's service area;
- 7.8.8.2.5. The Provider's board certification status;
- 7.8.8.2.6. All street addresses where the Provider practices;
- 7.8.8.2.7. All telephone numbers associated with the practice sites;
- 7.8.8.2.8. Availability of evening or weekend hours;

7.8.8.2.9. The Provider’s cultural and linguistic capabilities, including languages (including American Sign Language) spoken by the Provider or a skilled medical interpreter at the Provider’s office;

7.8.8.2.10. Whether the Provider has completed cultural competency training;

7.8.8.2.11. A picture of the Provider, if available;

7.8.8.2.12. Whether the Provider’s office/facility has accommodations for Members for physical disabilities, including officers, exam room(s), and equipment.

7.8.8.3. The Contractor must maintain a publicly accessible standards-based Provider Directory API described in 42 CFR 431.70, which must include the information in Section 7.8.8.2.

7.8.8.4. The Provider Directory APIs must meet the technical standards finalized in the HHS Office of the National Coordinator (ONC) 21st Century Cures Act final rule at 45 CFR 170.215.

#### 7.8.9. Drug Formulary

The Contractor must make its drug formulary available in machine readable, online, and paper formats and address the following:

7.8.9.1. Which medications are covered (both generic and name brand); and

7.8.9.2. The tier for each medication.

#### 7.8.10. Member Grievances and Appeals

7.8.10.1. The Contractor shall establish a system for Members, which includes a Grievance process, an Appeal process, and access to the State Fair Hearing system. The authority for the following provisions concerning Member Grievances and Appeals is found in 42 CFR part 438, subpart F (42 CFR 438.400 – 42 CFR 438.424). Additional and cross-referenced regulations include 42 CFR part 431, subpart E (State Fair Hearing process), 438.10(c) and (d) (format for written Member communications), and 42 CFR 438.210(c) (Adverse Benefit Determinations related to service authorization requests). NRS695G.090 exempts Medicaid from the provisions of NRS 695G.200- 695G 230 regarding Grievances and Appeals.

7.8.10.2. A Grievance is an expression of dissatisfaction or making a complaint about any matter other than one of the actions listed below, regardless of whether the communication requests any remedial actions. Possible issues for Grievances include, but are not limited to, access to care,

quality of services, interpersonal relationships between Contractor staff and Members, and failure to respect a Member's rights.

7.8.10.3. An Appeal is a specific request for review of one of the following Adverse Benefit Determinations:

The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered service;

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

7.8.10.3.2. The denial, in whole or part, of a payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an Adverse Benefit Determination;

7.8.10.3.3. The failure to provide services in a timely manner; or

7.8.10.3.4. The failure of a Contractor to process Grievances, Appeals, or expedited Appeals within the required timeframes, including resolution and notification.

7.8.10.3.5. For a resident of rural area with only one Vendor, the denial of a Member's request to exercise his or her right, to obtain services outside the Network (note the geographic service area for this program does not include rural areas).

7.8.10.3.6. The denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities (note there is no financial liability for Members under the managed care program).

7.8.10.4. The Contractor must provide information about these systems to Members at the time of enrollment. The Contractor must inform Providers and Subcontractors at the time they enter into a contract with the Contractor. The information must include:

7.8.10.4.1. The Member's right to file Grievances and Appeals and the requirements and timeframes for filing;

7.8.10.4.2. The availability of assistance with filing;

7.8.10.4.3. The Member's right to request a State Fair Hearing after the Contractor made a determination on a Member's Appeal that was adverse to the Member;

- 7.8.10.4.4. The Member's right to request continuation of benefits during an Appeal or State Fair Hearing although the Member may be liable for the cost of any continued benefits if the Adverse Benefit Determination is upheld; and
- 7.8.10.4.5. The toll free number to file oral Grievances and Appeals.
- 7.8.10.4.6. Any state-determined Provider's appeal rights to challenge the failure of the Contractor to cover a service.
- 7.8.10.5. Oversight and Management of the Grievance and Appeal System
  - 7.8.10.5.1. The Contractor's Member Grievance and Appeal system must be in writing and submitted to the State for review and approval at the time the Contractor's policies and procedures are submitted, and at any time thereafter when the Contractor's Member Grievances and Appeals policies and procedures have been revised or updated (not including grammatical or readability revisions or updates). The Contractor may not implement any policies and procedures concerning its Member Grievance and Appeal system without first obtaining the written approval of the State.
  - 7.8.10.5.2. The Contractor must have only one level of Appeal.
  - 7.8.10.5.3. The Contractor is required to establish and maintain an expedited review process for Appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. The Contractor must ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports an appeal. If the Contractor 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 Member prompt oral notice of the denial and follow up within two (2) Calendar days with a written notice.
  - 7.8.10.5.4. The Contractor must submit monthly and quarterly reports to the State that document the Grievance and Appeal activities on the templates provided by the State. The report must be broken out by hearing issue; date requested and dates resolved, program and outcome for tracking,

trending and corrective action. For tracking purposes, an oral Appeal or Grievance is differentiated from a routine telephone inquiry by the content of the inquiry. The State will review these reports as part of the State's Quality Strategy.

- 7.8.10.5.5. The Contractor must have a contact person who is knowledgeable of the Grievance and Appeal procedures and shall direct all Grievance and Appeals, whether verbal or the Member chooses to file in writing. Should a Member choose to Appeal in writing, the Member must be instructed to file via mail or fax to the designated P.O. Box or fax number for medical Appeals.
- 7.8.10.5.6. The Contractor shall have sufficient support staff (clerical and professional) available to process Grievance and Appeals in accordance with the requirements of the Contract. The Contractor must notify the State of the names of appointed staff and their phone numbers. Staff shall be knowledgeable about the applicable state and federal law, Contractor's policies and procedures, and all court orders governing Appeal procedures, as they become effective.
- 7.8.10.5.7. The Contractor, and its Subcontractors, must retain Member Grievance and Appeal records for a period of no less than 10 (ten) years. This applies to all records as specified in 42 CFR 438.3(u).
- 7.8.10.5.8. The State will conduct an annual audit of the Appeals process to ascertain compliance with federal and state regulations as well as contractual compliance.

#### 7.8.10.6. General Requirements for the Filing of Grievances and Appeals

- 7.8.10.6.1. A Member, or a Provider acting on behalf of the Member, may file an Appeal or Grievance either orally or in writing with the Contractor. In the event a Provider files an Appeal on the Member's behalf, the Provider must first obtain the Member's written permission with the exception of an expedited appeal. If a Grievance or Appeal is filed orally, the Contractor is required to document the contact for tracking purposes and to establish the earliest date of receipt. The Contractor must not require the Member to submit a written Appeal after making an oral Appeal. There is no requirement to track routine telephone inquiries.
- 7.8.10.6.2. In the case of Appeals, the Member must first exhaust the Contractor's Appeal process, but if not satisfied with the

outcome, may request a State Fair Hearing with the State. The Contractor is required to provide access to and information about the State Fair Hearing process in the event a Member's Appeal is not resolved in favor of the Member. Grievances are not eligible for referral to the State Fair Hearing process.

7.8.10.6.3. The Contractor must allow the Member, or Provider acting on behalf of the Member, to file an Appeal within sixty (60) Calendar Days from the date on the Contractor's Notice of Adverse Benefit Determination.

7.8.10.6.4. The Contractor must allow the Member, or Provider acting on behalf of the Member, to file a Grievance at any time.

#### 7.8.10.7. Notice of Adverse Benefit Determination

7.8.10.7.1. The Contractor must provide a written Notice of Adverse Benefit Determination to the Member when the Contractor makes an Adverse Benefit Determination affecting the Member. If a Provider has made a request on a Member's behalf and the Contractor makes an Adverse Benefit Determination, the Provider must be notified but this notification need not be in writing.

7.8.10.7.2. The Notice of Adverse Benefit Determination must meet all of the following requirements:

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

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

7.8.10.7.2.3. Use easily understood language and in compliance with the format requirements of 42 CFR 438.404(c) and 42 CFR 438.10(c) and (d).

7.8.10.7.2.4. Must explain the action the Contractor or its Subcontractor has taken or intends to take;

7.8.10.7.2.5. Must explain the reasons for the Adverse Benefit Determination, including the right of the Member to be provided upon request and free of charge, reasonable

access to and copies all documents, records, and other information relevant to the Member's Adverse Benefit Determination. Such information includes Medical Necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits ;

- 7.8.10.7.2.6. Must explain the Member's or the Provider's right to file an Appeal, if he/she disagrees with decision;
- 7.8.10.7.2.7. Must explain the Member's right to request a State Fair Hearing after the Member has exhausted the Contractor's internal one level of Appeal procedures;
- 7.8.10.7.2.8. Must explain the procedures for exercising the Member's rights to Appeal;
- 7.8.10.7.2.9. Must explain the circumstances under which expedited resolution is available and how to request it;
- 7.8.10.7.2.10. Must explain the Member's rights to have benefits continue pending Appeal if the Appeal is filed on or before the later of the following: within ten (10) Calendar Days of the Contractor mailing the Notice of Adverse Benefit Determination or the intended effective date or the proposed Adverse Benefit Determination pending the resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services;
- 7.8.10.7.2.11. Must explain that the Member may represent himself or herself or use legal counsel, a relative, a friend, or other spokesman;
- 7.8.10.7.2.12. Must explain the specific regulations that support, or the change in federal or State law that requires the Adverse Benefit Determination; and
- 7.8.10.7.2.13. Must explain the Member's right to request an evidentiary hearing if one is

available or a state agency hearing, or in cases of an Adverse Benefit Determination based on change in law, the circumstances under which a hearing will be granted.

- 7.8.10.7.3. The Contractor must give notice at least ten (10) Calendar Days before the date of the Adverse Benefit Determination when the Adverse Benefit Determination is a termination, suspension, or reduction of previously authorized Covered Services. This timeframe may be shortened to five (5) Calendar Days if probable Member fraud has been verified.
- 7.8.10.7.4. The Contractor must give a Notice of Adverse Benefit Determination on the date of the Adverse Benefit Determination when the action is a denial of payment.
- 7.8.10.7.5. The Contractor 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 Benefit Determinations.
- 7.8.10.7.6. The Contractor must give notice no later than the date of the Adverse Benefit Determination for the following circumstances:
  - 7.8.10.7.6.1. The Contractor has factual information confirming the death of the Member;
  - 7.8.10.7.6.2. The Contractor has a signed Member statement stating the Member no longer wishes services or requesting termination or reduction of services (where the Member understands that this must be the result of supplying that information);
  - 7.8.10.7.6.3. The Member's admission to an institution that results in ineligibility for future Medicaid services;
  - 7.8.10.7.6.4. The Member's address is unknown and the post office returns mail indicating no forwarding address;
  - 7.8.10.7.6.5. The Member has been accepted for Medicaid services by another local

jurisdiction, state, territory, or commonwealth;

7.8.10.7.6.6. The Member's physician prescribes a change in the level of medical care;

7.8.10.7.6.7. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions; or

7.8.10.7.6.8. When being transferred from a nursing facility for the following reasons:

7.8.10.7.6.8.1 The Member's health improves sufficiently to allow a more immediate transfer or discharge;

7.8.10.7.6.8.2 An immediate transfer or discharge is required by the Member's urgent medical needs; or

7.8.10.7.6.8.3 The Member has not resided in a nursing facility for thirty (30) Calendar Days (applies only to adverse action for nursing facility transfers).

7.8.10.8. Continuation of Benefits While the Contractor's Appeal Process and the State Fair Hearing are Pending

7.8.10.8.1. The Contractor must continue the Member's benefits while the Contractor's internal Appeals process is pending and while the State Fair Hearing is pending if all of the following conditions exist:

7.8.10.8.1.1. The request for continuation of benefits is submitted to the Contractor on or before the later of the following: within ten (10) Calendar Days of the Contractor mailing the Notice of Adverse Benefit Determination; or, the intended effective date of the Contractor's proposed Adverse Benefit Determination;

- 7.8.10.8.1.2. The Member files the request for an Appeal within sixty (60) Calendar days following the date on the Adverse Benefit Determination notice;
  - 7.8.10.8.1.3. The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
  - 7.8.10.8.1.4. The services were ordered by an authorized Provider;
  - 7.8.10.8.1.5. The original periods covered by the original authorization have not expired; and
  - 7.8.10.8.1.6. The Member requests an extension of benefits.
- 7.8.10.8.2. If, at the Member's request, the Contractor continues the Member's benefits while the Appeal is pending, the benefits must be continued until one of the following occurs:
- 7.8.10.8.2.1. The Member withdraws the Appeal;
  - 7.8.10.8.2.2. Ten (10) Calendar Days pass after the Contractor mails the Notice of Adverse Benefit Determination, providing the resolution of the Appeal against the Member, unless the Member, within the ten (10) Calendar Day timeframe has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached; or
  - 7.8.10.8.2.3. A State Fair Hearing Officer issues a hearing decision adverse to the Member.
- 7.8.10.8.3. If the final resolution of the Appeal is adverse to the Member, the Contractor may recover the cost of the services furnished to the Member 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).
- 7.8.10.8.4. If the Contractor or State Fair Hearing Officer reverses an action to deny, limit, or delay services that were not furnished while the Appeal was pending, the Contractor must authorize or provide the disputed services promptly

and as expeditiously as the Member's health condition requires but no later than seventy-two (72) hours from the date the Contractor receives notice reversing the determination. If the Contractor or State Fair Hearing Officer reverses a decision to deny authorization of services, and the Member received the disputed services while the Appeal was pending, the Contractor must pay for those services.

#### 7.8.10.9. Timeframes for Disposition of Grievances and Appeals

- 7.8.10.9.1. The Contractor is required to dispose of each Grievance and resolve each Appeal and to provide notice as expeditiously as the Member's health condition requires within the State's established timeframes specified as follows:
  - 7.8.10.9.1.1. Standard disposition of Grievances: The Contractor is allowed no more than ninety (90) Calendar Days from the date of receipt of the Grievance.
  - 7.8.10.9.1.2. Standard resolution of Appeals: The Contractor is allowed no more than thirty (30) Calendar Days from the date of receipt of the Appeal.
  - 7.8.10.9.1.3. Expedited resolution of Appeals: The Contractor must resolve each expedited Appeal and provide notice, as expeditiously as the Member's health condition requires, not to exceed seventy-two (72) hours after the Contractor receives the expedited Appeal request.
- 7.8.10.9.2. The Contractor must inform the Member 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 Appeal.
- 7.8.10.9.3. These timeframes for resolution of standard and expedited Appeals and Grievances may be extended up to fourteen (14) Calendar Days if the Member requests such an extension or the Contractor demonstrates to the satisfaction of the State that there is a need for additional information and how the extension is in the Member's interests. If the State grants the Contractor's request for an extension, the Contractor must give the Member written notice of the reason for the delay within two (2) Calendar Days and inform the Member of the right to file

a Grievance if the Member disagrees with the decision. Prompt oral notice must be provided in addition to the written notice for expedited Appeals. In the event of an extension, the Contractor must resolve the Appeal or Grievance as expeditiously as possible, but no later than the date the extension expires.

- 7.8.10.9.4. In the event the Contractor fails to adhere to the notice and timing requirements for Appeals specified in the Contract, and in accordance with 42 CFR 438.408, the Member is deemed to have exhausted the Contractor's Appeals process. The Member may initiate a State Fair Hearing.

#### 7.8.10.10. Handling of Grievances and Appeals

The Contractor must meet the requirements of this section in the administration of the Grievance and Appeals system.

- 7.8.10.10.1. Provide Members any reasonable assistance in completing forms and taking other procedural steps, including assisting the Member and/or the Member'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;
- 7.8.10.10.2. Acknowledge receipt of each Grievance and Appeal;
- 7.8.10.10.3. 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
- 7.8.10.10.4. Ensure that the individuals who make decisions on Grievances and Appeals are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the Member's condition or disease if the grievance or appeal involves any of the following:
  - 7.8.10.10.4.1. An Appeal of a denial that is based on Medical Necessity;
  - 7.8.10.10.4.2. A Grievance regarding the denial of an expedited resolution of an appeal; or
  - 7.8.10.10.4.3. A Grievance or Appeal that involves clinical issues.

- 7.8.10.10.5. Oral inquiries seeking to Appeal an Adverse Benefit Determination are treated as Appeals;
- 7.8.10.10.6. The Member must be provided a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing, and that the Member is informed by the Contractor of the limited time available for this in the case of expedited resolution;
- 7.8.10.10.7. The Member and his/her representative must be provided the opportunity, before and during the Appeals process, to examine the Member's case file, including medical records, and any other document and records considered during the Appeals process. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for Appeals; and
- 7.8.10.10.8. The Contractor to include, as parties to the Appeal, the Member and his/her representative or the legal representative of a deceased Member's estate.

7.8.10.11. Notice of Resolution of a Grievance or Appeal

- 7.8.10.11.1. The Contractor must notify the Member 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. In addition, reasonable efforts must be made to provide oral notice of the resolution of the Grievance or Appeal. For expedited Appeal resolution requests, the Contractor is required to make a good faith effort to provide an oral notice of the disposition in addition to the required written notice.
- 7.8.10.11.2. For Appeals that are not wholly resolved in favor of the Member, the notice must also include:
  - 7.8.10.11.2.1. The right of the Member to request a State Fair Hearing from the State and how to do so;
  - 7.8.10.11.2.2. The right to request to receive benefits while the hearing is pending and how to make this request; and
  - 7.8.10.11.2.3. That the Member may be held liable for the cost of those benefits if the State Fair Hearing's Officer upholds the Contractor's Adverse Benefit Determination.

#### 7.8.10.12. State Fair Hearing Process

- 7.8.10.12.1. The State Fair Hearing process is described in MSM Chapter 3100. A Member, Member's representative or the representative of a deceased Member's estate has the right to request a State Fair Hearing from the State when they have exhausted the Contractor'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 Contractor's notice of resolution of the Appeal.
- 7.8.10.12.2. The Contractor is required to inform the Member of their right to a State Fair Hearing, how to obtain such a hearing, requirements for continuation of benefits, and representation rules must be explained and provided in writing to the Member by the Contractor pursuant to 42 CFR 431.200(b); 42 CFR 431.220(a)(6) and 42 CFR 438.408(e)(2)(i).
- 7.8.10.12.3. The Contractor will participate in the State Fair Hearing process, at the Contractor's expense, in each circumstance in which a Member for whom the Contractor has made an Adverse Benefit Determination requests a State Fair Hearing. The Contractor 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.)
- 7.8.10.12.4. The State will not accept requests for State Fair Hearings that address provider enrollment, termination or other contract disputes between the Contractor and its Providers and/or Subcontractors. Likewise, Grievances are not eligible for State Fair Hearings.
- 7.8.10.12.5. The Contractor is bound by the decision of the State Fair Hearing Officer and must comply with any decision resulting from the State Fair Hearing process.

#### 7.8.10.13. Expedited State Fair Hearing

The State's timeframe for reaching an expedited State Fair Hearing decision is as expeditiously as the Member'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:

- 7.8.10.13.1. Meets the criteria for an expedited appeal process but was not resolved within the Contractor's expedited Appeal timeframes, or

7.8.10.13.2. Was resolved wholly or partially adversely using the Contractor's expedited Appeal timeframes.

## **7.9. QUALITY IMPROVEMENT AND PERFORMANCE PROGRAM**

### **7.9.1. State Quality Assessment and Performance Strategy**

7.9.1.1. The State has developed a Medicaid and Nevada Check Up Managed Care Quality Assessment and Performance Improvement Strategy (henceforth, referred to as the Quality Strategy), pursuant to 42 CFR 438.340. The State's Quality Strategy has two basic purposes:

7.9.1.1.1. To ensure compliance with federal and state statutory and regulatory requirements on quality; and

7.9.1.1.2. 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 and Nevada Check Up Members.

7.9.1.2. The State's responsibilities related to the development and maintenance of the Quality Strategy is as follows:

7.9.1.2.1. Have a written strategy for assessing and improving the quality of managed care services offered by all Contractors;

7.9.1.2.2. Obtain the input of Members and other stakeholders in the development of the final Quality Strategy and make the strategy available for public comment before adopting it to final;

7.9.1.2.3. Ensure that Contractors comply with the Standards established by the State;

7.9.1.2.4. Conduct periodic reviews to evaluate the effectiveness of the Quality Strategy, and update the Quality Strategy periodically, as needed;

7.9.1.2.5. Submit to CMS one (1) copy of the initial Quality Strategy and a copy of the revised Quality Strategy whenever significant changes are made; and

7.9.1.2.6. The State will approve the Quality Strategy and maintain ultimate authority for overseeing its management and direction. The Contractor is also required to participate in quality initiatives that align with the goals and objectives identified in the State's performance measures, as defined

the in the State budget, and to use the Quality Strategy to inform the Contractor's Population Health strategy. The Quality Strategy is in two parts: an overriding conceptual program and an annual Work Plan.

- 7.9.1.3. The Quality Strategy incorporates procedures that:
- 7.9.1.3.1. Assess the quality and appropriateness of care and services furnished to all Medicaid and Nevada Check Up Members.
  - 7.9.1.3.2. Require the Contractor to develop a cultural competency plan as set forth in Section 7.5.3.2 that includes methods to encourage culturally competent contact between Members and Providers, staff recruitment, staff training, translation services, and the development of appropriate health education materials.
  - 7.9.1.3.3. Monitor and evaluate the Contractor's compliance with the standards. It will include a description of how the State will complete this monitoring in line with the Quality Strategy.
  - 7.9.1.3.4. 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 by each Contractor.
  - 7.9.1.3.5. Designates the performance measures and levels developed by CMS in consultation with states and other relevant stakeholders;
  - 7.9.1.3.6. Designates an information system that supports the initial and ongoing operation and review of the State's Quality Strategy;
  - 7.9.1.3.7. Designates a description of how the State uses intermediate sanctions in support of its Quality Strategy. These sanctions meeting the requirements specified in 42 CFR 438, subpart I. The State's description specifies its methodology for using sanctions as a vehicle for addressing identified quality of care problems; and
  - 7.9.1.3.8. Identifies standards, at least as stringent as those in 42 CFR part 438 for access to care, structure and operations, and quality measurement and improvement.

## 7.9.2. Standards for Internal Quality Assurance Programs

- 7.9.2.1. Federal regulations (42 CFR 438.330) mandate that States must, through its contracts, require each managed care organization (Contractor) to have an ongoing quality assessment and performance improvement program for the services it furnishes its Members through implanted strategies to improve population health and reduce health disparities. Internal Quality Assurance Programs (IQAPs) consist of systematic activities, undertaken by the Contractor, to monitor and evaluate the care delivered to Members according to predetermined, objective standards, and effect improvements as needed.
- 7.9.2.2. In accordance with the requirements set forth in 42 USC 300kk, the Contractor must develop and maintain the ability to collect and report data on race, ethnicity, sex, primary language, and disability status for the Member and Member's parents or legal guardians if Members are minors or legally incapacitated individuals.
- 7.9.2.3. The State or its designee will conduct an annual review of the Contractor. In addition, the State will monitor and analyze Grievances and Appeals, Provider Disputes and will periodically conduct Member and Provider satisfaction surveys. The State will monitor the Contractor's progress in achieving the goals and objectives in the Contractor's IQAP and the State's Quality Strategy. If the State cannot confirm the Contractor's progress toward compliance, the State will notify and give the Contractor the opportunity to demonstrate evidence of progress and compliance before seeking to impose monetary penalties or other remedies under the Contract.
- 7.9.2.4. The Contractor must have its own evaluation of the impact and effectiveness of its quality assessment and IQAP.
- 7.9.2.5. The State will provide an IQAP program description and progress report template required for submission by the Contractor within ninety (90) Calendar Days of contract execution and by March 30 annually thereafter. The IQAP Program Description must address all of the requirements of Section 7.9.3, encompass all levels of the Contractor's organization and have a clear linkage to the State's Quality Strategy. At the request of the State, or as required by an amendment to the Contract, the Contractor must make changes to its IQAP and provide the State with a revised draft for review and approval.
- 7.9.2.6. The Contractor must plan for and implement necessary performance standards under the Contract pursuant to the following:
  - 7.9.2.6.1. The "reporting year" is the calendar year;
  - 7.9.2.6.2. The Contractor must submit HEDIS data, audited by a nationally recognized Contractor, to the State for all performance measures no later than June 30 of each year.

7.9.2.6.3. The Contractor must cooperate with the State's designated EQRO to validate the Contractor's HEDIS performance measures.

7.9.2.7. Plan of Correction (POC) Procedure

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

7.9.2.7.2. Specific problem(s) which require corrective action;

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

7.9.2.7.4. The goals of the corrective action;

7.9.2.7.5. The timetable for action;

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

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

7.9.2.7.8. The Contractor's staff person(s) responsible for implementing and monitoring the POC.

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

7.9.2.7.10. Unless otherwise specified by the State, the Contractor has thirty (30) Calendar Days from date of notification by the State to submit a POC, as specified. The Contractor's POC will be evaluated by the State to determine whether it satisfactorily addresses the actions needed to correct the deficiencies. If the Contractor's POC is unsatisfactory, the State will indicate the section(s) requiring revision and/or necessary additions and request a satisfactory plan be submitted by the Contractor, unless otherwise specified, within thirty (30) Calendar Days of receipt of the State's second directive. If the Contractor's second plan is unsatisfactory, the State may declare a material breach. Within ninety (90) Calendar Days after the Contractor has submitted an acceptable POC or one has

been imposed, the State will initiate a follow-up review, which may include an on-site review.

- 7.9.2.7.11. If the Contractor's non-compliance with the provision of covered Medically Necessary benefits and services becomes an impediment to ensuring the health care needs of Members and/or the ability of Providers to adequately attend to those health care needs, the State will take an administrative sanction against the Contractor. Such a sanction will disallow further enrollment and may also include adjusting auto-assignment formulas used for Member enrollment purposes. Such sanctions will continue until Contractor 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 Contractor.
- 7.9.2.8. The Contractor must report the status and results of each performance improvement project to the State as requested, including those that incorporate the requirements of 42 CFR 438.330(a)(2). Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects to be available to the State for its annual review of the Contractor's quality assessment and improvement program.
- 7.9.2.9. The Contractor must submit performance improvement measurement data annually using standard measures required by the State, including those that incorporate the requirements of 42 CFR 438.330(a)(2) and the State's Quality Strategy. The Contractor must submit data as specified by the State that enables the State to measure the Contractor's performance.
- 7.9.2.10. The State will use the most current sources for the IQAP guidelines and the most current NCQA specifications for HEDIS measure reporting. The State uses HEDIS data whenever possible to measure the Contractor's performance with specific indices of quality, timeliness and access to services. The State's EQRO conducts NCQA HEDIS Compliance Audits of the Contractor annually and reports the HEDIS results to the State.
- 7.9.2.11. The Contractor's senior leadership must foster and create an ongoing dynamic culture of innovation, continuous quality improvement and health care excellence through its Population Health and quality management programs. The Contractor, through its senior leadership, must:
  - 7.9.2.11.1. Provide direction and oversight of all quality and population health improvement efforts;

- 7.9.2.11.2. Promote culture that is focused on supporting an optimal health care delivery system through collaborative, cross-system health management strategies;
- 7.9.2.11.3. Ensure a focus on both individual- and system-wide levels of improving the quality of care and reducing health disparities;
- 7.9.2.11.4. Ensure that gaps in care are remedied at both the individual and systemic levels;
- 7.9.2.11.5. Consistently and frequently use data and analytics strategically to identify improvement opportunities, evaluate the effectiveness of improvement initiatives, and incorporate results and lessons learned into the Contractor's business processes;
- 7.9.2.11.6. Ensure the Contractor works collaboratively with other Contractors and the State to share results of improvement activities, and to develop and implement strategies to have a collective impact in improving population health outcomes, including addressing health equity and social determinants of health;
- 7.9.2.11.7. Ensure relevant cross-organization leaders (e.g., member services, provider relations, UM staff, CM staff) are engaged in quality improvement efforts (e.g., Care Coordination and quality improvement efforts) to inform and address barriers to optimal care and health outcomes;
- 7.9.2.11.8. Promote on-going, rapid-cycle improvement within quality improvement projects, including required performance improvement projects and services provided by the Contractor, its Subcontractors, and Providers.

### 7.9.3. Written IQAP Description

The Contractor must have a written description of its IQAP, which must meet the following criteria:

#### 7.9.3.1. Goals and Objectives

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

#### 7.9.3.2. Scope

- 7.9.3.2.1. 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.
- 7.9.3.2.2. The IQAP methodology must provide for review of the entire range of care provided by the Contractor, including services provided to CSHCN, by assuring that all demographic groups, care settings (e.g., inpatient, ambulatory, including care provided in private practice offices and home care); and types of services (e.g., preventive, primary, specialty care, and ancillary) are included in the scope of the review. The review of the entire range of care is expected to be carried out over multiple review periods and not on a concurrent basis. The State expects that this review occurs no less than annually.
- 7.9.3.2.3. The comprehensive IQAP program must include mechanisms to assess the quality and appropriateness of care furnished to Members using LTSS, including an assessment of care between care settings and a comparison of services and supports received with those set forth in the Member's treatment/service plan. In addition, this comprehensive IQAP program must include participation in efforts by the state to prevent, detect, and remediate critical incidents (consistent with assuring Member health and welfare that are based, at a minimum, of the requirements on the state for home and community-based waiver programs).

7.9.3.3. 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.

7.9.3.4. Continuous Activity

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

7.9.3.5. Provider Review

Review by physicians and other health professionals of the process followed in the provision of health services must be conducted and the

Contractor must provide feedback to health professionals and Contractor staff regarding performance and patient health care outcomes.

7.9.3.6. Focus on Health Outcomes

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

7.9.4. 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 Members 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:

7.9.4.1. Specification of clinical or health service delivery areas to be monitored.

7.9.4.2. The monitoring and evaluation of care must reflect the populations served by the Contractor in terms of age groups, disease categories and special risk status, including CSHCN.

7.9.4.3. The IQAP must monitor and evaluate, at a minimum, care and services in certain priority areas of concern selected by the State. These are selected from among those identified by the CMS and the State and are identified through the State's Quality Strategy.

7.9.4.4. Performance Improvement Projects (PIPs) in accordance Section 7.9.5.

7.9.4.5. Use of Quality Indicators

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

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

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

7.9.4.5.3. 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

- 7.9.4.5.4. 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 Contractor's PIU and the State SUR Unit for appropriate action.
- 7.9.4.6. Use of Clinical Care Standards/Practice Guidelines
  - 7.9.4.6.1. 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.
  - 7.9.4.6.2. The standards/guidelines are based on reasonable scientific evidence and developed or reviewed by Network Providers;
  - 7.9.4.6.3. The standards/guidelines must focus on the process and outcomes of health care delivery, as well as access to care;
  - 7.9.4.6.4. The Contractor must ensure a mechanism is in place for continuously updating the standards/guidelines;
  - 7.9.4.6.5. The standards/guidelines must be included in provider manuals developed for use by the Contractor'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 Members and Potential Members upon request;
  - 7.9.4.6.6. The standard/guidelines must address preventive health services;
  - 7.9.4.6.7. The standards/guidelines must be developed for the full spectrum of populations enrolled in the managed care program; and
  - 7.9.4.6.8. The IQAP shall use these standards/guidelines to evaluate the quality of care provided by the Contractor's Network Providers, whether the Providers are organized in groups, as individuals, or in combinations thereof.
- 7.9.4.7. Analysis of Clinical Care and Related Services
  - 7.9.4.7.1. 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 uses clinical care standards or practice guidelines.

- 7.9.4.7.2. Multi-disciplinary teams are required, when appropriate, to analyze and address systems issues. The Contractor must have mechanisms in effect to assess quality and appropriateness of care furnished to Members with special health care needs.
- 7.9.4.7.3. Clinical and related service areas requiring improvement are identified.
- 7.9.4.7.4. The Contractor must work collaboratively with the State to determine Member race and ethnicity. The Contractor must organize interventions specifically designed to reduce or eliminate disparities in health care, see Section 7.5 Population Health requirements.
- 7.9.4.7.5. The Contractor must allow the State access to clinical studies, when available and appropriate.
- 7.9.4.8. Implementation and Assessment of Plans of Correction
  - 7.9.4.8.1. The IQAP must include written procedures for taking corrective action, also referred to as Plans of Correction and as described in Section 7.9.2.7, whenever inappropriate or substandard services are furnished, or services that should have been furnished were not. These written corrective action procedures must include:
    - 7.9.4.8.1.1. Specification of the types of problems requiring corrective action;
    - 7.9.4.8.1.2. Specification of the person(s) or body responsible for making the final determinations regarding quality problems;
    - 7.9.4.8.1.3. Specific actions to be taken; provision of feedback to appropriate health professionals, providers and staff;
    - 7.9.4.8.1.4. The schedule and accountability for implementing corrective actions;
    - 7.9.4.8.1.5. The approach to modifying the corrective action if improvements do not occur; and
    - 7.9.4.8.1.6. Procedures for terminating the affiliation with the physician, or other health professional or Provider.

7.9.4.8.2. Assessment of Effectiveness of Plans of Correction (POC)

As actions are taken to improve care, the Contractor must monitor and evaluate the POC to assure required changes have been made. In addition, changes in practice patterns must be monitored. The Contractor must assure timely follow-up on identified issues to ensure actions for improvement have been effective.

7.9.4.9. Evaluation of Continuity and Effectiveness of the IQAP

7.9.4.9.1. The Contractor 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.

7.9.4.9.2. At the end of each calendar year, a written Quality Program Evaluation on the IQAP must be prepared and submitted to the State 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.

7.9.4.9.3. The Quality Program Evaluation will provide evidence that quality assurance activities have contributed to significant improvements in the care delivered to Members and include:

7.9.4.9.3.1. A description of State and Contractor-initiated improvement projects, including the annual PIPs; and the outcomes and trended results for each improvement project, including documentation of successful and unsuccessful interventions;

7.9.4.9.3.2. A summary of the Contractor's assessment of the effectiveness of improvement projects based on performance measurement data;

7.9.4.9.3.3. A description of how the Contractor meets the requirements for the development and dissemination of clinical practice guidelines described in this appendix;

7.9.4.9.3.4. A description of mechanisms the Contractor uses to detect both underutilization and overutilization;

- 7.9.4.9.3.5. A description of mechanisms the Contractor uses to assess the quality and appropriateness of care furnished to members with special health care needs and Members receiving long-term services and supports;
- 7.9.4.9.3.6. A description of the Contractor's efforts to prevent, detect, and remediate critical incidents Summary of quality committee structure and activity providing structure, at a minimum for the internal quality improvement committee that monitors the annual quality strategy and work plan; and internal Utilization Review oversight committee that monitors utilization against practice guidelines and treatment planning protocols and policies.
- 7.9.4.9.3.7. An assessment of the quality and appropriateness of care furnished to all Members, availability of services, second opinions, timely access and cultural considerations, with a report of aggregate data indicating methods used to monitor compliance;
- 7.9.4.9.3.8. An assessment of the quality and appropriateness of care furnished to Members with special health care needs, with a report of aggregate data indicating the number of Members identified and methods used to evaluate the need for direct access to Specialists;
- 7.9.4.9.3.9. A demonstration of improvement in an area of poor performance in Care Coordination for Members with special health care needs and behavioral conditions;
- 7.9.4.9.3.10. A report on the Member Grievance and Appeal system; and
- 7.9.4.9.3.11. Monitoring and enforcement of consumer rights and protections that ensures consistent response to complaints of violations of consumer rights and protections;

- 7.9.4.9.4. The report should include evidence that quality assurance activities have contributed to significant improvements in the care delivered to Members.
- 7.9.4.9.5. The Contractor's evaluation of the IQAP must demonstrate how it meets the requirements of this section, as well as how the Contractor evaluated the impact and effectiveness of each improvement activity within the IQAP. The Contractor's evaluation must also include:
  - 7.9.4.9.5.1. How the Contractor will incorporate the results in the Contractor's quality improvement strategy; and
  - 7.9.4.9.5.2. How the Contractor plans to update its quality improvement strategy based on the findings of the self-evaluation.

7.9.4.10. Accountability to the Governing Body

The Governing Body of the Contractor 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 Contractor that is responsible for the Contractor's IQAP review. Responsibilities of the Governing Body for monitoring, evaluating and making improvements to care include:

7.9.4.10.1. Oversight of IQAP

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

7.9.4.10.2. Oversight Entity

The Governing Body has formally designated an entity or entities within the Contractor 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.

7.9.4.10.3. 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.

7.9.4.10.4. Annual IQAP Review

The Governing Body formally reviews on a periodic basis, but no less frequently than annually, a written report on the IQAP. This annual quality program evaluation report must be submitted to the State in the second calendar quarter and at minimum must include studies undertaken; results; subsequent actions and aggregate data on utilization and quality of services rendered; and an assessment of the IQAPs continuity, effectiveness, and current acceptability.

7.9.4.10.5. 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 Contractor. 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.

7.9.4.11. Active Quality Assurance Committee

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

7.9.4.11.1. At a minimum, the Contractor's quality committee structure must include the following committees:

7.9.4.11.1.1. Executive Committee;

7.9.4.11.1.2. Quality Management Committee that reports to the Executive Committee;

7.9.4.11.1.3. UM Subcommittee that reports to the Quality Management Committee;

7.9.4.11.1.4. Care Management Subcommittee that reports to the Quality Management Committee;

7.9.4.11.1.5. Member Services Subcommittee that reports to the Quality Management Committee;

7.9.4.11.1.6. Member Advisory Board that reports to the Quality Management Committee;

7.9.4.11.1.7. Provider Services Subcommittee that reports to the Quality Management Committee; and

7.9.4.11.1.8. Provider Advisory Board that reports to the Quality Management Committee.

7.9.4.11.2. 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.

7.9.4.11.3. Established Parameters for Operating

The role, structure and function of the structure/committee must be specified; this includes a listing of all quality related committees with roles and responsibilities and Contractor staff and Provider titles on UM, Care Management and Provider Services Committees. The Contractor must devote a portion of its regularly scheduled Quality Management / Quality Improvement committee meetings to the review of Member Grievances and Appeals received.

7.9.4.11.4. Documentation

There must be records documenting the structure and committee's activities, findings, recommendations and actions. The Contractor must have mechanisms for maintenance of meeting minutes, signatures, and dates reflecting decisions made.

7.9.4.11.5. Accountability

The IQAP Executive Committees 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.

7.9.4.11.6. Membership

There must be active participation in the IQAP committee from Network Providers, who are representative of the composition of the Contractor's Network.

7.9.4.12. IQAP Supervision

The Contractor must designate a senior executive who is responsible for IQAP implementation. The Contractor's Medical Director must be involved in quality monitoring and improvement activities.

#### 7.9.4.13. 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. The Contractor must dedicate sufficient staff to fulfill the Contractor's set of clearly defined functions and responsibilities, so that staffing is proportionate to and adequate for the planned number of and types of quality improvement (QI) initiatives within the managed care program.

7.9.4.13.1. The Contractor must have a QI Manager dedicated to the managed care program with reporting authority to the Contractor's Medical Director.

7.9.4.13.2. The Contractor must have QI teams composed of Contractor staff fully dedicated to the managed care program that represent the following areas of expertise:

7.9.4.13.2.1. Continuous quality improvement;

7.9.4.13.2.2. Analytics;

7.9.4.13.2.3. Subject matter expertise in clinical and/or nonclinical improvement topic(s) being addressed through improvement efforts;

7.9.4.13.2.4. Health equity;

7.9.4.13.2.5. The Contractor's policies and processes related to the improvement topic; and

7.9.4.13.2.6. Member and Provider perspectives (may be staff or liaisons with the Contractor's Member and Provider Services departments).

#### 7.9.4.14. Provider Participation in IQAP

7.9.4.14.1. Network Providers and other providers must be kept informed about the written IQAP through Provider newsletters and updates to the provider manual.

7.9.4.14.2. The Contractor must include in its provider contracts and employment agreements, for physician and non-physician providers, a requirement securing cooperation with the IQAP.

- 7.9.4.14.3. Provider contracts must specify that hospitals and other Providers will allow the Contractor access to the medical records of its Members.
- 7.9.4.14.4. The Contractor must include Providers on, at a minimum, the UM and Provider Services Subcommittees.
- 7.9.4.14.5. The Contractor must organize and accommodate organization of a Provider Advisory Board that reports to the IQAP Provider Services Subcommittee or Executive Committee.
- 7.9.4.14.6. The Provider Advisory Board must have broad representation of Provider types in the Network, including at least one (1) PCP serving children and adolescents, one (1) PCP serving adults, one (1) OB/GYN, one (1) psychiatrist, one (1) licensed Behavioral Health clinical professional, one (1) substance abuse professional, one (1) community-based Care Coordinator or community Case Manager serving a Network Provider, one (1) peer support specialist or a Behavioral Health Case Manager, and other practitioners, such that there is broad representation from across the geographic service area under the Contract.
- 7.9.4.14.7. The Provider Advisory Board is required to meet quarterly with minutes submitted to the State within thirty (30) Calendar Days of the Meeting.
- 7.9.4.15. Member Participation in the IQAP
  - 7.9.4.15.1. Members must be kept informed about the quality initiatives and results through Member newsletters and Website postings and through the Member Advisory Board.
  - 7.9.4.15.2. The Contractor must organize and accommodate organization of a Member Advisory Board that reports into the Contractor's Quality Management Committee.
  - 7.9.4.15.3. Member Advisory Board input must be prioritized to improve service quality and member experience in the program.
  - 7.9.4.15.4. The Contractor must develop a Member Advisory Board comprised of a minimum of twelve (12) Members or Members' designated legal representatives from across the geographic service area under the Contract.

7.9.4.15.5. The Member Advisory Board is required to meet quarterly with minutes submitted to State within thirty (30) Calendar Days of the meeting.

7.9.4.15.6. The Contractor must develop methods to encourage and ensure adequate Member participation in the quarterly meetings including but not limited to: accommodating virtual participation, providing meeting materials ahead of time, providing meeting materials in literacy level appropriate for participants, arranging transportation when appropriate, and providing childcare when appropriate to ensure adequate participation.

#### 7.9.4.16. Delegation of IQAP Activities

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

7.9.4.16.1. Have a written description of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the Contractor;

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

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

#### 7.9.5. Performance Improvement Projects (PIPs)

7.9.5.1. 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 Members. The Contractor 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 Protocol 7 Implementation of Performance Improvement Projects. At its discretion and/or as required or directed by the State, the Contractor's IQAP must also monitor and evaluate other important aspects of care and service.

7.9.5.2. The Contractor must conduct performance improvement projects that are designed to achieve, through ongoing measurement and intervention, significant improvement, sustained over time that focus on clinical and non-clinical areas that are expected to have favorable effect on health outcomes and Member satisfaction that involve the following:

- 7.9.5.2.1. Measurement of performance using objective quality indicators;
  - 7.9.5.2.2. Implementation of system interventions to achieve improvement in quality;
  - 7.9.5.2.3. Evaluation of the effectiveness of the interventions; and
  - 7.9.5.2.4. Planning an initiation of activities for increasing or sustaining improvement.
- 7.9.5.3. The Contractor must report the status and results of each PIP to the State as requested, including those that incorporate the requirements of 42 CFR 438.330(a)(2) and 42 CFR 438.340. Each performance improvement project must be completed in a reasonable timeframe to generally allow for information on the success of PIPs to be available to the State for its annual review of the Contractor's quality assessment and improvement program.
- 7.9.5.4. The Contractor will be required annually to conduct and report on a minimum of three (3) clinical PIPs and three (3) non-clinical PIPs. Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, maternal and child health outcomes, 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 and Grievances.
- 7.9.5.5. The Contractor must participate in one (1) statewide PIP focusing on reduction in African American maternal and infant morbidity and mortality as defined by the State.
- 7.9.5.6. The Contractor must select an additional two (2) projects from the list below, to serve as the Contractor's required PIPs in accordance with 42 CFR 438.330(a)(2) and 42 CFR 438.358:
- 7.9.5.6.1. Increasing access to and use of primary care and preventive services across the covered population;
  - 7.9.5.6.2. Improving quality of and access to Behavioral Health Services;
  - 7.9.5.6.3. Reducing preventable thirty (30) day hospital readmissions; and
  - 7.9.5.6.4. Social determinants of health and health equity.

- 7.9.5.7. CMS, in consultation with the State and other stakeholders, may specify performance measures and topics for PIPs to be required in the Contract.
- 7.9.5.8. The Contractor's PIPs must be described in the Annual IQAP written description and include:
  - 7.9.5.8.1. How the PIP relates to the Contractor's other Population Health initiatives and the State's Quality Strategy;
  - 7.9.5.8.2. The theory of change for each PIP (e.g., cause and effect diagrams, key driver diagrams);
  - 7.9.5.8.3. Criteria considered when choosing and prioritizing the Contractor's PIPs by population stream;
  - 7.9.5.8.4. The Contractor's evaluation strategy addressing the process, outcome, and balancing measures for each initiative, including:
    - 7.9.5.8.4.1. Baseline, milestones, and target goals;
    - 7.9.5.8.4.2. Timeframes for baseline, milestones, and target goals;
    - 7.9.5.8.4.3. Data sources;
    - 7.9.5.8.4.4. Numerator and denominators for each measure; and Frequency of measurement (e.g., daily, weekly, monthly)
- 7.9.5.9. A statistically significant decline in one PIP (HEDIS or non-HEDIS) will result in a quality penalty fee until the measure increases above original measure or matches previous measure prior to decline. To determine if a change in PIP indicators or performance measures was statistically significant, the State expects a p-value to be less than or equal to 0.5. Statistical significance is calculated with a Chi-Squared test for probability where the p-value is less than or equal to 0.05.

#### 7.9.6. Credentialing and Recredentialing

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

##### 7.9.6.1. Written Policies and Procedures

The Contractor must have written policies and procedures that include a uniform documented process for credentialing, which include the

Contractor's initial credentialing of practitioners, as well as its subsequent recredentialing, recertifying and/or reappointment of practitioners in accordance with the requirements of Section 7.6.2.3 of the Contract. The State reserves the right to request and inspect the credentialing process and supporting documentation. The Contractor agrees to allow the State and/or its contracted EQRO to inspect its credentialing process and supporting documentation.

7.9.6.2. 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.

7.9.6.3. Credentialing Entity

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

7.9.6.4. Scope

The Contractor will identify those practitioners who fall under its scope of authority and action. This must include, at a minimum, all physicians and other licensed independent practitioners included in the Contractor's Network.

7.9.7. Member Rights and Responsibilities

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

7.9.7.1. Written Policy on Member Rights

The Contractor must have a written policy that recognizes the rights of Members as specified in Section 7.8.1.

7.9.7.2. Written Policy on Member Responsibilities

The Contractor must have a written policy that addresses the Member's responsibility for cooperating with those providing health care services. This written policy must address the Member's responsibility for:

7.9.7.2.1. Providing, to the extent possible, information needed by professional staff in caring for the Member; and

7.9.7.2.2. Following instructions and guidelines given by those providing health care services.

7.9.7.2.3. The Contractor should also include additional Member responsibilities in Member communications (such as, the Member is responsible for being on time for scheduled appointments and canceling appointments in a timely manner, the Member is responsible for reporting fraud and/or abuse, etc.).

7.9.7.3. Communication of Member Policies to Providers

A copy of the Contractor's policies on Member rights and responsibilities must be provided to all Network Providers upon initial credentialing and when significant changes are made.

7.9.7.4. Communication of Policies to Members

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

7.9.7.5. Member Grievance and Appeals Procedures

The Contractor must have a system(s) linked to the IQAP for addressing Member Grievances and providing Member Appeals. This system must include:

7.9.7.5.1. Procedures for registering and responding to grievances and appeals within thirty (30) Calendar days. The Contractor must establish and monitor standards for timeliness;

7.9.7.5.2. Documentation of the substance of Grievances, Appeals, and actions taken;

7.9.7.5.3. Procedures ensuring a resolution of the Grievance and providing the Member access to the State Fair Hearing process for appeals;

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

7.9.7.5.5. Compliance with State due process and fair hearing policies and procedures specific to Nevada Medicaid and Nevada Check Up Members; and

7.9.7.5.6. Compliance with 42 CFR part 438, subpart F Grievance and Appeals.

7.9.7.6. Member Suggestions

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

## 7.9.8. Steps to Assure Accessibility of Services

The Contractor must take steps to promote accessibility of services offered to Members. These steps include:

- 7.9.8.1. The points of access to primary care, specialty care and hospital services are identified for Members;
- 7.9.8.2. At a minimum, Members are given information about:
  - 7.9.8.2.1. How to obtain services during regular hours of operations;
  - 7.9.8.2.2. How to obtain emergency and after-hour care;
  - 7.9.8.2.3. How to obtain emergency out-of-service area care;
  - 7.9.8.2.4. How to obtain the names, qualifications and titles of the professionals who provide and are accepting medical patients and/or are responsible for their care; and
  - 7.9.8.2.5. How to access concierge services and if needed case management assistance from the Contractor when needed to gain access to care.

## 7.9.9. Confidentiality of Patient Information

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

- 7.9.9.1. Establish in writing, and enforce, policies and procedures on confidentiality, including confidentiality of medical records;
- 7.9.9.2. Ensure patient care offices/sites have implemented mechanisms to guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the Contractor;
- 7.9.9.3. Hold confidential all information obtained by its personnel about Members related to their examination, care and treatment and shall not divulge it without the Member's authorization, unless:
  - 7.9.9.3.1. It is required by law, or pursuant to a hearing request on the Member's behalf;
  - 7.9.9.3.2. It is necessary to coordinate the Member's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; or

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

7.9.9.4. Must report any release of information in response to a court order to the Member in a timely manner; and

7.9.9.5. May disclose Member records whether or not authorized by the Member, 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.

7.9.10. Treatment of Minors

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

7.9.11. Assessment of Member Satisfaction and CAHPS

The Contractor must conduct periodic surveys of Member satisfaction annually with its services through administration of the CAHPS or other survey approved by the State.

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

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

7.9.11.2.1. All Members;

7.9.11.2.2. Member requests to change practitioners and/or facilities; and

7.9.11.2.3. Disenrollment by Members.

7.9.11.3. As a result of the survey(s), the Contractor must:

7.9.11.3.1. Identify and investigate sources of dissatisfaction;

7.9.11.3.2. Outline action steps to follow up on the findings; and

7.9.11.3.3. Inform practitioners and providers of assessment results.

7.9.11.4. The Contractor must evaluate the effectiveness of the implemented quality improvement activities at least quarterly, with reporting to the Contractor's Quality Management Committee and adjust interventions as necessary to improve Member satisfaction.

7.9.12. Medical Record Standards

7.9.12.1. Accessibility and Availability of Medical Records

The Contractor must include provisions in all provider contracts for HIPAA compliance with regard to access to medical records for purposes of quality reviews conducted by the Secretary of the United States, Department of Health and Human Services (the Secretary), the State, or agents thereof. Medical Records must be available to health care practitioners at each encounter.

#### 7.9.12.2. Medical Record Review Process

7.9.12.2.1. The Contractor must have a system (record review process) to assess the content of medical records for legibility, organization, completion and conformance to its standards; and

7.9.12.2.2. The record assessment system must address documentation of the items listed in the Medical Records requirements in Section 7.6.13.

#### 7.9.13. Utilization Review

##### 7.9.13.1. Written Program Description and Scope

The Contractor must have a written Utilization Review program description, which includes, at a minimum:

7.9.13.1.1. Policies and procedures to evaluate Medical Necessity, compliant with applicable state legislative requirements and the requirements of the Contract, practice guidelines, and additional information sources;

7.9.13.1.2. The process used to review and approve the provision of Covered Services and any additional services;

7.9.13.1.3. Procedures for prospective and concurrent review of inpatient utilization;

7.9.13.1.4. Mechanisms to detect over-, under-, and inappropriate utilization of Covered Services and additional services by Members;

7.9.13.1.5. Demonstrate that qualified Providers made all Utilization Management decisions regarding coverage of services;

7.9.13.1.6. Appeal mechanisms for Providers and Members related to utilization decisions;

7.9.13.1.7. How the Utilization Management Committee fits into the organizational structure and design of the Contractor's committee structure;

- 7.9.13.1.8. How the Contractor ensures the Utilization Management program maintains sufficient and appropriate staff to perform all Utilization management review activities;
  - 7.9.13.1.9. The physical location of Utilization Management staff (in Nevada or outside of Nevada) if making Utilization Management determinations for Medicaid and Nevada Check Up Members;
  - 7.9.13.1.10. Mechanisms to ensure consistent application of review criteria and uniform decisions including the inter-rater reliability file audit process;
  - 7.9.13.1.11. How the Contractor’s Utilization Management (UM) and Case Management (CM) programs communicate and collaborate when a Member in Case Management requires authorization of services. The description must include information on UM-CM collaborative meetings, how UM and CM information systems are “linked” such that CM staff can visualize all UM determinations for a Member, including pharmacy determinations, and how UM staff can visualize if a Member is in Case Management and identify and contact the Member’s Case Manager.
- 7.9.13.2. The Contractor’s UM program must be supported by an annual work plan that the Contractor must evaluate annually and update as necessary. The UM Program Description and UM Annual work plan must be submitted to the State prior to Go-Live and annually in March thereafter.
- 7.9.13.3. UM Staffing
- 7.9.13.3.1. The Contractor must have appropriately qualified staff who are available by telephone, from 8 a.m. to 5 p.m. Pacific Time Monday through Friday (except State of Nevada holidays), to render UM decisions for providers and available by telephone 24 hours a day, seven days a week to respond to authorization requests for inpatient hospitalization, or policies and procedures that allow for emergency admissions with authorization the next Business Day.
  - 7.9.13.3.2. The Contractor must identify a UM Program lead with reporting structure to the CMO/Medical Director such that the CMO/Medical Director has ultimate responsibility in all UM activities.
- 7.9.13.4. If the Contractor delegates responsibility for utilization management, it has mechanisms to ensure that the delegate meets all requirements pertaining to utilization management in this Contract.

#### 7.9.13.5. Under-Utilization of Services

The Contractor must monitor for the potential under-utilization of services by Members in order to assure that all Medicaid Covered Services are provided as required. If any under-utilized services are identified, the Contractor must immediately investigate and, if indicated, correct the problem(s) that resulted in such under-utilization of services. At a minimum, the Contractor's monitoring efforts must include the following activities:

- 7.9.13.5.1. An annual review of their prior authorization procedures to determine that they do not unreasonably limit a Member's access to Medicaid Covered Services;
- 7.9.13.5.2. An annual review of the procedures Network Providers are to follow in appealing the Contractor's denial of a prior authorization request to determine that the process does not unreasonably limit a Member's access to Medicaid Covered Services; and
- 7.9.13.5.3. Ongoing monitoring of Contractor service denials and utilization in order to identify services which may be underutilized.

#### 7.9.14. Critical Incident Management System

7.9.14.1. The Contractor must designate a Critical Incident Manager responsible for administering the incident management system and ensuring compliance with the requirements of this section. This position may be assigned as a responsibility to a lead within the quality department and may or may not be a full FTE.

#### 7.9.14.2. Individual Critical Incident Reporting

The Contractor must submit an individual Critical Incident report for the following incidents:

- 7.9.14.2.1. Homicide or attempted homicide by a Member;
- 7.9.14.2.2. A major injury or major trauma that has the potential to cause prolonged disability or death of a Member that occurs in a facility licensed by the State to provide publicly funded Behavioral Health Services;
- 7.9.14.2.3. An unexpected death of a Member that occurs in a facility licensed by the State to provide publicly funded Behavioral Health Services;

- 7.9.14.2.4. Abuse, neglect or exploitation of a Member (not to include child abuse);
- 7.9.14.2.5. Violent acts allegedly committed by a Member to include:
  - 7.9.14.2.5.1. Arson;
  - 7.9.14.2.5.2. Assault resulting in serious bodily harm;
  - 7.9.14.2.5.3. Homicide or attempted homicide by abuse;
  - 7.9.14.2.5.4. Drive-by shooting;
  - 7.9.14.2.5.5. Extortion;
  - 7.9.14.2.5.6. Kidnapping;
  - 7.9.14.2.5.7. Rape, sexual assault or indecent liberties;
  - 7.9.14.2.5.8. Robbery; and
  - 7.9.14.2.5.9. Vehicular homicide.
- 7.9.14.2.6. Unauthorized leave of a mentally ill offender or a sexual or violent offender from a mental health facility, secure Community Transition Facilities (i.e., Evaluation and Treatment Centers, Crisis Stabilization Units, Secure Detox Units, and Triage Facilities) that accept involuntary admissions; and
- 7.9.14.2.7. Any event involving a Member that has attracted or is likely to attract media attention.
- 7.9.14.3. The Contractor shall report Critical Incidents within one (1) Business Day in which the Contractor becomes aware of the event. The report shall include:
  - 7.9.14.3.1. The date the Contractor became aware of the incident;
  - 7.9.14.3.2. The date of the incident;
  - 7.9.14.3.3. A description of the incident;
  - 7.9.14.3.4. The name of the facility where the incident occurred, or a description of the incident location;
  - 7.9.14.3.5. The name(s) and age(s) of Member(s) involved in the incident;

- 7.9.14.3.6. The name(s) and title(s) of facility personnel or other staff involved;
- 7.9.14.3.7. The name(s) and relationship(s), if known, of other persons involved and the nature and degree of their involvement;
- 7.9.14.3.8. The Member's whereabouts at the time of the report if known (i.e., home, jail, hospital, unknown, etc.) or actions taken by the Contractor to locate the Member;
- 7.9.14.3.9. Actions planned or taken by the Contractor to minimize harm resulting from the incident; and
- 7.9.14.3.10. Any legally required notifications made by the Contractor.

#### 7.9.14.4. Individual Critical Incident Resolution and Closure

The Contractor must submit follow-up reports using the Incident Reporting System and close the case within forty-five (45) Calendar Days after the critical incident was initially reported. A case cannot be closed until the following information is provided:

- 7.9.14.4.1. A summary of any debriefings;
- 7.9.14.4.2. Whether the Member is in custody (jail), in the hospital or in the community;
- 7.9.14.4.3. Whether the Member is receiving services and include the types of services provided;
- 7.9.14.4.4. If the Member cannot be located, the steps the Contractor has taken to locate the Member using available, local resources; and
- 7.9.14.4.5. In the case of the death of a Member, verification from official sources that includes the date, name and title of the sources. When official verification cannot be made, the Contractor shall document all attempts to retrieve it.

#### 7.9.15. External Quality Review

- 7.9.15.1. An annual review of the Contractor will be conducted by the State's EQRO and may include State staff. The EQRO will:
  - 7.9.15.1.1. Conduct a review of the Contractor's delivery of Medicaid and CHIP services;
  - 7.9.15.1.2. Perform a review which will include, at a minimum, the elements in 42 CFR 438.364(a)(2)(i) through (iv) and

mandatory and optional activities described in 42 CFR 438.358(b) and (c).

- 7.9.15.2. In conformance with 42 CFR 438.350, 42 CFR 438.358, and 42 CFR 457.1250, the Contractor must cooperate and require its Subcontractors and Network Providers to cooperate with the State by providing access to records and facilities, and sufficient information for the purpose of an annual external, independent professional review of the Contractor's compliance with all applicable State and federal rules and the requirements of this Contract.
- 7.9.15.3. Consistent with 42 CFR 438.350, the State will implement External Quality Review protocols in accordance with CMS protocols required by 42 CFR 438.352 and provide those protocols to the Contractor, prior to the EQRO review.
- 7.9.15.4. If the EQRO identifies an adverse clinical situation in which follow-up is needed to determine whether appropriate care was provided, the EQRO will report the findings to the State and the Contractor. The Contractor must address and require its Subcontractors or delegated entities to address any findings or recommendations identified in EQRO reports in a manner designed to correct the deficiency within a timeline acceptable to the State.

## **7.10. PROGRAM INTEGRITY**

### **7.10.1. General Requirements and Authorities**

- 7.10.1.1. The Contractor must 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.
- 7.10.1.2. The Contractor must be familiar with and compliant with all federal and state regulations related to Program Integrity, as well as all Nevada Medicaid policies. The Contractor must also require compliance from Subcontractors and Network Providers for the same. Medicaid payments to Contractors are government funds, funded by federal and state money. These payments made by the State to Contractors that result in payment to Subcontractors and Network Providers of medical services, supplies or drugs, for the benefit of Medicaid and Nevada Check Up Members, may be recovered if obtained by fraud, waste, abuse or improper billing. Any act of health care fraud involving such government funds will be subject to prosecution by the State Attorney General's Office under NRS 228.410 or actions brought 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.
  - 7.10.1.2.1. Sections 1128, 1156, and 1902(a)(68) of the Act;

- 7.10.1.2.2. 42 CFR part 438, subpart H;
- 7.10.1.2.3. 42 CFR part 455, subparts A, B and E;
- 7.10.1.2.4. 42 CFR parts 1000 through 1008;
- 7.10.1.2.5. 42 CFR 456.3, 42 CFR 456.4, and 42 CFR 456.23;
- 7.10.1.2.6. 42 CFR 457.1285;
- 7.10.1.2.7. Nevada Revised Statutes, Chapter 422;
- 7.10.1.2.8. Nevada DHCFP Medicaid Services Manual; and
- 7.10.1.2.9. Nevada DHCFP Medicaid Billing Guides.

## 7.10.2. Compliance Program

- 7.10.2.1. The Contractor must have a compliance program that implements and maintains administrative and management arrangements or procedures to detect and prevent fraud, waste and abuse. The compliance program may be reviewed and approved annually by the State.
- 7.10.2.2. The arrangements or procedures described in Section 7.10.2.1 must include a compliance plan that encompasses the elements necessary to monitor and enforce compliance with all applicable laws, policies, and Contract. At a minimum, the compliance plan must include all of the following elements and any others as directed by the State.
  - 7.10.2.2.1. Written policies, procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable requirements and standards under the Contract, and all applicable federal and State requirements;
  - 7.10.2.2.2. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the Board of Directors;
  - 7.10.2.2.3. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the Contractor's compliance program and its compliance with the requirements under the Contract;
  - 7.10.2.2.4. Effective communication between the Compliance Officer, the Contractor's employees, and the State;

- 7.10.2.2.5. Enforcement of standards through well-publicized disciplinary guidelines;
- 7.10.2.2.6. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance programs as identified in the course of self-evaluation and audits, correction of such programs promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract;
- 7.10.2.2.7. 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;
- 7.10.2.2.8. Delineation of the staff and division of responsibilities within the Contractor's Program Integrity Unit;
- 7.10.2.2.9. Specific objectives and goals for Program Integrity operations in the coming year;
- 7.10.2.2.10. Attestation that the Contractor has completed the False Claims Act Network Provider requirement of Section 7.10.2.3.3; and
- 7.10.2.2.11. A report on the success of the objectives and goals from the previous year.

### 7.10.2.3. Federal Whistleblower Protections

In order to comply with Section 1902(a)(68) of the Act and as a condition of receiving Medicaid payment, the Contractor must do the following:

- 7.10.2.3.1. Establish and make readily available written policies for all employees of the Contractor, including management, and of any Subcontractor or Network 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 Act);

7.10.2.3.2. The arrangements or procedures of Section 7.10.2.1 must include, in the case of Contractors that make or receive annual payments under the Contract or at least \$5,000,000, provisions for written policies employees of the Contractor, and Subcontractors or agents, that provide:

7.10.2.3.2.1. Detailed information about the False Claims Act and federal and state laws described in Section 1902(a)(68) of the Act:

7.10.2.3.2.2. Information about the rights of employees to be protected as whistleblowers;

7.10.2.3.2.3. Written policies and detailed provisions regarding the Contractor's policies and procedures for detecting and preventing fraud, waste, and abuse; and

7.10.2.3.2.4. The inclusion of any employee handbook for the Contractor, a specific discussion of the laws described above, the rights of employees to be protected as whistleblowers and the Contractor's policies and procedures for detecting and preventing fraud, waste, and abuse.

7.10.2.3.3. The arrangements and procedures of Section 7.10.2.1 must include provisions for the Contractor to ensure Network Provider compliance with the False Claims Act requirements applicable to all entities that make or receive annual payments under the provider contract of at least \$5,000,000.

#### 7.10.2.4. Verification of Services

7.10.2.4.1. The arrangements or procedures of Section 7.10.2.1 must include a provision for a method to verify, by samples or other methods:

7.10.2.4.1.1. Whether services represented to have been delivered by Network Providers were received by Members; and

7.10.2.4.1.2. That the application of such verification processes occurs on a regular basis.

7.10.2.4.2. The Contractor may use Explanation of Benefits (EOB) or Verification of Services (VOS) letters for such verification that, at a minimum, address the requirements of 42 CFR 455.20 and 42 CFR 43.116.

7.10.2.4.3. VOS letters, if used instead of EOBs, must be sent to at least five hundred (500) Members each month.

7.10.2.4.4. For both EOB and VOS letters, the Contractor must suppress information that, if revealed to other Members of the household, would be a violation of confidentiality requirements for women's healthcare, family planning, sexually transmitted diseases, and Behavioral Health Services.

7.10.2.5. Embezzlement and Theft

The Contractor must monitor activities on an ongoing basis to prevent and detect embezzlement or theft by employees, Network Providers, and Subcontractors. Any evidence of criminal activity must be reported to the appropriate authority and the State's Surveillance and Utilization Review (SUR) unit within five (5) Business Days.

7.10.3. Hotline for Reporting Suspected Fraud, Waste, Abuse or Improper Payments

7.10.3.1. The Contractor must acquire, maintain and monitor a hotline telephone number for the public, Members and Network Providers to report allegations of fraud, waste, abuse, or improper payments.

7.10.3.2. The hotline number must be prominently displayed in a stand-alone frame placed on the Contractor's front page of their Nevada Medicaid website.

7.10.3.3. The telephone line may be augmented by a web page used specifically for collecting and reporting to the Contractor's Program Integrity Unit complaint information entered by a fraud, waste and abuse complainant.

7.10.3.4. If the Contractor also uses a web page for receiving program integrity complaints, it must:

7.10.3.4.1. Be accessible and simple to use by the public, Members and Network Providers;

7.10.3.4.2. Have a stand-alone highlighted button or link on the Contractor's front page of their Nevada Medicaid website; and

7.10.3.4.3. Be identified with language which states clearly the button or link is for use in reporting Medicaid fraud, waste or abuse.

#### 7.10.4. Contractor's Program Integrity Unit

- 7.10.4.1. The Contractor 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.
- 7.10.4.2. The PIU must include a Compliance Officer and a compliance committee as specified in Sections 7.10.2.2.2 and 7.10.2.2.3. The Compliance Officer must be available to communicate with the State Program Integrity and SUR staff by telephone, email, text message, or other communication methods during State business hours.
- 7.10.4.3. The PIU must have adequate resources, data systems, and qualified staffing, with an associated division of responsibilities, to conduct reviews, recovery and reporting of improper payments, including FWA activities, as specified in the Contract.
- 7.10.4.4. The PIU will have adequate resources to meet either in person or via telephone on a regular basis to provide information and updates on cases.
- 7.10.4.5. Qualified staff must have experience in health care claims review, data analysis, professional medical coding or law enforcement.
- 7.10.4.6. The number of full-time equivalents (FTEs) dedicated solely to Nevada Medicaid Network Provider and Member fraud, waste and abuse investigations must be at least one per fifty thousand (1:50,000) Medicaid Members.
- 7.10.4.7. The PIU staff must receive on-going training in conducting compliance reviews, and must travel to the State for periodic meetings and trainings with SUR Unit staff.

#### 7.10.5. Fraud, Waste and Abuse Identification and Referral

- 7.10.5.1. The arrangements or procedures of Section 7.10.2.1 must include provisions for the prompt referral of any potential fraud, waste or abuse that the Contractor identifies to the State SUR unit. All Network Provider credible allegations of fraud (CAF) are referred directly to the Nevada Attorney General's Medicaid Fraud Control Unit (MFCU) with a carbon copy to the State SUR Unit.
- 7.10.5.2. The PIU will review and refer, as outlined in Section 7.10.5.1, all allegations, tips, complaints, and referrals in a timely manner (i.e., two (2) Business Days for CAFs and ten (10) Business Days for non-CAFs). Sources may include, but are not limited to:
  - 7.10.5.2.1. Fraud hotline or website;

- 7.10.5.2.2. Referrals from the State;
- 7.10.5.2.3. Referrals from the Contractor's own organization, including utilization of data systems to identify issues such a Provider profiling or data analysis;
- 7.10.5.2.4. EOB or VOS letters and complaints; or
- 7.10.5.2.5. Network Provider self-reported referrals.
- 7.10.5.3. All allegations, tips, complaints, and referrals must be tracked and reported to the State monthly regardless of outcome;
- 7.10.5.4. All allegations, tips, complaints, and referrals specifically alleging Member misconduct, whether a CAF or non-CAF, must be referred to the State SUR unit. No referral to the MFCU is necessary.
- 7.10.5.5. When the Contractor receives an allegation, tip, complaint or referral related to potential fraud, the Contractor must perform a preliminary investigation to determine whether a CAF exists.
- 7.10.5.6. If the Contractor determines that there is a CAF, the Contractor must submit a fraud referral via email to the MFCU with a carbon copy to the State's SUR Unit as soon as possible and within two (2) Business Days.
- 7.10.5.7. The Contractor's fraud referral must provide, at a minimum, the following information and any other information specified by the State:
  - 7.10.5.7.1. Network Provider's name, Medicaid provider number or the Provider's National Provider Identifier (NPI);
  - 7.10.5.7.2. Nevada Medicaid provider type;
  - 7.10.5.7.3. Member's name and Medicaid or Nevada Check Up number;
  - 7.10.5.7.4. Date and source of the original complaint or tip;
  - 7.10.5.7.5. Description of alleged fraudulent activity, including specific laws or Medicaid policies violated, dates of fraudulent conduct, and approximate value of fraudulently obtained payments;
  - 7.10.5.7.6. Any other agencies or entities (e.g., medical board, law enforcement) notified by Contractor, and any actions they have taken; and
  - 7.10.5.7.7. The findings from the Contractor's preliminary investigation and proposed actions.

- 7.10.5.8. After submitting the fraud referral, the Contractor will take no further action on the specific allegation until the MFCU or SUR Unit responds;
- 7.10.5.9. If the MFCU or SUR Unit notifies the Contractor that the fraud referral is declined, the Contractor must proceed with its own investigation to comply with the reporting requirements contained in this Contract; and
- 7.10.5.10. If the SUR Unit notifies the Contractor that the fraud referral is accepted, the Contractor 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 Contractor must provide the MFCU access to conduct private interviews of Contractor personnel, Subcontractors and their personnel, witnesses and Members. Contractor personnel, Subcontractors and their personnel must cooperate fully in making Contractor personnel, Subcontractors and their personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conference, and hearings, at their own expense.

#### 7.10.6. Payment Suspensions

The Contractor must establish policies and procedures to implement payment suspensions as directed by, and within two (2) Business Days upon notification from, the State, including those related to CAFs in accordance with 42 CFR 455.23. If the State instructs the Contractor to suspend payments to an entity or individual, and the Contractor fails to do so, the State may impose penalties.

#### 7.10.7. Network Provider Compliance Reviews by Contractor

- 7.10.7.1. The PIU will conduct a review, investigation or audit of all identified program integrity or fraud, waste and abuse issues by collecting and analyzing available relevant information, including but not limited to:
  - 7.10.7.1.1. Encounter Data;
  - 7.10.7.1.2. Network Provider Credentialing and enrollment records;
  - 7.10.7.1.3. Network Provider self-audits;
  - 7.10.7.1.4. Network Provider treatment records;
  - 7.10.7.1.5. Network Provider authorization records;
  - 7.10.7.1.6. Member Medical Records;
  - 7.10.7.1.7. Member EOB or VOS;
  - 7.10.7.1.8. Nevada Medical Services Manual (MSM); and
  - 7.10.7.1.9. Nevada Medicaid Billing Guidelines

- 7.10.7.2. The Contractor will recover and retain all Overpayments resulting from a Contractor-initiated fraud, waste and abuse review, investigation or audit.
- 7.10.7.3. The Contractor will maintain detailed records of Network Provider education for each fraud, waste and abuse investigation, as applicable.
  - 7.10.7.3.1. Written attestations should include, but not be limited to, the Network Provider's name, regulations and policies included in the education, date and time the educational attestation was signed, and the name and title of the individual making the attestation.
  - 7.10.7.3.2. Verbal education should include, but not be limited to, the Network Provider name, regulation and policies included in the education, date and time the education was provided, and the name and title of the individual receiving the education.
- 7.10.7.4. The PIU must notify the Network Provider of the identified Overpayment. The notification must include:
  - 7.10.7.4.1. The amount of the Overpayment;
  - 7.10.7.4.2. A detailed listing of the Encounters affected;
  - 7.10.7.4.3. Education and citations supporting the findings;
  - 7.10.7.4.4. Options for repayment;
  - 7.10.7.4.5. Any internal appeal rights afforded by the Contractor; and
  - 7.10.7.4.6. The Network Provider's right to an Administrative Fair Hearing through the State after the internal appeal with the Contractor is exhausted.
- 7.10.7.5. The Contractor must have a mechanism for a Network Provider to report to the Contractor when the Network Provider has received an overpayment, to return the overpayment to the Contractor within sixty (60) Calendar Days after the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment.
- 7.10.7.6. All affected Encounters will be adjusted or voided by the Contractor within sixty (60) Calendar Days following the identification of the Overpayments, regardless of whether the Contractor is able to recover the Overpayment from the Network Provider.

#### 7.10.8. Network Provider Compliance Reviews by the State

- 7.10.8.1. The State may conduct reviews of Encounter Data and Contractor Network Providers to ensure compliance with Nevada Medicaid policies and billing guidelines.
  - 7.10.8.2. Any improper payments identified by the State that have not been reported by the Contractor as being under review may be recovered and retained by the State.
  - 7.10.8.3. The State may instruct the Contractor to withhold payment to a Network Provider in its Network as a result of an Overpayment identified by the State. Any money withheld for this reason must be sent to the State within sixty (60) Calendar Days of notification, with an accounting of any Network Provider monies withheld, evidence of the associated claims adjustment(s), and any other information requested by the State.
  - 7.10.8.4. All affected Encounters will be adjusted or voided by the Contractor within sixty (60) Calendar Days following the notification from the State of the Overpayments.
- 7.10.9. Monetary Recoveries by State or Federal Entities
- 7.10.9.1. 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 Contractor has no claim to any portion of this recovery.
  - 7.10.9.2. Furthermore, the Contractor is fully subrogated and must 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 Contractor or Subcontractor(s) 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.
  - 7.10.9.3. Any funds recovered and retained by a government entity will be reported to the Actuary to consider in the rate-setting process.
  - 7.10.9.4. If any specific payments are identified as improper, those Encounters must be adjusted or voided, as appropriate.
  - 7.10.9.5. 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 Contractor or client in the collection against a third party.

#### 7.10.10. Reporting Requirements

- 7.10.10.1. All information provided to the State must be submitted according to the format and specifications directed by the State.
- 7.10.10.2. The Contractor must report certain information to the State on a per occurrence basis. This includes, but is not limited to:
  - 7.10.10.2.1. Every allegation, tip, complaint, or referral pertaining to overpayments whether caused by fraud, waste, abuse or billing errors;
  - 7.10.10.2.2. Every CAF;
  - 7.10.10.2.3. Every employee of the Contractor who is employed by, has ownership interest in, or contracts with, any Network Provider enrolled with Nevada Medicaid; and
  - 7.10.10.2.4. Every Network Provider that is de-credentialed or denied credentialing for whatever reason.
- 7.10.10.3. The Contractor must report and attest to certain information to the State on a monthly basis. This includes, but is not limited to:
  - 7.10.10.3.1. All active reviews and their status; and
  - 7.10.10.3.2. All completed reviews with a detailed reason, and the amount of each Overpayment identified and/or recovered from the Contractor's fraud, waste and abuse investigation or audits. This includes Contractor or Network Provider administrative errors and Network Provider self-reported Overpayments. Each review must be reported even if the determination was that there was no Overpayment.
- 7.10.10.4. In addition to reporting on overpayments for each completed review, the Contractor must report annually on the overpayments recovered per 42 CFR 438.608(d)(3).
- 7.10.10.5. Upon request, the Contractor must provide Encounter Data to the State and/or MFCU at no cost.
- 7.10.10.6. Provider Preventable Conditions (PPC)
  - 7.10.10.6.1. PPCs are defined in 42 CFR 447.26;
  - 7.10.10.6.2. The Contractor must require all Network Providers and Subcontractors to identify and report to the Contractor all

PPCs that are associated with claims for Medicaid payment or with course of treatment furnished to a Member for which Medicaid payment would otherwise be available. The Contractor must identify and report to the State SUR unit all PPCs that are associated with claims for Medicaid payment or with a course of treatment furnished to a Member for which Medicaid payment otherwise be available; and

- 7.10.10.6.3. As required by 42 CFR 447.26, Medicaid payments are prohibited for services related to PPCs. The Contractor must review all PPCs identified and ensure that payments are not made in violation of 42 CFR 447.26. If a non-compliant payment has already been made, it must be recovered and reported, and encounters adjusted as set forth in Section 7.10.7.

#### 7.10.11. Suspension, Termination or Other Actions Related to Network Providers

The Contractor must take appropriate action related to dual FFS and Network Providers, and provide all documentation related to any disciplinary action, sanction, de-credentialing, removal from the provider panel to State in a time and manner as determined by the State as follows:

- 7.10.11.1. Upon the Contractor's awareness through public sources of any disciplinary action, or any sanction taken against a Network Provider, or any suspected Provider fraud, waste or abuse, the Contractor must immediately inform the State's Provider Enrollment Unit;
- 7.10.11.2. The Contractor is required to check the Office of the Inspector General (OIG) website and the State's excluded Provider list at least monthly to confirm its Network Providers have not been sanctioned by the OIG or by the State; and
- 7.10.11.3. If the Contractor is notified or discovers that the OIG, the State, another state Medicaid agency, or certification/licensing entity has taken an action or imposed a sanction against a Network Provider, the Contractor must review the Provider's performance related to this Contract and take any action or impose any sanction, including disenrollment from the Contractor's Network.
- 7.10.11.4. The Contractor 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 CHIP.
- 7.10.11.5. The Contractor may refuse to enter into or may terminate a provider contract if the Contractor determines the Provider did not fully and accurately make any required disclosure.

7.10.11.6. The Contractor must also promptly notify the State's Provider Enrollment Unit of any action it takes on the Provider's application for participation in the program.

7.10.12. Affiliations with Debarred, Suspended or Excluded Persons or Entities

7.10.12.1. The Contractor must not employ or contract with Providers excluded from participation in federal healthcare programs.

7.10.12.2. The Contractor must not be controlled by a sanctioned individual.

7.10.12.3. The Contractor must 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; excluded from participation in any Federal health care program under section 1128 or 1128A of the Act; or debarred, suspended, or excluded from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

7.10.12.4. The Contractor must 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:

7.10.12.4.1. Any individual or entity excluded from participation in federal healthcare programs;

7.10.12.4.2. Any entity that would provide those services through an individual or entity.

7.10.12.5. The Contractor must have policies and procedures for ensuring that, pursuant to 42 CFR 438.610, the Contractor will not 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. Such relationships as specified in 42 CFR 438.610(b) are prohibited.

7.10.12.6. The Contractor is prohibited from knowingly having a relationship described in 42 CFR 438.610(c) with any individual or entity that is:

7.10.12.6.1. Debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or

7.10.12.6.2. An affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in Section 7.10.12.6.1.

7.10.12.7. If the State learns the Contractor has a prohibited relationship with a person or entity who is disbarred, suspended, or excluded from participation, the State will notify the Secretary of US DHHS of noncompliance. The State may continue the Contract with the Contractor unless the Secretary directs otherwise. The State may not renew or extend the existing agreement with the Contractor unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the Contract.

#### 7.10.13. Contractor Disclosures

7.10.13.1. The Contractor must disclose information to the State on ownership and control; information related to business transactions; information on persons convicted of a crime; and any prohibited affiliations. If the Contractor does not disclose required information under 42 CFR 455.104, any federal funds withheld or recouped from or any penalties assessed upon the State will be withheld and recouped from or assessed on the Contractor.

7.10.13.2. Disclosures are due at any of the following times:

7.10.13.2.1. Upon the Contractor submitting the Proposal in accordance with the State's procurement process.

7.10.13.2.2. Upon the Contractor executing the Contract with the State.

7.10.13.2.3. Upon renewal or extension of the Contractor's Contract.

7.10.13.2.4. Within five (5) Calendar Days after any change in ownership of the Contractor.

7.10.13.3. In accordance with 42 CFR 455.104(b), and sections 1903(m)(2)(A)(viii) and 1124(a)(2)(A) of the Act, the Contractor must disclose any person or entity with an ownership or control interest in the Contractor or a Subcontractor that:

7.10.13.3.1. Has direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the Contractor's or Subcontractor's equity.

7.10.13.3.2. Owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor or Subcontractor if that interest equals at least

five percent (5%) of the value of the Contractor's or Subcontractor's assets.

7.10.13.3.3. Is an officer or director of a Contractor or Subcontractor organized as a corporation.

7.10.13.3.4. Is a partner in a Contractor or Subcontractor organized as a partnership.

7.10.13.4. The following information must be disclosed per Section 7.10.13.3:

7.10.13.4.1. The name and address of any person (individual or business entity) with an ownership or control interest in the Contractor or Subcontractor. The address for business entities must include as applicable primary business address, every business location, and P.O. Box address.

7.10.13.4.2. Date of birth and Social Security Number (in the case of an individual).

7.10.13.4.3. Other tax identification number (in the case of a business entity) with an ownership or control interest in the Contractor or in any Subcontractor in which the Contractor has a five percent (5%) or more interest.

7.10.13.4.4. Whether the person (individual or business entity) with an ownership or control interest in the Contractor or Subcontractor is related to another person with ownership or control interest in the Contractor or Subcontractor 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 Contractor has a five percent (5%) or more interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling.

7.10.13.4.5. The name of any other Medicaid Provider or fiscal agent in which the person or corporation has an ownership or control interest.

7.10.13.4.6. The name, address, date of birth, and Social Security Number of any managing employee of the Contractor or Subcontractor.

7.10.14. Contractor requirements for collecting and validating information related to ownership and business transactions from Providers or Subcontractors

- 7.10.14.1. The Contractor must enter into an agreement with each Provider under which the Provider agrees to furnish upon request, information related to ownership and business transactions.
- 7.10.14.2. The Contractor must require the Provider or Subcontractors to submit full and complete information about:
  - 7.10.14.2.1. The ownership of any Subcontractor with whom the Provider has had business transactions totaling more than \$25,000 during the twelve (12) month period ending on the date of the request; and
  - 7.10.14.2.2. Any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any Subcontractor, during the five (5) year period ending on the date of the request.
- 7.10.15. Requirements for collecting and validating information related to Providers or Subcontractors convicted of crimes (42 CFR 455.106). Before the Contractor enters into or renews a provider contract, or at any time upon written request by the Contractor, the Provider must disclose to the Contractor the identity of any person who:
  - 7.10.15.1. Has ownership or control interest in the Provider, or is an agent or managing employee of the Provider or Subcontractors; and
  - 7.10.15.2. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or CHIP programs since the inception of those programs.

## **7.11. CONTRACTOR FINANCIAL MANAGEMENT**

### **7.11.1. Contractor Fiscal Standards**

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

### **7.11.2. Performance Security Deposit**

7.11.2.1. The Contractor 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 State in order to guarantee payment of the Contractor's obligations under this Contract. The performance security deposit may be utilized by the State to remedy any breach of contract or sanctions imposed on the Contractor.

7.11.2.2. An initial deposit of \$15,000,000 must be deposited within ten (10) Business Days following award of the contract to the Awarded Vendor, as stated in the ***Attachment D - 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.

- 7.11.2.3. The amount of the performance security deposit must be equal to one hundred and ten percent (110%) of the highest month's total Capitation amount in the first quarter or fifteen million dollars (\$15 million), whichever is greater. This must be deposited with the State Treasurer within fifteen (15) Calendar Days after the end of the first quarter of the Contract. The total Capitation amount is the sum of all Capitation Payments for all Members for the month.
- 7.11.2.4. After the initial year of the Contract the State will require the Contractor to increase the performance security deposit amount to reflect an amount equal to one hundred and ten percent (110%) of the preceding year's highest month's total Capitation Payment or fifteen million dollars (\$15 million), whichever is greater.
- 7.11.2.5. Contractors submitting performance security to the State of Nevada in the form a surety bond must utilize a company that meets the following listed requirements:
  - 7.11.2.5.1. A.M. Best A-VII rated insurance company;
  - 7.11.2.5.2. Certified by the Department of Treasury, Financial Management Services for Nevada; and
  - 7.11.2.5.3. Licensed by the Nevada Department of Business and Industry, Division of Insurance.
  - 7.11.2.5.4.
  - 7.11.2.5.5. The Contractor must maintain the performance security deposit after the Contract Term for a length of time to be determined by the State in order to cover all outstanding liabilities.

### 7.11.3. Financial Solvency

The Contractor must demonstrate that it has adequate financial reserves and administrative ability to carry out its contractual obligations. The Contractor must maintain financial records and provide the State with various financial statements and documentation upon request, as specified herein, in the State's electronic MoveIt reporting repository, or any successor repository, and revisions or additions to the documentation.

- 7.11.3.1. The Contractor must submit a copy of its annual Independent Audit Report to the State, as submitted to the Division of Insurance.
- 7.11.3.2. The Contractor must submit audited quarterly and annual financial reports, specific to the Medicaid and NCU lines of business, to the State. Generally accepted accounting and auditing principles (GAAAP) are to

be used in the preparation of these financial reports. All revenues and expenses must be reported using the accrual basis of accounting, which recognizes revenue when it is earned and expenses in the period incurred, without regard to the time of receipt or payment of cash.

#### 7.11.4. Reserving Requirement

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

#### 7.11.5. Medical Loss Ratio (MLR)

7.11.5.1. Contractors must calculate and report the MLR for the Medicaid and NCU programs separately for the MLR Reporting Year, which aligns with the twelve (12) month contract period. This requirement does not apply to the first twelve (12) month contract period for Contractor(s) that are new entrants to the program. The MLR must be calculated and reported in accordance with the State's instructions and reporting template, which are based on 42 CFR 438.8 and 42 CFR 457.1203(f), and provided to the State no later than nine (9) months of the end of the MLR Reporting Year. The State reserves the right to audit the Contractor's reported MLR and require recalculation if expenses or revenues are reported incorrectly. The MLR is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)).

7.11.5.2. The Medicaid MLR must be calculated and reported separately for each Rate Cell. Allocation of expenses must comply with 42 CFR 438.8(g). The Contractor's MLR report for Medicaid and NCU will include the following information in accordance with 42 CFR 438.8(k), as clarified in the report instructions:

7.11.5.2.1. Total incurred claims;

7.11.5.2.2. Expenditures on quality improving activities;

7.11.5.2.3. Expenditures for fraud prevention activities (if permitted per 42 CFR 438.8(e)(4));

7.11.5.2.4. Non-claims costs;

7.11.5.2.5. Premium revenue;

- 7.11.5.2.6. Taxes, licensing, and regulatory fees;
- 7.11.5.2.7. Methodology for allocation of expenditures;
- 7.11.5.2.8. Any credibility adjustment applied in accordance with 42 CFR 438.8(h);
- 7.11.5.2.9. The calculated MLR;
- 7.11.5.2.10. Any remittance owed to the State;
- 7.11.5.2.11. A comparison of the MLR with the annual audited financial report in Section 7.11.3.2;
- 7.11.5.2.12. The number of member months for the MLR Reporting Year; and
- 7.11.5.2.13. An attestation to the accuracy of the MLR calculation.

7.11.5.3. The Contractor must achieve an MLR of at least eighty-five percent (85%) for the Medicaid and NCU lines of business for the MLR reporting year. The minimum MLR of eighty-five percent (85%) is applied to each Rate Cell under the Contract. The minimum MLR of eighty-five percent (85%) for the CHIP line of business is applied in the aggregate. The Contractor will owe a remittance to the State if the MLR is less than eighty-five (85%) for any Rate Cell under the Medicaid and/or NCU lines of business. The amount of the remittance will be the reduction in premium revenues necessary to bring the Contractor's MLR to the minimum of eighty-five percent (85%).

7.11.5.4. The Contractor must require any third party vendor providing claims adjudication activities or a Subcontractor to provide all underlying data associated with MLR reporting to the Contractor within one hundred and eighty (180) Calendar Days of the end of the MLR Reporting Year, or within thirty (30) Calendar Days of a request by the Contractor, whichever comes sooner, to calculate and validate the accuracy of MLR reporting.

7.11.5.5. In the event the State makes a retroactive change to the Capitation Payments for the MLR reporting year after the Contractor submits the MLR report, the Contractor must recalculate and report the MLR.

7.11.6. Cost Containment and/or Cost Avoidance Initiatives

The Contractor must 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 State for review and approval prior to implementation.

The Contractor's operation of an effective claims processing system will minimize payment errors and, through the effective use of system edits and audits, prevent loss of public funds to fraud, abuse, and/or waste.

#### 7.11.7. Community Reinvestment Requirements

- 7.11.7.1. The Contractor must demonstrate a commitment to improving health outcomes in local communities in which it operates through community reinvestment activities. The Contractor's community reinvestment must be used to support population health strategies, which will include, but may not be limited to, financial support for Project ECHO and Nevada's Perinatal Quality Collaborative. The Contractor is encouraged to work with other Contractors to maximize the collective impact of community reinvestment activities.
- 7.11.7.2. The Contractor must not use community reinvestment funding to pay for Medicaid or CHIP services covered under the Contract.
- 7.11.7.3. The Contractor must contribute three percent (3%) of its annual pre-tax profits to community reinvestment. The State may require the Contractor to increase the percentage of community reinvestment contributions in future years of the Contract.
- 7.11.7.4. The Contractor must submit a plan on an annual basis, by March 1 of each Contract Year, detailing its anticipated community reinvestment activities for State review and approval.
- 7.11.7.5. The Contractor must submit an annual report of actual community reinvestment expenditures within three (3) months after the end of the Contract Year.

### **7.12. INFORMATION SYSTEMS AND TECHNICAL REQUIREMENTS**

#### 7.12.1. State's Medicaid Management Information System (MMIS)

- 7.12.1.1. The MMIS ensures the effectiveness of all elements of the process flows, requirements, interfaces and reports, support claims and encounter data processing, Capitation Payments, information needs, and includes the ability to support multiple claims systems.
- 7.12.1.2. The MMIS Claims Processor incorporates all FFS and managed care Capitation Payments and the various stand-alone applications, including the following databases: Nevada Check Up, Hospital Health Care, Surveillance/Utilization Review Subsystem (SURS), Notices of Decision (NODs), Hospice, High Risk Pregnancy Data and Care Coordination; Health Care Cost Containment, Pharmacy, and Home and Community Based Waiver Services.
- 7.12.1.3. The MMIS vendor provides the following administrative functions: Provider relations and training; third party liability recover (TPL) for

the FFS program only; FFS payment authorization requests; Pre-Admission Screening and Resident Review (PASRR) and Level of Care (LOC) assessments; Provider audits, including LOC, nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Hospital, FQHC, and RHC; FFS medical claims review; operation of the Drug Rebate Program (Medicaid Contractors or FFS, supplemental only FFS); eligibility determination information for Medicaid and Nevada Check Up; and data warehousing and Encounter Data collection, which are processed via encounter engine outside the MMIS and then stored in the data warehouse.

7.12.2. Contractor's Management Information System (MIS)

7.12.2.1. The Contractor must operate a Management Information System (MIS) capable of maintaining, providing, documenting and retaining information sufficient to substantiate and report the Contractor's compliance with the Contract requirements. The Contractor must have an MIS capable of documenting administrative and clinical procedures while maintaining the privacy and confidentiality requirements pursuant to HIPAA. The Contractor must provide the State with aggregate performance and outcome data, as well as its policies for transmission of data from Network Providers as outlined in this Contract and otherwise specified by the State. The Contractor must have internal procedures to ensure that data reported to the State are valid and to test validity and consistency on a regular basis.

7.12.2.2. The Contractor must provide compatible data in a State prescribed format for the following functions:

7.12.2.2.1. Enrollment;

7.12.2.2.2. Eligibility;

7.12.2.2.3. Provider Network Data;

7.12.2.2.4. PCP Assignment;

7.12.2.2.5. Claims Payment;

7.12.2.2.6. Encounter Data; and

7.12.2.2.7. Electronic Visit Verification (EVV)

7.12.2.3. The Contractor must work closely with the State and the State's fiscal agent to establish schedules for each interface. The State's MMIS will interface with the Contractor's system in the following areas, although not necessarily limited to these areas:

- 7.12.2.3.1. Health Plan – Encounter Data (Encounter Data reflects all services provided to Members for whom the Contractor pays);
- 7.12.2.3.2. Contractor – Weekly Stop Loss File;
- 7.12.2.3.3. Contractor – Weekly SOBRA File;
- 7.12.2.3.4. Contractor – Network Data File;
- 7.12.2.3.5. Contractor – Member Update File
- 7.12.2.3.6. MMIS – Encounter Data Error File (HIPAA X12 837 and NCPDP);
- 7.12.2.3.7. MMIS – Encounter Data Informational Errors File;
- 7.12.2.3.8. MMIS – SOBRA Error File;
- 7.12.2.3.9. MMIS – Stop Loss Error File;
- 7.12.2.3.10. MMIS – Stop Loss Rejection File;
- 7.12.2.3.11. MMIS – Contractor Error File;
- 7.12.2.3.12. MMIS – Third Party Liability Update File;
- 7.12.2.3.13. MMIS – Client Demographic Data;
- 7.12.2.3.14. MMIS – Newborn Data;
- 7.12.2.3.15. MMIS – Daily Contractor Member File;
- 7.12.2.3.16. MMIS – Contractor Member File;
- 7.12.2.3.17. MMIS – Network Data Exception File;
- 7.12.2.3.18. MMIS – Network PCP Updates;
- 7.12.2.3.19. MMIS – Member PCP Changes;
- 7.12.2.3.20. MMIS – Member Enrollment Updates;
- 7.12.2.3.21. MMIS – Contractor Notification;
- 7.12.2.3.22. DPBH, Immunization Information System, Immunization Registry, known as Nevada WebIZ;
- 7.12.2.3.23. Vital Statistics Birth Records

7.12.2.4. All transactions must be in a HIPAA-compliant format. In addition to complying with the requirements of the National EDI Transaction Set Implementation Guide, Contractors will find EDI Companion guides that contain HIPAA-compliant technical specifications at the following website: <https://www.medicaid.nv.gov/providers/edi.aspx>. The 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 by the State for the Contractor's compliance. The electronic transactions subject to the HIPAA-compliant format include, but are not limited to:

7.12.2.4.1. Capitation Payments (X12F 820);

7.12.2.4.2. Enrollment and disenrollment into a health plan (X12N 834);

7.12.2.4.3. Eligibility inquiry and response (X12N 270-inquiry and 217-response and approval of authorization);

7.12.2.4.4. Referrals and prior authorizations (X12N 278-both request and approval of authorization);

7.12.2.4.5. Claims Encounter Data (X12N 837 and NCPDP);

7.12.2.4.6. Claims status inquiry and response (X12N 276-inquiry and 277-response); and

7.12.2.4.7. Payment and remittance advice (X12N 835-remittance advice)

7.12.2.5. The Contractor is 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.

### 7.12.3. Eligibility Data

7.12.3.1. The Contractor's enrollment system must be capable of linking records for the same Member that are associated with different Medicaid and/or Nevada Check Up identification numbers; e.g., Members who are re-enrolled and assigned new identification numbers.

7.12.3.2. The Contractor must update its eligibility database whenever Members change names, phone numbers, and/or addresses, and must notify the State of such changes.

7.12.3.3. The Contractor must notify the State if the addresses of Members are not accurate.

### 7.12.4. Encounter Data and Claims Management

- 7.12.4.1. The Contractor 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 (see Section 7.9.2). 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 Contractor must comply include the following:
  - 7.12.4.1.1. Collect data on Member and Provider characteristics as specified by the State, and on services furnished to the Members through an encounter data system or other methods as may be specified by the State;
  - 7.12.4.1.2. 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) and (c), and assist the State in its validation of Encounter Data in accordance with 42 CFR 438.818; and
  - 7.12.4.1.3. Collect service information received from Providers in standardized formats.
  - 7.12.4.1.4. Make all collected data available as outlined in the Contract, the State's electronic MoveIt reporting repository, or any successor repository, attachments, guidance, as requested by the State, and upon request to CMS as required.
  - 7.12.4.1.5. Designate a lead person to collaborate with the State on the review and submission of encounter data to the State.
- 7.12.4.2. The Encounter Data reporting system must be designed to assure aggregated, unduplicated service counts provided across service categories, Provider types, and treatment facilities. The Contractor must use a standardized methodology capable of supporting CMS reporting categories for collecting service event data and costs associated with each category of service.
- 7.12.4.3. The Contractor must collect and submit service specific encounter data in the appropriate CMS-1500 and UB-04 format or an alternative format if prior approved by the State. The data submitted to the Actuary must balance with the data submitted to the State. The data must be submitted in accordance with the requirements set forth in the Contract. The data must include all services reimbursed by Medicaid.
- 7.12.4.4. The Contractor is required to submit Encounter Data for the Nevada Check Up program in the same manner as the Medicaid program. Nevada Check Up Members must be separately identified from

Medicaid Members, but the information can be combined for submission.

- 7.12.4.5. All Encounter Data must be submitted to the State or designated vendor per EDI standards and federal regulations. The Contractor must not submit Encounter Data for amounts expended for Providers excluded by Medicare, Medicaid, or CHIP.
- 7.12.4.6. All Encounter Data must reflect all adjustments and voids. Regardless of collection status, all improper payments must be adjusted or voided from the Encounter Data within timeframes specified by the State.
- 7.12.4.7. Pharmacy encounters must include the following data fields and any additional fields as specified by the State: Member name and Medicaid/NCU ID, date of birth, Provider name and NPI, prescription number, National Drug Code (NDC), units dispensed, day's supply, the plan code for reporting, date of service, paid date, paid amount.
- 7.12.4.8. All Encounters must be submitted for proper and accurate reporting and must be submitted to the State within ninety (90) Calendar Days of receipt of the Encounter.
- 7.12.4.9. Encounter Data Report Files
  - 7.12.4.9.1. Encounters must successfully pass through the HIPAA compliance editors used by the State's fiscal agent.
  - 7.12.4.9.2. Encounters must 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, passing all edits thereafter. In the event the Contractor 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 Contractor will not be held liable for encounters that do not successfully pass all encounter edits if the Contractor is not solely responsible for the failure.
  - 7.12.4.9.3. Encounters must be complete and accurate to establish Capitation Rates. Providing inaccurate or incomplete Encounter Data may create a false claim under the False Claims Act and other laws.
  - 7.12.4.9.4. Encounters must be submitted electronically as fully HIPAA compliant 'shadow claims.' This includes, but is not limited to, providing the State, through its fiscal agent,

the NPI on all Providers, including billing, servicing, and Ordering, Prescribing and Referring (ORP).

- 7.12.4.9.5. Without exception, all Network Providers must be registered with the State as a Medicaid Provider. This includes any Providers who are required to have NPI and those who are not required by CMS, but are eligible to receive an NPI. If an eligible Provider submits their claims on paper, they must still use an NPI, and the shadow claim of that paper encounter must be submitted from the Contractor to the State's fiscal agent electronically and it must include the Provider's NPI. This applies to 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 State. 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 Contractor rebills.
- 7.12.4.9.6. Without exception, all encounters from sub-capitated Providers must be captured by the Contractor 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.
- 7.12.4.9.7. For those Providers who are defined as "Atypical" by federal regulation, a similar state devised numbering system will be used. The State calls this an Atypical Provider Identifier. This Atypical Provider Identifier is issued by the State's fiscal agent on behalf of the State. The Contractor must be capable of accepting and transmitting this Atypical Provider Identifier. All encounters from Atypical Providers must be captured by the Contractor and submitted to the State's fiscal agent using the Atypical Provider Identifier. The Contractor must ensure that every Atypical Provider contracted with them has obtained this Atypical Provider Identifier from the State's fiscal agent before any payment can be made by the Contractor to that Provider.
- 7.12.4.9.8. Within sixty (60) Calendar Days of receipt of any disputed encounter file from the State or its vendor, the Contractor must, if needed, correct and resubmit any disputed encounters and send a response file that includes corrected and resubmitted encounters and/or an

explanation of why the disputed encounters could not be corrected.

#### 7.12.5. Certification of Data, Documentation, and Information

The Contractor must certify enrollment information, Encounter Data, payment data, and other information submitted to the State for purposes of developing Capitation Rates and other payments from the State to the Contractor authorized under the Contract. Data must comply with the applicable certification requirements for data and documents specified by State pursuant to 42 CFR 438.604, 438.606 and 457.1201, 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.

7.12.5.1. The data submitted by the Contractor to the State for purposes of determining payments to the Contractor must be certified by one of the following:

7.12.5.1.1. The Contractor's Chief Executive Officer;

7.12.5.1.2. The Contractor's Chief Financial Officer; or

7.12.5.1.3. An individual who has delegated authority to sign for, and who reports directly to the Contractor's Chief Executive Officer or Chief Financial Officer.

7.12.5.2. The certification must be provided concurrently with the submission of data, documentation, or information required at 42 CFR 438.604(a) and (b).

7.12.5.3. The certification standards in Section 7.12.5 also apply to the data and documentation specified in 42 CFR 438.604(a)(3)-(a)(7) and additional data specified by the Secretary.

7.12.5.4. Compliance with the requirement of data certification in this Contract is a condition for payment by the federal government.

#### 7.12.6. Interoperability Requirements

In addition to the Provider Directory API requirements in Section 7.8.8.3 and 7.8.8.4, the Contractor must implement a Patient Access Application Programming Interface (API) as specified in 42 CFR 431.60 as if such requirements applied directly to the Contractor. Data maintained on or after January 1, 2016 must be made available to facilitate the creation and maintenance of a Member's cumulative health record.

7.12.6.1. At a minimum, the Contractor must permit third-party applications to retrieve, with the approval and at the direction of the Member, the Member's:

- 7.12.6.1.1. Adjudicated claims, Application Programming Interface (API) as specified in 42 CFR 431.60 as if such requirements applied directly to the Contractor. Data maintained on or after January 1, 2016 must be made available to facilitate the creation and maintenance of a Member's cumulative health record.
  - 7.12.6.1.2. Encounter Data, including Encounter Data from any Network Providers the Contractor is compensating on the basis of Capitation Payments and adjudicated claims and Encounter Data from any Subcontractors, no later than one (1) Business Day after receiving the data from Providers;
  - 7.12.6.1.3. Clinical data, including laboratory results, no later than one (1) Business Day after the data is received by the Contractor; and
  - 7.12.6.1.4. Information about outpatient drug coverage and updates to such information, including, where applicable, preferred drug list information, no later than one (1) Business Day after the effective date of any such information or updates to such information.
- 7.12.6.2. The Contractor may deny or discontinue any third-party application's connection to an API if it reasonably determines, consistent with its security risk analysis under the HIPAA Security Rule that continued access presents an unacceptable level of risk to the security of protected health information. The determination must be made using objective verifiable criteria that are applied fairly and consistently across all applications and developers, including but not limited to criteria that may rely on automated monitoring and risk mitigation tools.
- 7.12.7. The Contractor must implement the State's contracted EVV system for the following services: Personal Care Services, upon the Contract Go-Live date, and Home Health Services, no later than January 1, 2023, and any additional services identified by the State. The dates listed herein are in effect, unless the State specifies alternative dates as directed by CMS. The Contractor may not pass any EVV-related costs to Providers or Members. The Contractor must provide assistance, as necessary, on utilization of the data collection system to Providers and Members receiving services. The Contractor must adhere to all State EVV requirements, including applicable federal and state laws, rules and regulations, the Contract, and the Medicaid Services Manual.

## **7.13. PAYMENTS TO THE CONTRACTOR**

### **7.13.1. Capitation Payments**

- 7.13.1.1. Consideration will be paid on a risk-based Capitated Rate basis. The methodology used to determine the Capitation Rates has been certified to be Actuarially Sound. The State will review and revise the rates, using a certified Actuarially Sound Capitation Rate development method. The Contractor will be notified by letter from the State of changes to the Capitation Rates or to the benefit package as they occur. Capitation Rates will be actuarially determined for each Contract Year under the term of the Contract. The State agrees to pay the Contractor the Capitated Rate for all Medicaid and Nevada Check Up Members enrolled with the Contractor except for conditions that are denied by CMS under 42 CFR 438.730(e). The Contractor will be capitated for all services in the Contractor benefit package described in Section 7, Scope of Work. The final Capitation Rates for the Contract will be developed and identified, and payment will be made in accordance with 42 CFR 438.3(c) and 42 CFR 438.4 – 438.7. Specific to the Nevada Check Up Capitation Rates, the aforementioned federal regulations apply, except the requirement for CMS preapproval of contracts and contract rates must be submitted to CMS upon request of the Secretary in accordance with 42 CFR 457.1201.
- 7.13.1.2. For each Medicaid and Nevada Check Up Member, the State will make a Capitation Payment as payment in full for any and all Medically Necessary Covered Services included in this Contractor provided to the Member. All Capitation Payments will be paid monthly. The Contractor may only retain Capitation Payments for Members that were eligible for Medicaid and Nevada Check Up for the month in which the Capitation Payment was made.
- 7.13.1.3. In the event the Contractor does not receive a monthly Capitation Payment for an eligible Member, the Contractor will have one hundred eighty (180) Calendar Days to submit a request for a retroactive Capitation Payment to the State. The State will process requests retroactive Capitation Payments within sixty (60) Calendar Days of receipt. Capitation Payments will be sent to the Contractor by the fiscal agent, either by electron funds transfer or overnight mail. The Contractor is responsible for direct payment of any and all overnight mail charges. The Contractor must meet the requirements of 42 CFR 438.606 regarding certification of data used for billing purposes.
- 7.13.1.4. The Contractor must not accept compensation for work performed under the Contract from any other department of the State of Nevada, from either Medicaid or Nevada Check Up Member, or from any other source including the federal government or other clients except for the collection of third-party liability (TPL).
- 7.13.1.5. The State does not issue payment prior to receipt of goods or services and the Contractor must bill the State as outlined in the Contract and/or payment schedule.

- 7.13.1.6. The State reserves the right to adjust Capitation Payments or to bill the Contractor to recover improperly paid Capitation Payments for a period of not more than three (3) years.
- 7.13.1.7. The State reserves the right to recover pro-rated or the full month of the Capitation Payment whenever the Contractor's responsibility to pay medical claims ends in mid-month or other reasons as specified below. A situation where a mid-month or full month Capitation Payment recovery may occur includes, but is not limited to:
  - 7.13.1.7.1. Member is placed in an out-of-home placement;
  - 7.13.1.7.2. Member enters an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID); and
  - 7.13.1.7.3. Partial monthly Capitation Payments for Members aged 21-64 who receive inpatient services within an IMD for psychiatric or substance use disorder inpatient care within a hospital setting, or for psychiatric or substance use disorder crisis residential services in a sub-acute facility with stays longer than fifteen (15) cumulative days during the period of the monthly Capitation Payment will be recovered for the portion of the month for which the Member was in the facility. By the fifteenth (15th) of every month, the Contractor must report to the State the Members who were admitted as an inpatient in an IMD for more than fifteen (15) days in the prior calendar month. Example; by August 15th, the Contractor must submit a list of Medicaid Members who had an IMD inpatient stay for more than fifteen (15) days during the month of July.
  - 7.13.1.7.4. A Member who becomes incarcerated will remain in his or her Contractor until their aid category changes or their Medicaid eligibility terminates. The State will recover Capitation Payments for those Members incarcerated in a public institution, effective the date the aid category changes. Section 1905(a) of the Act excludes federal financial participation (FFP) for medical care provided to inmates except "when the inmate is admitted as an inpatient in a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility." FFP is available for any covered Medicaid services that are provided to the inmate "while an inpatient in these facilities".
- 7.13.1.8. For those Medicaid Members exempt from mandatory enrollment for the reasons specified below, Capitation Payments will be made as follows:

- 7.13.1.8.1. For Medicaid Members enrolled with the Contractor on a voluntary basis due to the identification as Children with Special Health Care Needs (CSHCN), the State will make a Capitation Payment as payment in full for all Covered Services provided to the Member. The Capitation Payment includes the cost of the initial assessment from the Nevada Early Intervention Program. The payment will be determined in the same manner as it is for other Members: by Rate Cell in the rate schedule.
  - 7.13.1.8.2. For Medicaid Members enrolled with the Contractor on a voluntary basis due to identification of a serious emotional disturbance (SED), the State will make a Capitation Payment as payment in full for all Medically Necessary Covered Services provided to the Member. This payment includes the cost of the initial assessment for determining SED as well as on-going patient care all covered Medically Necessary mental health services. The payment will be determined in the same manner as it is for other Members: by Rate Cell in ***Attachment O – Capitation Rates***.
  - 7.13.1.8.3. A Medicaid-eligible eligible Indian can enroll with a Contractor on a voluntary basis and the State will make a Capitation Payment as payment in full for all Covered Services provided to the Member. The payment will be determined in the same manner as it is for other Members: by Rate Cell in ***Attachment O – Capitation Rates***. Eligible Indian Members can access services at Indian Health Service facilities (IHS) and Tribal Clinics while enrolled with the Contractor.
- 7.13.2. Maternity Kick Payment (Sixth Omnibus Budget Reconciliation Act aka SOBRA)
- 7.13.2.1. When a Member gives birth to a live infant of any gestational age, and there is an accompanying Provider claim for the delivery, the Contractor will receive the full Maternity Kick payment. In order for the Contractor to qualify for a Maternity Kick payment for either a miscarriage or stillbirth, the Member must be in the third trimester of pregnancy, which commences with the twenty-seventh (27th) week of gestation, when the miscarriage or stillbirth occurs. However, only one Maternity Kick payment will be processed per delivery episode regardless of how many babies are delivered.
  - 7.13.2.2. Maternity Kick claim adjudication will be initiated upon electronic receipt of birth information via the Provider Supplied Data File. The Provider Supplied Data File will specifically include: Provider Number, Record Type, Record Creation Date, Member Billing ID Number, Member Name, Member SSN, Delivery Date, Birth Indicator, Gender, Birth Provider Number, Birth Location, and Gestational Weeks

Pregnant. Additional birth information may be requested to complete SOBRA financial reporting. The Contractor must provide documentation required for verification within twenty-one (21) Calendar Days of request by the State. Failure to comply may result in rejection of the SOBRA claim in question.

- 7.13.2.3. The Maternity Kick Payment is intended to offset most of the costs to the Contractor's for costs associated specifically with the covered delivery of a child, including prenatal and postpartum care. Ante partum care is included in the Capitation Rate paid for the mother. Costs of care for the newborn are included in the newborn Capitation Rate. The Contractor will also receive a full-month Capitation Payment for the birth mother and the child for the month of birth, if the child is eligible from the date of birth, and for all subsequent months, the child remains program eligible and enrolled with the Contractor.
- 7.13.2.4. Maternity Kick Payment requests must be submitted within one hundred eighty (180) Calendar Days from date of delivery. The State will process and pay requests for payment within thirty (30) Calendar Days of receipt of the verifiable SOBRA request as specified the State's electronic MoveIt reporting repository, or any successor repository. The maternity kick payment will be paid in the first month following the month of the State's receipt to an electronic submission of the record of the child's delivery.
- 7.13.2.5. The State will not pay a SOBRA payment when there is no accompanying Provider claim for the delivery.

### 7.13.3. Low Birth Weight Babies

The Capitation Payment for the zero (0) to one (1) age group will be adjusted to allow funding for a low birth weight supplemental payment to Contractors.

- 7.13.3.1. This amount will be determined by the State's Actuary, and will remain budget neutral to the State. Money drawn from the zero (0) to one (1) age group will be distributed in an Actuarially Sound manner to offset expenses to any Contractor that receives a disproportionately large number of low birth weight babies. It is not expected that the money will end up evenly distributed among the Contractors, nor is it expected that these supplemental payments will fully offset the actual medical cost of these low birth-weight babies.
- 7.13.3.2. Once determined and agreed upon by the submitting Contractor and the State as meeting the criteria for payment, any claims will be paid within thirty (30) Calendar Days of receipt by the State. The distribution will be incident based throughout the year and there will be no requirement for bundling of claims by the Contractors. Although incident based, it is not limited by birth episode criteria but will be paid out for each child delivered, for example, twice for twins, three times for triplets, etc. The weight to be considered low birth weight will be determined by the

State with the mutual agreement of the State's Actuary and the Contractor, and with the understanding that the actual weight in grams may be considered very low birth weight, or worse, by some national standards.

7.13.3.3. Claims requesting payments for births of low birth-weight babies (1500 grams or less) infants must be submitted to the State within ninety (90) Calendar Days from date of delivery, unless an Out-of-State Provider is utilized in which case the Contractor will have an additional forty-five (45) Calendar Days to submit the claim.

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

#### 7.13.4. Risk Adjusted Capitation Rates

7.13.4.1. In order to mitigate the impact of adverse Member selection among the Contractors, the State intends to periodically adjust the Contractor's base Capitation Rates. The State intends to use the CDPS+Rx model developed by the University of California at San Diego to measure the relative health risk of each Contractor's membership on a budget neutral basis. However, the State may choose another risk adjustment model if another model will more appropriately serve the State's interests. Rate tiers specific to children under age one (1) and maternity kick payments are not expected to be risk adjusted, but this is subject to change.

7.13.4.2. Risk adjustment has historically been applied retrospectively to the prior calendar year's base Capitation Rates (e.g., retrospective risk adjustment factors developed in 2023 applied to the calendar year 2022 Capitation Rates), but the State reserves the right to transition to prospective risk adjustment at any point during the term of this Contract. The methodology used to produce risk scores and the final risk adjusted Capitation Rates will be developed in a budget neutral manner consistent with generally accepted actuarial principles and practices. The State will provide the Contractor with information regarding the development of the applicable risk adjustment factors.

7.13.4.3. In the event the risk adjustment process for a particular timeframe is not yet completed, the prior period's risk adjustment factors, if applicable, will be used on an interim basis or the State may choose not to apply

any interim risk adjustment until the new factors are completed. Notwithstanding any provision of this Contract to the contrary, the Contractor hereby agrees to accept the resulting final risk adjusted Capitation Rates, including any retroactive adjustments, without further Contract negotiations or amendments.

#### 7.13.5. Performance Withhold Arrangement

7.13.5.1. The Contractor is subject to a one and a half percent (1.5%) withhold arrangement, subject to the contractual conditions specified in 42 CFR 438.6(b)(3), namely:

7.13.5.1.1. The withhold arrangement is for a fixed period of time, not to be renewed automatically, and performance is measured during the Contract Year in which the withhold arrangement is applied.

7.13.5.1.2. To the extent applicable, the withhold arrangement is made available to both public and private Contractors under the same terms of performance. The withhold arrangement does not condition the Contractor's participation on the Contractor entering into or adhering to intergovernmental transfer agreements.

7.13.5.2. The State will provide a written communication to the Contractor on an annual basis, no later than September 1, of each Calendar Year, that specifies the performance measures and quality outcomes that apply to the withhold arrangement for the next Contract Year. The performance measures may focus on maternal and infant health outcomes, reductions in emergency room utilization, and other initiatives aligned with the State's Quality Strategy.

7.13.5.3. The State reserves the right to establish a Pay for Performance (P4P) incentive program to provide financial rewards to a Contractor that achieves specific levels of performance in program priority areas. The Capitation Payments are the total payments to the Contractor except in a situation in which the Contractor receives an additional payment through a P4P incentive program.

#### 7.13.6. Stop Loss Arrangement for Inpatient Stays

7.13.6.1. The State will assume partial risk for Member inpatient hospital medical costs that exceed five hundred thousand dollars (\$500,000.00) during a Contract Year. The State will reimburse the Contractor at seventy-five percent (75%) of the Contractor's paid amount for a Member's inpatient hospital medical costs above five hundred thousand dollars (\$500,000.00) threshold, inclusive of a thirty (30) Calendar Day period prior to the commencement of the Contract Year. The Contractor will be responsible for the remaining twenty-five percent (25%) of the costs

and must continue to care for the Member under the terms of the Contract.

7.13.6.2. Requests for reimbursement must be accompanied by all required documentation. Complete and correct stop loss requests must be submitted within ninety (90) Calendar Days from the date of a payment causing the \$500,000.00 threshold to be reached. Subsequent additional claims for the same Contract Year will be submitted within ninety (90) Calendar Days from the last date of payment listed on a claim. The ninety (90) day limit is based upon the date paid, as given on the Explanation of Benefits (EOB) or Explanation of Payment (EOP). If an Out-of-State Provider is utilized, the Contractor will have an additional forty-five (45) Calendar Days to submit the claim. Stop loss requests for re-adjusted claim submissions will only be considered if the Contractor re-adjusted a claims payment within eighteen (18) months from the last date of service. The Contractor must process complete requests for reimbursement within sixty (60) Calendar Days of receipt of a complete and correct request for reimbursement.

#### 7.13.7. Disputed Capitation and Requests for Retroactive Capitation

Any notice of disputed Capitation and requests for retroactive Capitation Payments must be made by the Contractor in writing in the required format (refer to the State's electronic MoveIt reporting repository) within one hundred eighty (180) Calendar Days from the date of receipt of a particular month's capitation. The notice must include the Member's Medicaid or NCU ID number and month of enrollment. If the Member is a child, the notice must additionally include the mother's Medicaid ID number and month of enrollment. Failure to notify the State within one hundred eighty (180) Calendar Days waives the right of the Contractor to seek an adjustment. No payment will be made unless such changes or adjustments and the amount therefore have been authorized in writing by the State. The State will make its determination within sixty (60) Business Days from receipt of a dispute. The Contractor may appeal the State's decision concerning Capitation disputes, adjustment decisions or retroactive Capitation Payments.

#### 7.13.8. Notification to State of Incorrect Capitation Payments or Other Payments under the Contract

The Contractor has the responsibility for proactively review Capitation Payments received to determine whether any excess Capitation Payments have been received. The Contractor must report to the State within sixty (60) Calendar Days when it has identified Capitation Payments or other payments in excess of amounts specified in the Contract.

#### 7.13.9. Impact to Capitation Due to Invalidation or Repeal

Should any part of the SOW under this Contract related to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part after the effective date of the

loss of program authority. The State must adjust Capitation Payments to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If the State paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the State. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the State included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

#### 7.13.10. Payment from the State and Billing

7.13.10.1. Upon review and acceptance by the State, payments for invoices are normally made within forty-five to sixty (45-60) Calendar Days of receipt, providing all required information, documents and/or attachments have been received.

7.13.10.2. Pursuant to NRS 227.185 and NRS 333.450, the State will pay claims for supplies, materials, equipment, and services purchased under the provisions of this RFP electronically, unless determined by the State Controller that the electronic payment would cause the payee to suffer undue hardship or extreme inconvenience.

7.13.10.3. The State does not issue payment prior to receipt of goods or services.

7.13.10.4. The Contractor must bill the State as outlined in the approved contract and/or payment schedule.

### **7.14. REPORTING REQUIREMENTS**

7.14.1. The reporting schedule and specifications under the Contract are specified in the State's electronic MoveIt reporting repository, or any successor repository. The Contractor is required to utilize information in that repository, or as otherwise specified by the State, for submission of all required reports and forms. Failure to meet all reporting requirements and timeframes required by the Contract and all attachments thereto may be considered to be in default or breach of the Contract. The list of reports is not exhaustive and the Contractor must adhere to all required reporting specified in the Contract and the MoveIt reporting repository, or any successor repository.

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

The Contractor may clearly label individual documents as a "trade secret" or "confidential" provided that the Contractor agrees to indemnify and defend the State for honoring such a designation. The failure to label any document that is released by the State will constitute a complete waiver of 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 Contractor of the request and delay access to the material until seven (7) Business Days after notification to the Contractor. Within that time delay, it will be the duty of Contractor to act in protection of its labeled record. Failure to act constitutes a complete waiver.

#### 7.14.3. Dispute Resolution Reporting

7.14.3.1. The Contractor must provide the State with reports documenting the number and types of Provider Disputes, Member Grievances, Appeals and fair hearing requests received by the Contractor and its Subcontractors.

7.14.3.2. These reports are to include, but not be limited to, the total number of Members grievances, the total number of notices provided to Members, the total number of Member appeals requests, and Provider Disputes filed, including reporting of all Subcontractor's Member Grievances, notices, Appeals and Provider Disputes. The reports must identify the Member Grievance or Appeal issue or Provider dispute received; and verify the resolution timeframe for Member Grievances and Appeals and Provider Disputes.

7.14.3.3. Comprehensive Member Grievance, notice, and Appeal information, fair hearing requests, and Provider Dispute information, including specific outcomes, must be retained for each occurrence for review by the State.

#### 7.14.4. Quality Assurance Reporting

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

#### 7.14.5. Member Satisfaction Reporting

The Contractor must collect and submit to the State a child and adult Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, as well as a CAHPS survey for Children with Chronic Conditions (CCC), measuring Member satisfaction prior to the third quarter of each Contract Year, unless the requirement is waived by the State due to an EQRO performed survey. This may be done in

conjunction with the Contractor's own satisfaction survey. The State requires data stratified to indicate the satisfaction level of parents or guardians of Nevada Check Up Members. The Contractor is required to report results from the CAHPS Child Medicaid Survey, the CAHPS CCC Survey, and the Supplemental Items for the Child Questionnaires on access to specialist care and coordination of care from other health care Providers. The State may request a specific sample, and/or survey tool. Survey results must be disclosed to the State or Members upon the request of the State or the Member.

#### 7.14.6. Sales and Transaction Reporting

In accordance with section 1903(m)(4)(A)-(B) of the Act, the Contractor must report transactions between the Contractor and parties in interest to the State or other agencies and made available to Members upon reasonable request.

#### 7.14.7. Financial Reporting

The Contractor must meet the financial reporting requirements set forth in this Contract, including any revisions or additions to the requirements, and in accordance with templates

#### 7.14.8. EPSDT Tracking System

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

#### 7.14.9. Other Reporting

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

#### 7.14.10. Record Retention Requirements

7.14.10.1. The Contractor and any Subcontractors must retain the following information for a period of no less than ten (10) years:

7.14.10.1.1. Member Grievance and Appeal records developed in accordance with 42 CFR 438.416;

7.14.10.1.2. Encounter data and audited financial reports;

7.14.10.1.3. Medical Loss Ratio reports developed in accordance with Section 7.11.5.2 of the Contract;

- 7.14.10.1.4. Data on the basis of which the State determines the Contractor has made adequate provision against the risk of insolvency;
  - 7.14.10.1.5. Documentation supporting the Contractor's compliance with the Network adequacy and availability and accessibility of services requirements of the Contract;
  - 7.14.10.1.6. Disclosures on information and control as required per 42 CFR 455.104 for the Contractor and any Subcontractors;
  - 7.14.10.1.7. The annual report of overpayment recoveries required per 42 CFR 438.608(d)(3); and
  - 7.14.10.1.8. Any data and documentation related to the Contractor's obligations pursuant to 42 CFR 438.608 and any prohibited affiliations as specified in 42 CFR 438.610.
- 7.14.10.2. Any other data, documentation, or information created by the Contractor and any Subcontractors pursuant to this Contract is subject to the State's record retention period of ten (10) years.

## **7.15. SANCTIONS, MONETARY PENALTIES AND OTHER REMEDIES**

### **7.15.1. General Provisions**

- 7.15.1.1. In the event that the Contractor or any person with an ownership interest in the Contractor, affiliate, parent, or Subcontractor, fails to comply with this Contract, the State may impose, at the State's discretion, sanctions (inclusive of the specific monetary penalties and other penalties) described in this section.
- 7.15.1.2. The State retains the right to apply progressively strict sanctions against the Contractor for failure to perform in any areas of the Contract.
- 7.15.1.3. Any sanction, including the withholding of Capitation Payments, does not constitute just cause for the Contractor to interrupt providing Covered Services to Members.
- 7.15.1.4. The State, at its discretion, may direct the Contractor to expend any portion of monetary penalties for Provider network development and enhancement activities that will directly benefit Medicaid Members.
- 7.15.1.5. The State may impose any other administrative, contractual or legal remedies available under federal or State law for the Contractor's noncompliance under this Contract.
- 7.15.1.6. In addition to monetary penalties and intermediate sanctions, the Contractor will be responsible for any fines or sanctions imposed upon

the State by regulatory agencies as a result of the Contractor's non-compliance.

#### 7.15.2. Plan of Correction (POC)

- 7.15.2.1. If the State determines that the Contractor is not in compliance with one or more requirements in this Contract, the State will provide written notice to the Contractor regarding the details of the noncompliance with directives (either in the form of a Plan of Correction (POC) or a State Directed Plan of Correction (DPOC)) for ameliorating the deficiencies. A notice from the State of noncompliance directing a POC or DPOC will also serve as a notice for sanctions in the event the State determines that sanctions are also necessary.
- 7.15.2.2. The Contractor must provide POCs to the State within fourteen (14) Calendar Days of receipt of a noncompliance notice from the State. POCs are subject to review and approval by the State.
- 7.15.2.3. If the State imposes a DPOC on the Contractor, the Contractor will have fourteen (14) Calendar Days to respond to the State.
- 7.15.2.4. If the Contractor does not effectively implement the POC/DPOC within the timeframe specified in the POC/DPOC, the State may impose additional sanctions.
- 7.15.2.5. If the Contractor has not complied with the POC/DPOC at the end of the specified time period, the State will proceed with the imposition of sanctions and other remedies, as it deems appropriate. The Contractor may be subject to a \$10,000 monetary penalty, per POC/DPOC that must be resubmitted by the Contractor because of the Contractor's continued non-compliance.
- 7.15.2.6. If State staff are required to spend ten (10) hours or more per week monitoring a POC or DPOC, the State will provide notice to the Contractor that the Contractor Must contract with a third party, either designated by the State or approved by the State, to oversee the Contractor's compliance with the POC(s) or DPOC(s).
- 7.15.2.7. The Contractor must implement the POC/DPOC in compliance as specified in this Contract, including all attachments. The State may provide quality assurance monitoring to the Contractor, including but not limited to, site reviews, documentation reviews, data analysis, medical audits, customer and provider satisfaction surveys, and grievance and hearings data tracking and analysis. The quality assurance monitoring may come from the State, its EQRO, or from an outside quality review agent hired by the State at the expense of the Contractor.

#### 7.15.3. Sanctions

- 7.15.3.1. The State may impose any or all of the non-monetary sanctions and monetary penalties based on determination of noncompliance as described in this Contract to the extent authorized by federal and State law. The State may base its determinations on findings from onsite surveys, Member or other complaints, financial status, or any other source. Nothing in this section prohibits the State from imposing additional sanctions under State law that address areas of non-compliance specified in this section, as well as additional areas of non-compliance.
- 7.15.3.2. Except as provided in 42 CFR 438.706(c), before imposing any intermediate sanction, monetary penalties, or other remedy against the Contractor, the State will provide the Contractor with written notice that explains the basis and nature of the sanction and such other due process protections as the State may provide.
- 7.15.3.3. The State may impose against the Contractor non-monetary or monetary intermediate sanctions if the Contractor:
  - 7.15.3.3.1. Fails substantially to provide covered Medically Necessary items and services that the Contractor is required (under law or under this Contract with the State) to be provided to a Member covered under this Contract;
  - 7.15.3.3.2. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program; or
  - 7.15.3.3.3. Acts to discriminate among Members based on their health status or need for health care services. This includes termination of enrollment or refusal to re-enroll a Member, except as permitted by this Contract, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the organization by Potential Members whose medical condition or history indicates a need for substantial future medical services; or
  - 7.15.3.3.4. Misrepresentation or falsification of information furnished:
    - 7.15.3.3.4.1. To the Secretary or the State, or CMS, in furtherance of this Contract; or
    - 7.15.3.3.4.2. To a Member, Potential Member, or a health care Provider under this contract.
  - 7.15.3.3.5. Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 42 CFR 422.210; or

- 7.15.3.3.6. Distributes directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.
- 7.15.3.3.7. Violates any of the other requirements of Sections 1903(m) or 1932 of the Social Security Act, or any implementing regulations. For any violations of this section, only the sanctions specified in 42 CFR 438.702(a)(3), (4), and (5) may be imposed.
- 7.15.3.4. The Contractor agrees that all provisions of 42 CFR part 438, subpart I apply. In addition to termination of the Contract, the State's remedies under this Contract include intermediate sanctions as follows:
  - 7.15.3.4.1. Civil penalties in the amounts specified in 42 CFR 438.704;
  - 7.15.3.4.2. Appointment of temporary management for the Contractor as provided in 42 CFR 438.706;
  - 7.15.3.4.3. Granting Members the right to terminate enrollment without cause and notifying the affected Members of their right to disenroll;
  - 7.15.3.4.4. Suspensions of all new enrollment, including default enrollment, after the date the Secretary or the State notifies the Contractor of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act;
  - 7.15.3.4.5. Suspension of payment for Members enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur; or
  - 7.15.3.4.6. Any additional sanctions allowed under State statute or State regulations that address areas of noncompliance specified in 42 CFR 438.700 as well as additional areas of noncompliance. Additional sanctions may include monetary penalties and imposition of plans of correction in addition to its remedies at law.
- 7.15.3.5. Civil Monetary Penalties, as provided under 42 CFR 438.702(a)(1), may be assessed as follows:
  - 7.15.3.5.1. Not more than twenty-five thousand dollars (\$25,000.00) for each determination under 42 CFR 438.700(b)(1), (5), (6), and (c).

- 7.15.3.5.2. Not more than one hundred thousand dollars (\$100,000.00) for each determination under 42 CFR 438.700(b)(3) or (4).
- 7.15.3.5.3. Fifteen thousand dollars (\$15,000.00) for each individual the State determines was not enrolled because of a discriminatory practice under 42 CFR 438.700(b)(3). This is subject to the overall limit of one hundred thousand dollars (\$100,000) at Section 7.15.3.5.2.
- 7.15.3.5.4. For premiums or charges in excess of the amounts permitted under the Medicaid program, twenty-five thousand dollars (\$25,000.00) or double the amount of the excess charges, whichever is greater. The State will deduct from the penalty the amount of overcharge and return it to the affected Member(s).

#### 7.15.3.6. Appointment of Temporary Management

- 7.15.3.6.1. The State may impose the optional sanction of temporary management under 42 CFR 438.702(a)(2) if it finds (through onsite surveys, Member or other complaints, financial status, or any other means) any of the following:
  - 7.15.3.6.1.1. Continued egregious behavior by the Contractor, including but not limited to behavior described in 42 CFR 438.700, or that is contrary to any requirements of 1903(m) and 1932 of the Act.
  - 7.15.3.6.1.2. There is substantial risk to the Member's health.
  - 7.15.3.6.1.3. The sanction is necessary to ensure the health of the Contractor's Members while improvements are made to remedy violations of 42 CFR 438.700 or until there is an orderly termination or reorganization of the Contractor.
- 7.15.3.6.2. The State will impose the sanction of temporary management (regardless of any other sanction that may be imposed) if it finds that the Contractor has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the Act, or 42 CFR 438 Subpart I. The State will grant Members the right to terminate enrollment without cause, as described in CFR 438.702(a)(3), and will notify the affected Members of their right to terminate enrollment.

- 7.15.3.6.3. The State will not delay the imposition of temporary management, whether optional or required, in order to provide a hearing before imposing this sanction.
- 7.15.3.6.4. The State will not terminate a temporary management sanction until it determines the Contractor can ensure that the sanctioned behavior will not recur.
- 7.15.3.6.5. The Contractor must pay the expenses associated with the imposition of temporary management. If necessary, the State may utilize funds from the Contractor's performance security deposit to cover expenses associated with the imposition of temporary management.

7.15.3.7. Termination of Contract

- 7.15.3.7.1. The State may terminate the Contract and enroll the Contractor's Members in other MCOs or provide their Covered Services through other options in the Medicaid and CHIP State Plans; if the State determines that, the Contractor has failed to carry out the substantive terms of the Contract or has failed to meet applicable requirements of Section 1932 or 1903(m) of the Act.
- 7.15.3.7.2. Prior to termination of the Contract, the State will provide a pre-termination hearing in accordance with 42 CFR 438.710.

7.15.3.8. Notice of Sanction

Except as provided in CFR 438.706(c), before imposing any of the intermediate sanctions specified in this Contract, the State will give the Contractor written notice that explains the basis and nature of the sanction and any other appeal rights that the State elects to provide.

7.15.3.9. Pre-Termination Hearing

- 7.15.3.9.1. Before terminating the Contract, the State will provide the Contractor a pre-termination hearing. The State will give the Contractor written notice of the State's intent to terminate, the reason for termination, and the time and place of the hearing.
- 7.15.3.9.2. After the hearing, give the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of termination.

- 7.15.3.9.3. For an affirming decision, the State will give the Members enrolled with the Contractor written notice of the termination and information, consistent with CFR 438.10, on their options for receiving Medicaid services following the effective date of termination, which includes the ability for Members to disenroll immediately without cause from the Contractor.
- 7.15.3.10. Payments to the Contractor provided for under this Contract will be denied for new Members when, and for so long as, payment for those Members is denied by CMS under 42 CFR 438.730(e).
- 7.15.3.11. Monetary Penalties and Other Sanctions
- 7.15.3.12. The parties agree that in some cases it is foreseeable that actual damages may be difficult to calculate, and therefore monetary penalties may be imposed in lieu of, or in addition to, actual damages at the discretion of the State. The Contractor will not be assessed monetary penalties when the failure of the Contractor to meet contract standards is determined to be a result of inaccuracies in the information supplied by the State, or actions or inaction on the part of the State. The Contractor will not be responsible for verifying the accuracy of the information supplied by the State. However, if the Contractor suspects that the information supplied by the State is in error, then the Contractor must contact the State, in writing, within ten (10) Business Days of discovery.
- 7.15.3.13. When the State determines the Contractor has a deficiency in a specific area that is not improving, the State may take certain actions to include the provision of trainings, webinars and/or on-site technical assistance until the issue is resolved. Such actions may result in a fee of up to \$5,000 per day. The Contractor will be required to provide a dedicated workspace during the time that State staff is on-site.
- 7.15.3.14. Monetary penalties may be imposed in addition to other remedies. When no specific monetary penalty is listed in this Contract, the State may assess monetary penalties in the amount of five hundred dollars (\$500.00) per day if the Contractor fails to meet the conditions as set forth in this Contract.
- 7.15.3.15. Any known or willful false statement, representation or material omission of a material fact in any financial statement or disclosure filed pursuant to this policy will cause the State to impose monetary penalty sanctions. The State may assess monetary penalties for one hundred thousand dollars (\$100,000.00). Further, both the Contractor and any culpable employee, officer, director or agent may be subject to prosecution through the Medicaid Fraud Control Unit (MFCU) or adverse administrative action.
- 7.15.3.16. In the event any Subcontract is determined not to meet federal requirements and results in a federal disallowance of federal funds, the

Contractor will be financially responsible to refund the amount of the federal disallowance and the corresponding State share to the State. The State share will be considered monetary penalties. If such disallowance is treated as a default or breach, or otherwise subjects the Contractor to sanctions under this section, any such monetary penalties 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 must be amended. All future subcontracts must meet the requirements of this Contract and any amendments thereto.

- 7.15.3.17. The State may recover actual damages incurred by the State and/or Members resulting from the Contractor's non-performance of obligations under this Contract;
- 7.15.3.18. Monetary penalties in an amount equal to the costs of obtaining alternative health benefits to a Member in the event of the Contractor's noncompliance in providing Covered Services. The monetary penalties will include the difference in the Capitation Payments that would have been paid to the Contractor and the Capitation Payments paid to the replacement MCO. The State may withhold payment to the Contractor for damages until such damages are paid in full;
- 7.15.3.19. Monetary penalties for non-compliance of this Contract that may potentially involve risk or harm to Members or the integrity of the Medicaid program may be assessed at up to five percent (5%) of the Contractor's Medicaid Capitation Payment for each month in which the penalty is assessed.
- 7.15.3.20. Other monetary penalties for failure to perform specific responsibilities in the Contract are as follows:

<b>Program Requirements and Monetary Penalties</b>	
<b>Program Requirements</b>	<b>Monetary Penalty</b>
Noncompliance with Readiness Review deliverables, for either timeliness or completeness.	One thousand dollars (\$1,000) a day the deliverable is late or completeness issues persist.
Failure to file full, complete, and certified Independent Audited Financial statements within one hundred-twenty (120) Calendar days of the Contractor's fiscal year end.	Two percent (2%) of one (1) month's total Capitation for each month, or pro-rata portion thereof, until such statements are received by the State.
Failure to file accurate, timely and complete quarterly and annual financial reports to the State within the specified timeframes.	One percent (1%) of one (1) month's Capitation for each month, or pro-rata portion thereof, until the reports are received by the state.
The sum of the quarterly financial (and other) statements must, where applicable and in accordance with GAAP and/or logical flow, reconcile to within plus or minus (+/-) ten	Up to two percent (2%) of one (1) month's Capitation in total for variances exceeding the permissible reconciliation guidelines per quarter.

<b>Program Requirements and Monetary Penalties</b>	
<b>Program Requirements</b>	<b>Monetary Penalty</b>
percent (10%) of the annual audited financial statements (and other annual statements). The State may assess monetary penalties up to two percent (2%) of one (1) month's capitation in total for variances exceeding the aforementioned guidelines per quarter.	
Requests for retroactive Capitation Payments per Section 7.13.1.3 for ineligible Members.	Five thousand dollars (\$5,000) for each capitation month the State determines ten percent (10%) or more of the retroactive Capitation Payments requested by the Contractor to be invalid.
Failure to comply with Encounter submission as described in Section 7.12.4.9.2.	The liquidated damages would be two percent (2%) of one (1) month's capitation, or ten thousand dollars (\$10,000), whichever is greater for each month until the State determines the Contractor complies with the requirements of Section 7.12.4.9.2.
Failure to comply with the comprehensive assessment timeframes in Section 7.5.6.7.12.	One thousand dollars (\$1,000) per Member in which the Contractor fails to comply with the timeframes for that Member.
Failure to comply with the person centered treatment plan timeframes in Section 7.5.6.7.13.1.	One thousand dollars (\$1,000) per Member in which the Contractor fails to comply with the timeframes for that Member.
Failure to comply with timely claims payment requirements as described in Section 7.7.1.5 of this Contract.	Five thousand dollars (\$5,000) per day until the State determines the Contractor complies with the requirements of Section 7.7.1.5.
Failure to comply with provider directory requirements described in Section 7.8.8 of the Contract.  At least ninety percent (90%) of listed Providers will confirm participation in the Contractor's Network and that their demographic data is accurate.	\$15,000 for each incident and an additional \$500 per day until the provider directory is accurate.
Failure to obtain approval of Member materials as required by Section 7.8.5 of the Contract.	Five thousand dollars (\$5,000) per day for each Calendar Day that the State determines the Contractor has provided Member materials that have not been approved by the State. The \$5,000 per day damage amounts will double every ten (10) Calendar Days.
Failure to obtain advance written approval of a Subcontract from the State per Section 7.2.2.3.	Twenty-five thousand dollars (\$25,000) for each incident.

<b>Program Requirements and Monetary Penalties</b>	
<b>Program Requirements</b>	<b>Monetary Penalty</b>
Failure to submit reports as designated in Reporting Guide	Five thousand dollars (\$5,000) per report, per occurrence. One thousand dollars (\$1,000) per report, per Calendar day. The one thousand dollar (\$1,000) per day penalty amounts will double every ten (10) Calendar Days.
Statistically significant decline in one PIP (HEDIS or NON-HEDIS) will result in a quality penalty fee until the measure increases above original measure or matches previous measure prior to decline (see Section 7.9.5.9).	Monetary penalty of \$25,000 for each determination.
Failure to comply with the timeframe for responding to Grievances and Appeals for Members and Providers required in Section 7.8.10 and 7.6.14.	\$1,000 per occurrence in which the Contractor fails to comply with the required timeframes.
Failure to complete or comply with POCs/DPOCs.	0.12% of the monthly Capitation Payment per Calendar Day for each day the POC/DPOC is not completed or complied with as required.

#### 7.15.3.21. Payment of Monetary Penalties

In the event that the State decides to assess monetary penalties, the following procedure will be followed:

- 7.15.3.21.1. The State will send an invoice for payment of monetary penalties to the Contractor. The invoice will explain the basis for the assessment;
- 7.15.3.21.2. The Contractor will, within thirty (30) Calendar Days of receipt of the invoice, either pay the invoice in full or the State will withhold the amount of the monetary penalties from future Capitation Payments; and
- 7.15.3.21.3. Payment of the invoice does not relieve the Contractor of the responsibility to comply in future reporting periods and/or instances.
- 7.15.3.21.4. The collection of monetary penalties by the State must be made without regard to any appeal rights the Contractor

may have pursuant to this Contract; however, in the event an appeal by the Contractor results in a decision in favor of the Contractor, any such funds withheld by the State will be immediately returned to the Contractor.

- 7.15.3.21.5. Monetary penalties as described in this Contract are assessed by the State to the Contractor and not to Subcontractors, or Network Providers. The Contractor is responsible to the State for such monetary penalties.

#### 7.15.3.22. Suspension of Enrollment

The State may suspend enrollment in the Contractor with two (2) Business Days' notice when:

- 7.15.3.22.1. The Contractor has a minimum of thirty percent (30%) fewer Primary Care Providers, or a minimum of thirty percent (30%) of Members than the Primary Care Physician (PCP)-to-Member ratio allows for the affected geographic service area; or
- 7.15.3.22.2. The Contractor's data systems are not in place or operating in such a manner to allow accurate and timely electronic transfer of information to or from the State. Enrollment will not be reinstated until the condition is corrected.
- 7.15.3.22.3. Marketing violations;
- 7.15.3.22.4. Failure to meet contractual requirements on monthly, quarterly, and annual reports;
- 7.15.3.22.5. Material deficiency in the Contractor's Provider Network;
- 7.15.3.22.6. Material deficiency in quality of care and quality management issues;
- 7.15.3.22.7. Failure to process claims in a contractually required and timely manner;
- 7.15.3.22.8. Failure to meet contractual encounter data requirements;
- 7.15.3.22.9. Failing to provide or denying payments for Medically Necessary Covered Services; and
- 7.15.3.22.10. Inappropriately denying or pending claims or payments for Medically Necessary Covered Services provided to Members.

#### 7.15.3.23. Waiver of Sanctions

The State may waive the application of sanctions (including monetary penalties) at its discretion if the State determines that such waiver is in the best interests of the Medicaid program and its Members. Such waiver will not constitute an ongoing waiver of sanctions or penalties and is not construed as a waiver of the State's right to exercise the application of sanctions in any other instance.