

Division of Health Care Financing and Policy

Managed Care Expansion Listening Session Comments and Responses

- Are the managed care reimbursement rates lower than fee for service? If so, this will negatively impact providers; especially in the rural areas where it is more difficult to recruit providers.

The managed care plans negotiate the rate with each provider; therefore some rates may be higher or lower. The DHCFP does not have oversight of these negotiations.

- Is the dual eligible population (those with Medicare and Medicaid) being considered for enrollment in managed care?

Yes, all Medicaid categories are being evaluated.

- Do you have to, or will you be forced to, refuse your Medicare benefits?

No, you will not be forced to refuse your Medicare benefits, and in fact Medicaid will expect you to have Medicare if you are eligible as Medicare is the first payor. Medicaid will then pay your co-pays, deductibles or services not paid for by Medicare.

- How will the managed care plans be held accountable to ensure that they live up to their contract agreements and what type of grievance process is available to providers and recipients if they have complaints?

The Nevada Medicaid agency will monitor contract compliance. Per contract, the managed care plans must provide a grievance and appeals process to their members. If you are not satisfied with the outcome of the appeal, you can request a fair hearing with the state of Nevada.

- The managed care plans control their respective network. There is concern that they will limit their panel and the availability of providers will diminish. This will cause an interruption in the delivery of services and there will be no continuity of care.

Managed care does have the ability to control their networks; however, they must maintain an adequate network to ensure the medical needs of members are met. They're also continuity of care requirements where the managed care organization must assure the recipient can get the services from their current provider until an in-network provider is located.

- It is expensive to become a managed care provider due to the rigorous credentialing process. Could the state oversee that and allow providers to pay a "one time" fee that would permit them to be enrolled in all managed care plans?

Managed care plans are required to credential their networks, but the state is looking at how this process can be simplified or integrated so that it is a less cumbersome process.

- Are there eligibility differences to qualify for managed care Medicaid versus fee-for-service Medicaid?

Medicaid eligibility criteria is determined by the Division of Welfare and Supportive Services and is the same for everyone regardless if you are fee-for-service or in managed care.

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- Will the state be looking at quality care and improved health outcomes as well as potential cost savings when considering moving to the managed care delivery model?

The state does currently look at quality of care and health outcomes and is planning on implementing a pay for performance and sanction processes if goals are not met. The state has a managed care quality strategy located at:

http://dhcfp.nv.gov/uploadedFiles/dhcfpnv.gov/content/Members/BLU/NV2016-17_QAPIS_Report_F1.pdf

- What assurances will the state mandate to ensure that the managed care plans are able to deliver non-medical services such as adult day health care?

If managed care is expanded to cover additional services, quality indicators to monitor these services will be developed with public input.

- Within the current managed care delivery model, are recipients happy?

Satisfaction surveys are completed annually and the results can be found at: http://dhcfp.nv.gov/uploadedFiles/dhcfpnv.gov/content/Members/BLU/FY2015_EQR_Technical_Report.pdf

- How are the capitation rates determined?

Capitation rates are determined based on actual expenditures from the prior year. When new services or programs are added, there is research into the cost of these services and other programs, such as fee for service or what other states reimburse to help determine the rate.

- How do managed care organizations provide patient education and how do they “incentivize” their members?

Each plan has their own processes, some things include: gift cards, school back packs, reminder calls, and brochures on how to manage your health condition. You can access our current managed cares’ websites for additional information.

For Amerigroup: <https://www.myamerigroup.com/pages/welcome.aspx>

For Health Plan of Nevada: <http://www.hpnmedicaidnvcheckup.com/>

- Will services be cut?

No

- Will the managed care plans incorporate person centered planning, and if so, will they look at the “whole person” and their needs?

Yes. Person Centered Planning principles are incorporated into the care planning process which will align with requirements in other service delivery models such as the Home and Community Based Waivers

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- If the delivery model switches to 100% managed care, how will this impact state employees, including community health workers?

The impact on state employees has not been determined. In some states, the managed care organization contracts with the states for the services state employees provide or the employees transition to other roles within their respective agencies.

Currently, community health workers are not state employees; however both managed care organizations have hired community health workers. The state is evaluating impact to state workers and how to best proceed going forward to ensure an adequate workforce and no interruption or gaps in service to recipients.

- Will the managed care organizations assign a case manager to everyone? Will they actually do home visits and assess the needs of individuals; as many recipients aren't able to accurately verbalize their needs.

It is unlikely the managed care organizations will assign a case manager to everyone in their programs, however in the home and community based waiver programs, this is a requirement that they would have to follow. Managed Care Organizations are required to provide case management services to individuals that have been identified through a screening assessment, at risk criteria, or those individuals having certain clinical and/or behavioral health conditions.

- For many, the process to obtain prior authorization for services from managed care organizations has been a negative experience. How will the state address this in future contracts?

The state would need additional information, but the managed care organizations are required to provide medically necessary care. The State plans on creating a workgroup that includes representatives from the MCOs to evaluate the possibility of developing a standard prior authorization (PA) form and aligning billing codes that require PAs to streamline and simplify the PA process.

- Will the managed care organizations have a presence in the rural and frontier areas of Nevada; as the dynamics are different in these areas?

This is one of the things being evaluated; if all areas are included, there will likely need to be different requirements for the different areas to address these different dynamics. The State has procured a vendor to evaluate services, populations and geographic areas that are not currently included in MCO contracts and make recommendations for expansion and assistance with planning for transition as indicated.

- Where is the data to show that managed care is better than the traditional fee for service model? There should be data available from the first implementation in Clark and Washoe counties.

This is what we are working to evaluate by looking at different areas in the country.

The individuals enrolled in managed care in Nevada in the 90s are a very different population group than the additional groups that are currently being evaluated.

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- Rural and frontier areas are different from urban areas of the state. Will managed care be tailored to meet the needs in these areas?

If managed care is going to cover both areas, it would be expected there would be differences to meet the area's needs. The MCOs are required to have an adequate network for covered services and must ensure continuity of care.

- Can a recipient/provider be both managed care and fee for service?

A recipient would either be fee for service or managed care; a provider can be both.

- Many providers are happy with the responsiveness from the Medicaid agency and feel that issues are resolved expediently. What assurance will the providers have that the managed care organizations will provide that level of responsiveness?

The current contracts have standards for grievances and appeals. It's the state's responsibility to monitor contract compliance.

- What will happen if providers refuse to enroll in the managed care network?

They will not be able to provide services to recipients enrolled in that managed care organization.

- Accessing mental health services in the current managed care delivery model is difficult. How will this change in the future?

Individuals should call the managed care organization they are enrolled in for assistance in getting services they need. If the managed care does not provide the assistance they need, they should inform the state so the state can work with the managed care to provide the appropriate assistance.

- Transferring or referring patients who are in managed care is difficult. Many providers don't accept managed care patients, or are not enrolled in the particular plan. This will only become more difficult if the state chooses to expand managed care. How will the state assist/intervene to ensure patients get the proper services?

The managed care organizations must provide medically necessary services and assist recipients in getting access to care. If the recipient is not getting the assistance they need, the recipient should call the state to let us know. The state will call the managed care organization to provide the assistance.

- The literature that is sent out from the current managed care plans is often difficult to understand and interpret, and often provider listings online are incorrect. Can the state ensure that the material is in an easy to read format and provider lists are current?

The managed care contracts require information to be presented at an 8th grade level. If there are certain items that an individual is having understanding, the state would appreciate getting copies of these to have managed care organizations update their material. If the recipient does not understand the material, the recipient should call the state to let us know. The state will call the managed care organization to provide the assistance.