MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

August 23, 2017

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3800 – CARE MANAGEMENT ORGANIZATION

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3800 – Care Management Organization are being proposed to ensure policy is accurate in regard to the 1115(a) Nevada Comprehensive Care Waiver. Changes are necessary to make the policy current and aligned to the parameters of the program as outlined within the waiver. Changes were made to the document in full. The changes include modification of the title of "recipient" rather than varying use of titles for consistency purposes. Removal of Health Homes throughout the document in its entirety was completed as this is not currently in effect within the guidelines of the 1115(a) Nevada Comprehensive Care Waiver. Family Medical Coverage Categories have been removed as these are no longer accurate and replaced with up-to-date categories due to the implementation of the Patient Protection and Affordable Care Act (ACA) (CFR 45 parts 146,147,148). Contract language was removed from document as it is unnecessary within the MSM chapter.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: There are no entities expected to be affected by these updates.

Financial Impact on Local Government: There is no expected financial impact on local government.

These changes are effective August 24, 2017.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL30364 MSM 3800 Care Management Organization	MTL 19/13 MSM 3800 Care Management Organization

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3800	**Introduction**	Language modified and participation requirements added to this section. The dates of the waiver inserted.
3801	**Authority**	Language modified for clarity purposes.
3803.1	**Covered Services**	Grammar corrected. The acronym HCGP (Health Care Guidance Program) replaced the use of the acronym CMO (Care Management Organization) for consistency.
3803.2	**Eligibility and Enrollment**	Title of Eligibility and Enrollment added to the section.
3803.2(A)	**Enrollment and Disenrollment Requirements and Limitations**	Updated language for clarity of enrollment process. Added paragraph of non-discrimination in enrollment to this section. Auto Assignment Process removed from this section and added to Eligible Groups Section.
3803.2(B)	**Eligible Groups**	All specific eligibility groups for the program are listed. The section has been re-formatted for clarity.
3803.2(C)	**Auto-Assignment Process**	Auto Assignment Process moved to this section from Section 3803.2(A)(3) as it applies to the enrollment of the eligible groups. Language has been added to provide clarification on the processes of both initial and re-enrollment into the program.
3803.2(D)	**Medicaid Recipients Excluded from the Health Care Guidance Program**	Title of Medicaid Recipients Excluded from the Health Care Guidance Program added. Bullet number (6), removal of Mentally Retarded (MR) acronym to reflect current language. Acronyms for the HCGP used within section, Family Medical Coverage Categories updated to current and accurate categories. Enrollees replaced with recipients for consistency purposes.
3803.2(E)	**Voluntarily Enrolled Recipients**	Voluntarily Enrolled Recipients specified and language clarified.
3803.2(F)	**Enrollment Wait List**	Program Policy regarding the Wait List provided.
3803.2(G)	**Disenrollment Requirements and Limitations**	The explanation of disenrollment process was itemized for easier understanding. Good cause conditions defined and examples given for greater clarity. Part of this definition was moved from Section 3803.2(B)

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3803.3	**Change in a Recipient's Status**	Time frames regarding notification clarified and language modified to program language rather than contract language.
3803.4	**Transitioning Recipients into Care Management**	The section details the process in which recipients are transitioned into Care Management Program. Previously listed contract language removed.
3803.5	**Transferring Recipients Between Managed Care/Other Entities**	The steps of the procedure followed for transferring information regarding recipients between specified entities described. Contract Language removed, acronyms modified for consistency purposes.
3803.6	**Recipient Services**	Clarification given on aspects of recipient identification and prioritization policies. Previous section of Medical Records moved to Section 3803.9(D) for improved flow and reorganization of document as a whole.
3803.6(A)	**Client Identification and Prioritization**	Formatting of section modified for clearer understanding. Contract language removed for better flow and appropriateness of content.
3803.6(B)	**Primary Care Provider Selection**	Formatting of section modified for clearer understanding. Contract language removed for better flow and appropriateness of content. Acronyms used for consistency purposes.
3803.6(C)	**Care Plan Development**	Title of Care Plan Development added to this section. The process for creation of and use of care plans within the HCGP specified. Use of recipient replaced use of enrollee for consistency. Contract language removed due to lack of necessity.
3803.6(D)	**Recipient Education**	Title of Recipient Education added. The process steps regarding the way in which the HCGP educates recipients enrolled in the program are detailed. This section was previously titled "Enrollee Education," has been moved from section 3803.6(I).
3803.6(E)	**Disease Management Interventions**	The ways in which the HCGP will assist recipients in caring for chronic diseases, including care plans, resources and provider care coordination are detailed in this section. Contract language removed from this section.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3803.6(F)	**Care Management Interventions**	Contract language removed from this section.
3803.6(G)	**Complex Condition Management**	The various disease management programs are detailed regarding the ways in which they assist the recipients and providers with the services they provide. Contract language has been removed from this section. "Enrollee Education" section has been moved from this section and re-titled "Recipient Education." Recipient Education moved to section 3803.6(D). Nurse Triage and Nurse Advice Call Services moved to its own section in Section 3803.6(J).
3803.6(H)	**Nurse Triage and Nurse Advice Call Services**	The language modified to non-contract language to ensure ease of understanding for those reviewing the policy. Excessive contract language removed. This section was previously a portion of 3803.6(I) and has been moved to its own titled section for clarity within the chapter.
3803.6(I)	**Continuity of Care Transitions**	Title of Continuity of Care Transitions added to this section. The HCGP's process from completion of transitions between plans outlined within this section. Contract Language removed from this section.
3803.6(J)	**Emergency Department Redirection Management**	Contract language removed from this section. Formatting changes completed for clarity within the section.
3803.6(K)	**Linking to Community Resources**	Title of Linking to Community Resources added to this section. Contract language removed from section. Advanced Directives Requirements removed from this section as it does not pertain to a program procedure.
3803.7(A)	**Provider Policy and Procedures**	This section clarified the policies that are in place for providers, including the HCGP's process on the provider manual, notice of changes to the providers, provider announcements, real time referrals for recipients, provider education provided by the HCGP and receipt and processing of provider feedback.
3803.7(B)	**Provider Announcements and Notices**	Clarification provided to ensure audience is aware the HCGP is responsible for provider announcements and notices.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3803.7(C)	**Real Time Referral**	Title of Real Time Referral added to this section. The procedure for submission of a Real Time Referral is broken down for clarity.
3803.7(D)	**Provider Education**	Title of Provider Education added to this section. Contract language removed from this section.
3803.7(E)	**Provider Feedback**	Title of Provider Feedback added to this section. Contract language removed from the section. Management Information System (MIS) paragraph removed from this section and moved to Section 3803.9(B).
3803.8	**Information Requirements**	Title of Information Requirements added to this section. General Information requirements for the HCGP including all that are sent out to providers and beneficiaries reviewed within this section. The processes and policies in which the HCGP writes the various letters, announcements and handbooks are detailed. The required vendor department to handle recipient issues/difficulties is outlined, along with its responsibilities.
3803.9	**Operation and Reporting Requirements**	Mandatory reports listed. Extensive contract language removed for clearer understanding for the reader. Details of individual steps required to complete each report removed as not pertinent to policy.
3803.9(A)	**Mandatory Reports**	Outline of mandatory reporting from the HCGP to the State is listed. Unnecessary detailed contract language has been removed.
3803.9(B)	**Management Information System (MIS)**	Contract language removed for clarity purposes. Moved from Section 3808.14.
3803.9(C)	**Eligibility and Claims Data**	Contract language removed for clarity purposes.
3803.9(D)	**Recipient Services and Contact Records**	Acronym of CMO replaced with HCGP for consistency throughout the chapter.
3803.9(E)	**Medical Records**	New title added Medical Records. Section of Medical Records moved from Section 3803.6 for improved flow and reorganization of document as a whole.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3803.10	**Payment**	This section has been removed as it is not relevant to the policy.
3803.11	**Medical/Health Home Infrastructure Administration**	All references to Medical Health Homes have been removed from the chapter as it is not a part of the currently approved Health Care Guidance Program.
3803.13	**Operational Requirements**	Section has been removed due to being contractual language and not relevant to policy.
3804	**Grievances, Appeals, and Fair Hearings**	Contract language removed for better clarity. Grievance and Appeal Process explained within this section.
3804(B)	**Notice of Decision/Handling of Appeals**	Clarification regarding appeals provided.
3804(C)	**Provider Complaints and Disputes**	The acronym CMO replaced with HCGP for consistency throughout the chapter. Details of non-policy related internal procedures removed as they are non-related to the policy.

3800 INTRODUCTION

The Division of Health Care Financing and Policy (DHCFP) recognizes that there are many individuals ~~who are~~ at increased risk ~~o~~for hospitalization due to chronic conditions. ~~To assist individuals at risk for costly medical care and connect them to preventative care, t~~The DHCFP has developed a Care Management Organization (CMO) ~~program~~ under the Nevada Comprehensive Care Waiver (NCCW) to assist this at-risk population in connecting with preventative care. The CMO ~~program~~ is part of the NCCW ~~program~~ adopted by the State of Nevada within the Section 1115(a) Medicaid Research and Demonstration Waiver granted by the Secretary of Health and Human Services~~. The CMO program is intended to develop another delivery method for~~ July 1, 2013 and continues through June 30, 2018.

Under this statewide research and demonstration waiver, Nevada Medicaid enrolls eligible individuals, having certain qualifying conditions, in a care management ~~to targeted recipients that do not currently have any form of care management in the Medicaid Fee-for-Service (FFS) system~~program. The program ~~is targeted at~~targets recipients that have chronic conditions, co-morbidities, high-cost and/or high-utilization patterns~~.~~ who do not currently have any form of care management in the Fee-for-Service (FFS) system. Recipients eligible for the State's existing care management option, including the Managed Care Organizations (MCOs), are not eligible for the CMO.

Participation is mandatory, except for American Indians/Alaskan Natives (AI/AN), for whom participation is voluntary.

The care management services are provided by a CMO, known as the Health Care Guidance Program (HCGP), using a primary care case management model (PCCM). The state must ensure that all recipients have a choice of care manager.

3801 AUTHORITY

Under ~~authority granted by~~the provisions of Nevada Revised Statute (NRS) 422~~, the Division of Health Care Financing~~ and ~~Policy (DHCFP) has obtained authority~~ under Section 1115(a) of the Social Security Act (SSA),~~that provides the Secretary of Health and Human Services broad authority to authorize~~which authorizes experimental, pilot~~,~~ or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. The DHCFP may test new coverage approaches not otherwise allowed under the Medicaid program. The Section 1115(a) "waiver"~~. It~~ is intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. ~~The State of Nevada, u~~Under Section 1115(a), ~~has been approved~~Nevada received approval to implement Nevada's ~~Care Management Organization (~~CMO~~)~~ program, known as the Health Care Guidance Program (HCGP), under the ~~Nevada Comprehensive Care Waiver (~~NCCW~~)~~. This project is funded under Title XIX of the ~~Social Security Act~~SSA.

The ~~CMO~~ HCGP must meet all requirements of the NCCW, as approved by Centers for Medicare and Medicaid Services (CMS).~~ This includes additional requirements or modifications to the NCCW by CMS throughout the life of the NCCW.~~

3802 RESERVED

3803 POLICY

3803.1 COVERED SERVICES

~~No enrolled recipient shall~~HCGP enrollees remain in the Medicaid FFS delivery model and therefore will receive ~~fewer~~ all services in the ~~Care Management Organization (CMO) program than they would receive in the~~ current Nevada State Plan under ~~Fee-for-Service (~~FFS~~)~~.

The ~~CMO~~ HCGP provides ~~additional~~ coordination of medical~~, and~~ behavioral health and social services for targeted recipients in the Nevada Medicaid FFS program. The ~~CMO will perform~~HCGP performs integrated medical, behavioral and social case management with enrollees. The ~~CMO~~ HCGP does not provide any medical diagnosis or make any form of a medical determination for the recipient.

3803.2 ELIGIBILITY AND ENROLLMENT

A. ENROLLMENT AND DISENROLLMENT REQUIREMENTS AND LIMITATIONS

~~The e~~Eligibility and enrollment ~~functions~~ for all forms of Medicaid (MCO and FFS) are the responsibility of the ~~Division of Health Care Financing and Policy (~~DHCFP~~)~~ and the Division of Welfare and Supportive Services (DWSS). ~~The CMO shall accept each recipient who is enrolled in or assigned to the CMO program by the DHCFP and/or its enrollment sections and/or for whom a payment has been made by the DHCFP to the CMO.~~

1. HCGP Enrollment Process

The ~~DHCFP will work with the CMO~~HCGP receives a monthly master recipient list from the DHCFP, and then uses a predictive algorithm to identify ~~Medicaid~~ recipients who meet ~~the~~ eligibility criteria ~~for enrollment in the CMO. The DHCFP will provide data files to the CMO on a reoccurring basis~~. The HCGP completes the enrollment process.

~~Prior to enrolling any members in the CMO program, the DHCFP and the vendor must agree on the algorithm used to identify targeted recipients. Once the algorithm has been agreed to by both parties, the vendor will submit a sample list of enrollees to the DHCFP using the algorithm at least 45 days prior to enrolling members. This list must be verified by the DHCFP's contracted actuary prior to enrolling members.~~

2. Non-Discrimination in Enrollment

The ~~CMO must accept~~HCGP accepts recipients eligible for enrollment in the order in which they ~~apply~~ become eligible for the program, without restriction, up to the limits set under the ~~Contract~~waiver. The ~~CMO~~ HCGP will not, on the basis of health status or need for health services, discriminate against recipients eligible to

enroll. The ~~CMO~~ HCGP will not deny ~~the~~ enrollment nor discriminate against any Medicaid recipients eligible to enroll on the basis of race, color, national origin, religion, sex, age, disability ~~(including HIV/AIDS or related conditions)~~ or any other class status protected by federal or state law or regulation by programs receiving Federal Financial Participation (FFP).

~~3. Auto-Assignment Process~~

B. ELIGIBLE GROUPS

MANDATORY HCGP PROGRAM ENROLLEES

The following categories of Medicaid eligible recipients, not enrolled in an MCO, are accepted into the HCGP: ~~who meet the targeted conditions defined in Section 3803.3, will be assigned to the CMO program. The CMO acknowledges that enrollment is mandatory for covered recipients except in the case of allowable disenrollments defined in Section 3803.2.e.~~

~~4. Automatic Reenrollment~~

~~A recipient who is disenrolled from the CMO solely because he or she loses Medicaid eligibility will be auto-assigned with the CMO once the recipient regains eligibility, if the recipient still meets the CMO program criteria.~~

~~5.~~3. ~~Disenrollment Requirements and Limitations~~

~~1. A recipient who is enrolled in the CMO on a mandatory basis may request disenrollment from the CMO program in order to enroll with a Nevada Medicaid qualified Medical Home/Health Home Provider, if any have been established and approved by the DHCFP. The recipient is required to notify the DHCFP of his/her decision to disenroll and, as a mandatory recipient, will be instructed to select a Medical Home/Health Home provider, if one is available. The DHCFP will document the basis of the recipient's request to disenroll. If the recipient is to be enrolled with a Medical Home/Health Home Provider, the new provider will receive electronic notification of the enrollment.~~

~~2. The Awarded vendor must abide by all provisions outlined in 42 Code of Federal Regulations (CFR) 438.56. Except for enrollment with a Medical Home/Health Home provider, a recipient who is enrolled in care management through the CMO on a mandatory basis may only request disenrollment from the CMO for good cause. Good cause for disenrollment is determined solely by the DHCFP and will be determined on a case-by-case basis. An example of good cause would be the transition to a~~

~~medical/health home. The recipient is required to notify the DHCFP of his/her request to disenroll. The DHCFP will document the basis of the recipient's request to disenroll and make a decision.~~

1.

~~If the DHCFP determines the request for disenrollment should first be pursued through the grievance process, the DHCFP will refer the request to the CMO. After the CMO has completed the grievance process and reported the resolution to the DHCFP, the DHCFP will make the determination on the recipient's request for disenrollment. If the DHCFP determines the disenrollment request does not need to be pursued through the grievance process, the DHCFP will provide a notice of decision within 30 days. If the request for disenrollment is approved by the DHCFP, the DHCFP will confirm with the recipient the effective date of disenrollment from the CMO based on the administrative cutoff date.~~

~~3. The CMO may request disenrollment of a recipient if the continued enrollment of the recipient seriously impairs the CMO's ability to furnish services to either this particular recipient or other recipients. In addition, the CMO must confirm the recipient has been referred to the CMO's Enrollee Services Department and has either refused to comply with this referral or refused to act in good faith to attempt to resolve the problem. Prior approval by the DHCFP of the CMO's request for the recipient's disenrollment is required. If approval is granted, the recipient will be given notice by the CMO that disenrollment will occur effective the first day of the next month following administrative cut off. The DHCFP will make a determination on such a request within ten working days. In the event the DHCFP fails to make a disenrollment determination within the timeframes specified, the disenrollment shall be considered approved.~~

~~4. The CMO may not request disenrollment of a recipient for any of the following reasons:~~

~~1. An adverse change in the recipient's health status;~~

~~2. Pre-existing medical condition;~~

~~3. The recipient's utilization of medical services;~~

~~4. Diminished mental capacity;~~

~~5. Uncooperative or disruptive behavior resulting from his/her special needs (except when continued enrollment of such a recipient seriously impairs the CMO's ability to furnish services to either this~~

~~particular recipient or other recipients as provided for in section 3803.2.e.3);~~

~~6. A recipient's attempt to exercise his/her grievance or appeal rights;~~

~~7. Based on the recipient's national origin, creed, color, sex, religion, age or other factors pursuant to Section 3803.2 and applicable CFR's; or~~

~~8. A finding of Seriously Emotionally Disturbed (SED) or Severely Mentally Ill (SMI) status or Children with Special Health Care Needs (CSHCN) or the recipient is receiving Mental Health Services.~~

~~a. The CMO must have written policies and procedures in place that describe the process to respond to an enrollee who contacts the CMO to request disenrollment. All disenrollments will be determined solely by the DHCFP, except those disenrollment requests by American Indian/Alaskan Natives. If a Nevada Medicaid (Title XIX) eligible American Indian/Alaskan Native elects to disenroll from the CMO Vendor, the disenrollment will be automatic and commence no later than the first day of the second administrative month after which notice is provided.~~

~~b. The CMO must maintain a waiting list any time it is not enrolling individuals into the program due to reaching the CMS and/or contract maximum allowable number of enrollees at any one time. Potential enrollees will be placed on the waiting list in chronological order of the determination of the individual's eligibility. As enrollment space becomes available, either through attrition or an increase in enrollment, the CMO will re-examine the waiting list, beginning with the individual who has been on the list the longest and continuing in chronological order, to determine if the potential enrollee still meets the program eligibility criteria. Following confirmation of program eligibility, the CMO must work with the DHCFP to notify the individual of his or her enrollment in the program. The CMO must establish the waiting list process in their policy and procedures and submit to the DHCFP for approval.~~

~~6. Enrollment, Disenrollment and Other Updates~~

~~The CMO must have written policies and procedures for receiving monthly updates from the DHCFP of recipients enrolled in, and disenrolled from, the CMO program, and other updates pertaining to these recipients.~~

~~7. Less Than Full Month Enrollment~~

~~The DHCFP shall, at its sole discretion, have the ability to enroll Medicaid recipients into, or disenroll Medicaid recipients from, the care management program at any time. In such case where the effective date of enrollment or disenrollment with the CMO is not the first day of the month due to the DHCFP's actions, the CMO could receive a pro-rated payment in accordance with Section 3803.10.~~

~~3803.3 ELIGIBLE GROUPS~~

~~A. Mandatory CMO Program Enrollees~~

1. ~~The CMO program includes the Medicaid eligibility categories of~~Parent and caretakers;
2. Poverty Level Children and Pregnant Women;
3. Aged, Blind and Disabled (ABD);
4. ~~Family Medical Category (FMC) which includes Temporary Assistance for Needy Families (TANF), Child Health Assurance Program (CHAP), Parents and Other Caretaker Relatives, Pregnant Women,~~ Infants and Children under age 19;
5. Former Foster Care Children~~,~~; and
6. Transitional Medical~~,~~ and Post Medical assistance groups in the FFS populations.

~~This~~ The HCGP screens this population ~~served by the CMO encompasses Medicaid~~for recipients who are high utilizers of treatment, have at least one chronic condition or a serious and persistent mental health condition as defined by the International Classification of Diseases (ICD). The ~~CMO must use~~HCGP utilizes the current version of the ICD being utilized used by the DHCFP. The following conditions are eligible for the program:

a. Asthma;

b. Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis and Emphysema;

c. Diabetes Mellitus;

d. End Stage Renal Disease (ESRD) and/or Chronic Kidney Disease (CKD);

e. Heart Disease and/or Coronary Artery Disease (CAD);

f. Neoplasm~~/~~ and/or tumor;

g. Obesity;

h. Mental Health Disorders including: dementia, psychotic disorders, anxiety disorders, psychosis, paranoia, bipolar disorder, schizophrenia, amnesia, delirium and mood disorders;

i. Substance Use Disorder;

j. HIV/AIDS;

k. Musculoskeletal system: diseases including: osteoarthritis~~osis~~, spondylosis, disc displacement, Schmorl's Nodes, disc degeneration, disc disorder with and without myelopathy, postlaminectomy syndrome, cervical disorders, spinal stenosis, spondylolisthesis, nonappopathic lesion, fracture of the femur and spinal sprain;

l. Pregnancy; and

m. Complex Condition/High Utilizers: individuals with complex conditions incurring high treatment costs exceeding $100,000 per year in claims.

~~B. Medicaid Recipients Exempt from CMO Program~~

C. AUTO-ASSIGNMENT PROCESS

1. Medicaid recipients who meet the targeted conditions defined in this section are assigned to the HCGP. Enrollment is mandatory for covered recipients except in the case of allowable disenrollment defined in Section 3803.F.

2. A recipient who is disenrolled from the HCGP solely because he or she loses Medicaid eligibility will be auto-assigned with the HCGP once the recipient regains Medicaid eligibility. This is based on if the recipient still meets the HCGP program criteria.

D. MEDICAID RECIPIENTS EXCLUDED FROM THE HEALTH CARE GUIDANCE PROGRAM

Certain Medicaid recipients are excluded from enrollment in the ~~CMO~~HCGP. These recipients include:

1. Recipients who are dually eligible for Medicaid and Medicare coverage (i.e. dual eligibles);

2. Recipients of adoption assistance and foster care under Title IV-E of the ~~Social Security Act (~~SSA~~)~~;

3. Recipients of Medicaid Home and Community-Based Services (HCBS) Waiver case management services;

~~3.~~4. Recipients enrolled in the Intellectual Disabilities/Developmental Disabilities (ID/DD) or Section 1915(c) Waiver;

5. Recipients of Medicaid covered ~~t~~Targeted ~~c~~Case ~~m~~Management (TCM);

~~4.~~6. ~~FMC~~Parents and Caretakers, including ~~TANF~~ Poverty Level Children and ~~CHAP~~ Pregnant Women recipients in service areas that require enrollment in a Medicaid ~~Managed Care Organization (~~MCO~~)~~;

~~5.~~7. Recipients enrolled in the State's Title XXI Children's Health Insurance Program (CHIP), entitled to Nevada Check Up (NCU);

~~6. Recipients enrolled in the Intellectual Disabilities/Developmental Disabilities (ID/DD or MR/DD) Section 1915 (c) Waiver;~~

~~7.~~8. ~~Individuals~~ Recipients receiving emergency Medicaid; ~~and~~

~~8.~~9. Residents of Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID)~~.~~; and

~~C. Voluntarily Enrolled CMO Program Recipients:~~

9. ~~Although the following~~Recipients newly eligible for Medicaid ~~recipients are exempt from mandatory enrollment in the CMO, they are allowed~~and Childless Adults according to ~~voluntarily enroll in the CMO if they choose~~the Affordable Care Act (ACA).~~:~~

E. VOLUNTARILY ENROLLED RECIPIENTS:

~~1.~~ Native ~~American Indians, with eligible qualifying conditions,~~ AI/AN as defined by Medicaid Service Manual (MSM) Chapter 3000 (Indian Health), who are members of federally recognized tribes with eligible qualifying conditions have the right to disenroll from the HCGP. These recipients continue to be automatically enrolled into the program with an option to disenroll from the HCGP if they choose. If one of the above mentioned recipients chooses to be disenrolled from the program, they follow the guidelines for disenrollment listed below. ~~except when the MCO is the Indian Health Service (IHS); or an Indian Health program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the IHS.~~

F. ENROLLMENT WAIT LIST

The HCGP maintains a wait list any time it is not actively enrolling individuals because the contract maximum allowable number of enrollees have been reached. Any recipients that are found eligible for enrollment after the maximum amount of enrollees has been met will be placed on the wait list in chronological order of the determination of the individual's eligibility. As space becomes available, either through attrition or a decrease in current enrollment, the HCGP will enroll recipients in the order in which they became eligible. The HCGP notifies the recipient of his or her enrollment in the program once space becomes available through mailings, telephonic or face-to-face contact depending on risk level.

G. DISENROLLMENT REQUIREMENTS AND LIMITATIONS

The HCGP abides by all provisions outlined in 42 C.F.R. §438.56 under the authority of the CMS.

1. RECIPIENT INITIATED DISENROLLMENT

A recipient who is mandatorily enrolled in the HCGP may only request disenrollment from the HCGP for good cause. Good cause for disenrollment is determined solely by the DHCFP and will be determined on a case-by-case basis. An example of good cause would be an enrollee who moves out of an FFS program eligible service area or out of the state. The recipient is required to notify the HCGP of his/her request to disenroll through the following process:

a. Recipient makes a request for disenrollment from program via phone, in person or mail;

b. The HCGP mails a letter to confirm request, along with disenrollment request form to the recipient;

c. Recipient completes, signs and returns disenrollment request form to HCGP;

d. The HCGP sends disenrollment request form to the DHCFP;

~~a.~~e. The DHCFP reviews and makes a determination to approve or deny within five business days of receiving the request;

f. The DHCFP notifies recipient of final decision in writing; and

g. If recipient wishes to appeal the decision, they may submit in writing their request to appeal within 30 business days of receiving the Notice of Decision (NOD).

2. PROGRAM INITIATED DISENROLLMENT

a. The DHCFP or the HCGP vendor may disenroll recipients from the HCGP program for the following reasons:

1. Noncompliance, failure to communicate and/or cooperate with the HCGP. The HCGP may request disenrollment of a recipient if the continued enrollment of the recipient seriously impairs the HCGP's ability to furnish services to either this particular recipient or other recipients. The HCGP must confirm the recipient has been referred to the HCGP Enrollee Services Department and has either refused to comply with this referral or refused to act in good faith to attempt to resolve the problem;

2. Recipient improves and no longer meets qualifications for the program; and/or

3. Recipient no longer qualifies for FFS Medicaid, therefore excluding them from the HCGP program based on change in their FFS eligibility status.

b. The HCGP may not disenroll a recipient for any of the following reasons:

1. An adverse change in the recipient's health status;

2. Pre-existing medical condition;

3. The recipient's utilization of medical services;

4. Diminished mental capacity;

5. Uncooperative or disruptive behavior resulting from his/her special needs (except when continued enrollment of such a recipient seriously impairs the HCGP's ability to furnish services to either this particular recipient or other recipients as provided for in this section; and

6. A recipient's attempt to exercise his/her grievance or appeal rights;

c. The HCGP's request for recipient to be removed must be approved by the DHCFP.

1. If approval is granted, the recipient will be given notice that disenrollment will occur effective the first day of the month following request for determination.

3. DISENROLLMENT DETERMINATIONS

The DHCFP will determine all final disenrollment's on a case by case basis, except those disenrollment requests by AI/ANs. If a Nevada Medicaid (Title XIX) eligible American Indian/Alaskan Native elects to disenroll from the HCGP, the disenrollment will be automatic and commence no later than the first day of the first month following request for disenrollment.

3803.~~4~~3 CHANGE IN A RECIPIENT'S STATUS

The ~~CMO must require~~HCGP requires that a recipient reports any changes in the recipient's status immediately to the DWSS eligibility worker, including family size and residence. ~~The CMO must provide the DHCFP with notification of all deaths.~~ Within seven calendar days of becoming aware of any changes in a recipient's status, ~~including changes in residence,~~ the ~~CMO~~ HCGP ~~must~~ electronically reports the change(s) to the DHCFP. The HCGP provides the DHCFP with notification of all Medicaid enrollee deaths within seven calendar days of the HCGP's awareness of death.

3803.~~4~~5 TRANSITIONING RECIPIENTS INTO CARE MANAGEMENT

~~The CMO is responsible for recipients as soon as they are enrolled. The CMO must have policies and procedures for transitioning recipients who are currently receiving certain services in the FFS system with chronic illness into the CMO program. The CMO must have policies and procedures including, without limitation, the following to ensure a recipient's smooth transition to enrollment with the CMO:~~

~~a. Recipients with medical conditions such as:~~

1. ~~Pregnancy;~~
2. ~~3. Major organ or tissue transplantation services in process;~~

~~4. Terminal illness; and/or~~

~~5.~~2. ~~Intractable pain~~.

~~b.~~ Upon enrolling ~~R~~recipients into the program, the HCGP will:~~who, at the time of enrollment, are receiving:~~

~~1. Chemotherapy and/or radiation therapy;~~

~~2. Significant outpatient treatment or dialysis;~~

~~3. Prescription medications or Durable Medical Equipment (DME); and/or~~

~~4. Other services not included in the State Plan but covered by Medicaid under Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements for children under Title XIX and Title XXI of the SSA.~~

~~c. Recipients who at enrollment:~~

~~A. Are scheduled for inpatient surgery(ies);~~

~~B. Are currently in the hospital;~~

~~C. Have prior authorization for procedures and/or therapies for dates after their enrollment; and/or~~

A. ~~Have post-surgical follow-up visits scheduled after~~ Send all recipients a letter to notify recipient of their enrollment into the HCGP;~~.~~

B. Complete, based on the claims review of recipient need, an in person or over the phone telephonic assessment and develop a recipient care plan;

C. Assist recipients in obtaining access to resources to ensure that they are able to actively participate in their care plan; and

D. Provide up-to-date feedback to physicians regarding the recipients enrolled in the program to assist in their continuity of care.

3803.~~5~~6 TRANSFERRING RECIPIENTS BETWEEN MANAGED CARE ~~PROGRAMS~~/OTHER ENTITIES

~~A.~~ ~~It may be necessary to transfer~~When a recipient transfers from the ~~CMO program~~HCGP to another case management system or managed care program ~~for a variety of reasons. When notified that an enrollee has been transferred to another managed care program, the CMO must have written policies and procedures for transferring/receiving~~, the HCGP will transfer relevant recipient/patient information, medical records and other pertinent materials ~~to the health plan,~~

~~Medical Home/Health Home provider, if available, or other managed care program~~. This data includes:

A. Verification with the accepting provider ~~Prior~~ to confirm the transferring ~~a recipient, the CMO must send the receiving plan or provider~~of information regarding the recipient~~,'s condition. This information shall~~to include:

1. ~~t~~The nature of the ~~enrollee's~~ recipient's chronic illness~~,~~;

2. ~~-~~The nature of care management services received through the ~~CMO, the designated CMO~~HCGP;

3. The HCGP care manager's name and phone number~~,~~;

4. ~~and~~ The recipient's Primary Care Physician's (PCP) name and phone number; and ~~of the Primary Care Physician (PCP), as well as the following~~

~~B.~~5. ~~i~~Information, without limitation, as to whether the recipient is:

a. Hospitalized;

b. Pregnant;

c. Receiving dialysis;

d. Receiving significant outpatient treatment and/or medications, and/or pending payment authorization request for evaluation or treatment;

e. On an apnea monitor;

f. Receiving behavioral or mental health services;

g. 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;

h. Involved in, or pending authorization for, major organ or tissue transplantation;

i. Scheduled for surgery or post-surgical follow-up on a date subsequent to transition;

j. Scheduled for prior authorized procedures and/or therapies on a date subsequent to transition;

k. Receiving care from or referred to a specialist(s);

l. Receiving substance abuse treatment;

m. Receiving prescription medications; and

n. Receiving durable medical equipment or currently using rental equipment.~~;~~

~~and/or~~

~~15. Currently experiencing health problems.~~

3803.~~76~~ ~~MEDICAL RECORDS~~RECIPIENT SERVICES

~~A. Appropriate medical records shall be maintained by the CMO for each enrolled recipient. Medical records may be on paper or electronic. The CMO must take steps to promote maintenance of medical records in a legible, current, detailed, retrievable organized and comprehensive manner that permits effective patient care and quality review.~~

~~B. The CMO shall establish standards for enrollee medical records. The records reflect all aspects of care management, including incorporation of health care service delivery information. These standards shall, at a minimum, include requirements for:~~

~~1. Patient Identification Information – Each page on electronic file in record contains the patient's name or patient ID number;~~

~~2. Personal/Demographic Data – Personal/biographical data includes: age, sex, race, address, employer, home and work telephone number and marital status;~~

~~3. Entry Date – All entries are dated;~~

~~4. Provider Identification – All entries are identified as to author;~~

~~5. Legibility – The record is legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer;~~

~~6. Allergies – Medication allergies and adverse reaction are prominently noted on the record. Absence of allergies (No Known Allergies (NKA)) is noted in an easily recognizable location;~~

~~7. Past Medical History – Past medical history is easily identified including serious accidents, operations and illnesses. For children, past medical history relates to prenatal care and birth;~~

~~8. Immunization for Pediatric Records (ages 20 and under) – there is a completed immunization record or a notation that immunizations are up to date with documentation of specific vaccines administered and those received previously or (by history);~~

~~9. Diagnostic Information;~~

~~10. Medication Information;~~

~~11. Identification of Current Problems – Significant illnesses, medical conditions and health maintenance concerns are identified in the medical record;~~

~~12. Smoking, Alcohol or Substance Abuse – Notation concerning cigarettes, alcohol and substance abuse is present;~~

~~13. Consultations, Referrals and Specialist Reports – Notes from any consultations are in the record. Consultation involving significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans;~~

~~14. Emergency Care;~~

~~15. Hospital Discharge Summaries – Discharge summaries are included as part of the medical record for:~~

~~a. All hospital admissions that occur while the patient is enrolled with the CMO; and~~

~~b. Prior admissions, as available.~~

~~16. Advance Directives – For medical records of adults, 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 recipient 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; and~~

~~17. Enrollee Care Management Interventions – Documentation of individual encounters must provide adequate evidence of, at a minimum:~~

~~a. Plan of Care (POC);~~

~~b. a. Assessment and periodic reassessment;~~

~~c. a. Consultation with the PCP and other members of the Health Care Team;~~

~~d. Education and other targeted interventions directly with the enrollee;~~

~~e.~~ ~~a.~~ ~~Referrals and results thereof; and~~

~~f.~~ b. ~~All other aspects of care management, including ancillary services.~~

~~C. The CMO shall have written policies and procedures to maintain the confidentiality of all medical records and for sharing medical records when an enrolled recipient changes PCPs or transfers between managed care programs.~~

~~D. The CMO shall assist the enrollee or the parent/legal guardian of the enrollee in obtaining a copy of the enrollee's medical records pursuit to Nevada Revised Statute (NRS) 629.061. Records shall be furnished in a timely manner upon receipt of such a request but not more than 30 days from the date of request. Each enrollee or parent/legal guardian of the enrollee is entitled to one free copy of the requested medical records. The fee for additional copies shall not exceed the actual cost of time and materials used to compile copy.~~

~~E. The CMO must have a system for record review to assess the content of medical records for legibility, organization, completion and conformance to the DHCFP's standards.~~

~~F. The records shall be available for review by duly authorized representatives of the Secretary of the United States Department of Health and Human Services (the Secretary), the DHCFP, or agents thereof. Not more than ten calendar days after submitting a request, the State shall have access to an enrollee's medical record, whether electronic or paper, and has the right to obtain copies at the CMO's expense.~~

~~1. The CMO shall have policies and procedures, subject to the DHCFP's approval, related to retention and disposal of medical records in accordance with Medicaid Services Manual (MSM) Chapter 100, Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance and applicable NRS.~~

~~3803.8 INFORMATION REQUIREMENTS~~

~~The CMO must have written information about its services and access to services available upon request to enrollees and potential enrollees. This written information must also be available in the prevalent non-English languages, as determined by the State, in its particular geographic service area. The current prevalent languages are English and Spanish. The CMO must make free, oral interpretation services available to each enrollee and potential enrollee. This applies to all non-English languages, not just those that the State identifies as prevalent. All written material directed to enrollees and potential enrollees shall be approved by the DHCFP prior to distribution.~~

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

~~The CMO's written material to enrollee's and potential enrollee's must use an easily understood format not to exceed an eighth grade reading level. The CMO must also develop appropriate alternative methods for communicating with visually and hearing-impaired enrollees, and accommodating physically disabled recipients in accordance with the requirements of the Americans with Disabilities Act of 1990. All enrollees and potential enrollees must be informed that this information is available in alternative formats and how to access those formats. The CMO will publish materials for enrollees and potential enrollees on the CMO's website upon contract implementation and will update the website, as needed, to keep materials current. The CMO is responsible for effectively informing Title XIX Medicaid and Title XXI NCU enrollees who are eligible for EPSDT services.~~

~~The CMO must abide by all marketing regulations outlined in 42 CFR 438.104.~~

~~The CMO must work with the DHCFP to develop and send a Notice of Enrollment letter prior to beginning services to all new enrollees, including new enrollees who are added throughout the length of the program.~~

~~a. Enrollee Handbook~~

~~1. The CMO must provide all enrollees with an Enrollee Handbook. The handbook must be written at no higher than an eighth grade reading level and must conspicuously state the following in bold print:~~

~~"THIS HANDBOOK IS NOT A CERTIFICATE OF INSURANCE AND SHALL NOT BE CONSTRUED OR INTERPRETED AS EVIDENCE OF INSURANCE COVERAGE BETWEEN THE CARE MANAGEMENT ORGANIZATION AND THE ENROLLEE."~~

~~2. The CMO must submit the Enrollee Handbook to the DHCFP before it is published and/or distributed. The DHCFP will review the handbook and has the sole authority to approve or disapprove the handbook and the CMO's policies and procedures. The CMO must agree to make modifications in handbook language if requested by the DHCFP, in order to comply with the requirements as described above or as required by the Centers for Medicare and Medicaid Services (CMS) or State law. In addition, the CMO must maintain documentation that the handbook is updated at least once per year. Thereafter, annual updates must be submitted to the DHCFP for approval before publication and/or distribution.~~

~~3. The CMO must furnish the handbook to all enrollees within five business days of receiving notice of the recipient's enrollment and must notify all enrollees of their right to request and obtain this information at least once per year or upon request. The CMO will also publish the Enrollee Handbook on the CMO's internet website upon contract implementation and will update the website, as needed, to keep the~~

~~Enrollee Handbook current. At a minimum, the information enumerated below must be included in the handbook:~~

~~a. Explanation of services, how to obtain those services and access to them, including the address and telephone number of the CMO's office or facility, and the days the office or facility is open and services are available; this includes the definition of an emergency medical condition, as well as how to access emergency services at all times, regardless if that provider has a relationship with the CMO;~~

~~b. The role of the PCP and description of the CMO's process for confirmation of the enrolled recipient's selection of a PCP and the process for assisting the enrolled recipient in finding a PCP. The CMO's care manager will have access to the FFS provider lists and will be able to assist the enrollee with selecting a provider based on the recipient's needs, including diagnosis, location, cultural competency (spoken language), specialty, and any Americans with Disabilities Act (ADA) modifications (as necessary);~~

~~c. Enrollee and disenrollment rights and protections, including information of the CMO's grievance procedures required in Section 3804 and the enrollee's right to be treated respectfully with dignity and privacy and receive information on alternative treatment options in a manner they can understand;~~

~~d. Information on procedures for recommending changes in policies and services;~~

~~e. To the extent available, quality and performance indicators, including enrollee satisfaction;~~

~~f. The CMO must provide adult enrollees with written information on advance directives policies and include a description of applicable State law. This information must reflect changes in State law as soon as possible but no later than 30 days after the effective date of the change. The CMO must ensure that a signed copy of the DHCFP's "Acknowledgment of Patient Information on Advance Directives" form is included in the recipient's medical record. (A sample form is available online at http://dhcfp.state.nv.us/advancedirectives.htm);~~

~~g. The Enrollee Handbook must include a distinct section for eligible recipients which explains the EPSDT program and includes a list of all the services available to children; a statement that services are free and a telephone number which the enrollee can call to receive assistance in scheduling an appointment; and~~

~~h. The CMO must give each enrollee written notice of any significant change, as defined by the DHCFP, at least 30 days in advance of the intended effective date of the change, in any of the enumerations noted above. The CMO shall issue updates to the Enrollee Handbook as directed by the DHCFP when there are material changes that will affect access to services and information about the Care Management Program.~~

A. CLIENT IDENTIFICATION AND PRIORITIZATION

~~b. Client Identification and Prioritization~~

1. ~~The CMO must establish and~~ The HCGP maintains a system for prioritizing the target population by risk and level of need to determine how to tailor care intervention.

2. ~~At~~ The HCGP uses a ~~minimum, the CMO must employ tools and strategies~~predictive modeling algorithm to assign a risk score to prioritize recipients. ~~stratify the target population, as provided by the DHCFP, which shall include,~~ This methodology includes, but ~~may~~ is not ~~be~~ limited to, the following:

   a. Diagnostic classification methods that assign primary and secondary chronic conditions to enrollees;

   b. Predictive models that identify ~~enrollees~~ recipients at risk for future high utilization, adverse events~~,~~ and/or costs~~ based upon the detailed administrative data~~; and

   c. Stratification of ~~enrollees~~ recipients that incorporates health risk assessment into predictive modeling ~~in order~~ to tier ~~enrollees~~ recipients into high need categories for intensive/face-to-face intervention.

~~3. The CMO must document their predictive modeling processes for stratifying the enrolled population by current and future risk level. The CMO must identify the specific risk classification method or methods (e.g., Chronic Illness and Disability Payment System, Hierarchical Condition Categories, other) to be used and how results of health risk assessments will factor into risk stratification.~~

~~c. Enrollee Assessment~~

~~1. The CMO must determine each enrollee's needs for care and for coordination, including physical, as well as social situation, emotional, and psychological health; functional status; current health and health history; self-management knowledge and behaviors; current treatment recommendations, including prescribed medications; and need for support services.~~

~~2. The CMO must conduct a comprehensive assessment of each enrollee which, at a minimum, shall include, but may not be limited to, the following:~~

~~a. Review and analysis of all claims data;~~

~~b. Verification of primary language, and communication or mobility accommodations;~~

~~c. Collection of additional/alternative phone number(s) and email(s);~~

~~d. Assessment/establishment of a routine source of care, which may include verification of a PCP identified through claims analysis;~~

~~e. Standardized general health screening/subjective evaluation of health;~~

~~f. Assessment of readiness to change;~~

~~g. Lifestyle assessment (nutrition, physical activity);~~

~~h. Functional assessment;~~

~~i. Depression screening;~~

~~j. Substance abuse screening;~~

~~k. Medication inventory, including over-the-counter (OTC) and prescription use;~~

~~l. Identification of medical conditions which are likely to trigger special health assessments; and~~

~~m. Evaluation of home/social environment for levels of common environmental triggers.~~

~~3. The CMO must document their assessment processes, including whether the CMO will use a single comprehensive assessment or separate assessments performed over a defined period of time. The CMO should also specify any standardized assessment instruments (e.g., Chronic Illness and Disability Payment System, Hierarchical Condition Categories, etc.) to be used. The CMO should provide samples of enrollee assessments for similar care management programs for Medicaid populations.~~

~~A. Primary Care Provider Selection~~

B. PRIMARY CARE PROVIDER SELECTION

1. The ~~CMO~~ HCGP establishes a ~~is responsible for establishing a usual~~ source of primary care for all ~~enrollees~~recipients. Upon initial assessment, the ~~CMO must~~HCGP validates the ~~enrollee's~~ recipient's PCP or facilitates the selection of a PCP if the ~~enrollee~~ recipient does not have a routine source of primary care.

~~2. The CMO must have a process to facilitate the PCP selection among enrollees, including analytical methods to assess whether an enrollee has a routine source of primary care identified from administrative data and methods for validating PCP when interacting with enrollees during the assessment process.~~

2. ~~The CMO will provide counseling to those enrollees~~The HCGP provides recipients who do not have a routine ~~PCP in order to facilitate selections~~source of primary care information about the importance of establishing a PCP. ~~by those enrollees. In assisting an enrollee in the selection of a PCP, the CMO will consider the following criteria:~~

3. The HCGP team provides assistance to those recipients who do not have a PCP. In assisting a recipient in the selection of a PCP, the HCGP considers the following:

   a. Providers ~~from~~ with whom ~~they~~ recipients have previously received services, as evidenced by ~~a receipt of a claim for services rendered by a PCP to the enrollee if the information is available in claims data~~claims data, as well as discussion with recipients regarding prior PCP access;

   b. Providers who are geographically accessible to the enrolled recipient per Nevada Administrative Code (NAC) 695C.160 (25 Mile Rule);

   c. Providers who ~~act as a PCP~~provide primary care to other family members as appropriate;

   d. Providers who are experienced in treating the chronic condition(s) known by the ~~CMO~~HCGP;

   e. Providers who are willing to serve as PCPs; and

   f. Providers ability to meet the recipient's needs in terms of diagnostic, location, cultural competency (spoken language), specialty and any Americans with Disabilities Act (ADA) modifications (as necessary).

4. The ~~CMO shall~~HCGP sends written confirmation of the ~~enrollee~~ recipient PCP selection to the recipient within five business days of verification. The ~~CMO must~~HCGP also provides notice to each PCP, either electronically, telephonically or by mail, within five business days of the ~~CMO~~ HCGP verification of PCP

selection. ~~The CMO must establish and implement a mechanism to inform~~The HCGP informs each PCP about all ~~enrollees~~ recipients that have selected the provider as their PCP on at least a monthly basis.

~~5. The CMO shall not assign enrollees to PCPs but must provide enrollees who do not have a routine source of primary care information about the importance of establishing a PCP.~~

~~6.~~5. An enrolled recipient may change a PCP for any reason. The ~~CMO shall notify~~HCGP notifies enrolled recipients of the procedures necessary to notify the ~~CMO~~ HCGP of PCP changes within beneficiary handbook and verbally during assessment. The materials used to notify enrolled recipients shall be approved by the DHCFP prior to publication and/or distribution.

~~7.~~6. In cases where the ~~CMO~~ HCGP has been informed that a PCP has been terminated by the DHCFP, the ~~CMO must~~HCGP will notify enrolled recipients in writing ~~within 15 business days of the receipt of Provider Data Files from the DHCFP~~of this termination in order to facilitate selection of another PCP within 10 business days of being made aware of PCPs termination.

~~e. Care Plan Development~~

C. CARE PLAN DEVELOPMENT

The HCGP develops a care plan for recipients.

1. The ~~CMO must establish and maintain a care plan, jointly created and managed by the~~ Health Care Team ~~defined in Section 3803.8.e.2~~establishes and maintains a care plan which outlines the ~~enrollee's~~ recipient's current and expected needs and goals for care, and identifies coordination gaps. ~~The plan is designed to fill gaps in coordination, establish care for enrollees and, in some cases, assist in establishing set goals for the enrollee's providers. Ideally, t~~The care plan anticipates routine needs and tracks current progress toward ~~enrollee~~ recipient goals.

2. The Health Care Team ~~involved in the development of a care plan must~~ consists of a multi-disciplinary care planning team which, at a minimum, includes:

   a. The ~~enrollee~~ recipient and/or the ~~enrollee's designee~~recipient's personal representative, including designated family members and/or legal guardians if recipient is a minor;

   b. A care manager, assigned by the ~~CMO~~ HCGP to the ~~enrollee~~ recipient to oversee and coordinate chronic care management activities;

   c. The ~~enrollee's~~ recipient's identified PCP;

d. A Nevada licensed psychiatrist, psychologist or a Nevada licensed/certified mental health specialist based on identified ~~client~~ recipient needs;

e. A pharmacist based on identified ~~client~~ recipient needs;

f. A nutritionist based on identified ~~client~~ recipient needs; and

g. Other key clinicians and caregivers identified as necessary to the ~~enrollee's~~ recipient's care.

3. The ~~CMO~~ care plan must document: ~~their~~

~~3.~~a. The process used for the care plan development and monitoring, including the composition of a multi-disciplinary care planning team. ~~The CMO~~It must ~~also specify criteria for when an enrollee's Health Care Team may~~document the decision to require inclusion of a licensed psychiatrist, psychologist or licensed/certified mental health specialist, a pharmacist and/or a nutritionist to participate in care plan development.

~~4.~~b. ~~The CMO must establish and maintain~~Any maintenance mechanisms for the ~~enrollee~~ recipient and/or the ~~enrollee's designee~~recipient's personal representative and care team to be actively involved in ~~the development of a care plan~~ and participate fully in decision-making regarding the ~~enrollee's~~ recipient's care. The HCGP follows a patient centered care model, with the care plans reflecting this approach.

~~5. The CMO must establish and maintain mechanisms for the enrollee's PCP and other treating providers to be actively involved in the development of a care plan and ensuring the enrollee's PCP is informed in advance of all proposed interventions conducted by the CMO, when possible.~~

~~6. The CMO must establish and maintain mechanisms to coordinate with treating providers and the CMO's Medical Director.~~

~~7.~~4. ~~The CMO must establish and maintain mechanisms for a~~Appropriate care referrals and scheduling assistance for ~~enrollees needing~~the recipient, including specialty health care or transportation services.

~~8.~~5. The tracking and monitoring of the referrals and follow-up of the recipient's needs.~~CMO, subject to the DHCFP's approval, may develop and implement a payment mechanism to PCPs for care plan input and/or approval.~~

~~9. The CMO must, jointly with the enrollee/designee, periodically assess progress toward care and coordination goals and monitor care delivery and coordination.~~

~~The CMO must refine the care plan as needed to accommodate new information or circumstances and to address any issues impacting the care plan through follow-up care on behalf of the enrollee.~~

~~10. The CMO must establish and maintain mechanisms for care plan monitoring and reassessment in which the frequency of review/reassessment is driven by severity of the enrollee's condition and/or direction from the enrollee's PCP.~~

~~11. The CMO must establish and maintain mechanisms for the enrollee or the enrollee's designee, the PCP, CMO Care Manager and other members of the Health Care Team to be actively involved in periodic reviews of the care plan.~~

~~12.~~6. The provision of tracking and monitoring of reminders to recipients and the recipient's PCP and/or other treating provider(s).

7. ~~The CMO must provide~~The provision of feedback to the ~~enrollee's~~ recipient's PCP and/or other treating provider(s) regarding the ~~enrollee's~~ recipient's adherence to the care plan. ~~The CMO must~~ This includes medication monitoring in its approach to care plan monitoring and reassessment for all recipients. ~~The CMO must provide feedback on~~This also includes any gaps between recommended care and actual care received by the ~~enrollee~~recipient to the ~~enrollee's~~recipient's PCP and/or other treating provider(s).

~~13. The CMO must monitor referral and follow-up of enrollees in need of specialty care and routine health care services.~~

~~14. The CMO must include medication monitoring in its approach to care plan monitoring and reassessment for all enrollees.~~

~~15. The CMO must routinely provide and collect pertinent clinical information to and from the enrollee's PCP.~~

~~16. The CMO must provide feedback on gaps between recommended care and actual care received by the enrollee to the enrollee's PCP and/or other treating provider(s).~~

~~17. The CMO must monitor and provide reminders to enrollees and the enrollee's PCP and/or other treating provider(s).~~

~~18. The CMO must facilitate care manager selection among enrollees between a minimum of not less than two care managers. The care managers must be registered nurses. Enrollees may change care managers at any time.~~

8. Any changes that are made to the care plan throughout the period of care for the recipient while enrolled in the HCGP. This includes accommodation of new information or circumstances and detailed documentation of any issues that are found to impact the care plan and how they are addressed.

~~A. Disease Management Interventions~~

D. RECIPIENT EDUCATION

1. The ~~CMO must have~~HCGP provides a health education system that includes programs, services, functions and resources necessary to provide health education, health promotion and patient education reflecting cultural competence and linguistic abilities.

2. The ~~CMO must~~HCGP provides health education, health promotion and patient education for all ~~enrollees~~recipients which, at a minimum, shall include, but may not be limited to, the following:

a. Assistance and education regarding:

1. ~~about a~~Appropriate use of health care services;

2. ~~Assistance and education about h~~Health risk-reduction and healthy lifestyle including tobacco cessation;

3. ~~Education to encourage u~~Use of the ~~CMO~~HCGP's nurse call services;

4. ~~Assistance and education about s~~Self-care and management of health condition, including coaching;

5. Assistance and education about Early Periodic Diagnostic Screening and Treatment (EPSDT), for Title XIX ~~enrollees~~recipients under age 21~~ and Title XXI enrollees through the age of 18~~;

6. ~~Assistance and education about t~~Teen pregnancy, maternity care programs and services for pregnant women; and

7. ~~Assistance and education about a~~Any new services the DHCFP implements.

3. The ~~CMO must establish and~~HCGP maintains an internet website at which the enrollees~~des~~ recipients can access health information and evidence-based health education.

4. The HCGP provides health education materials in formats easily understood by the ~~client~~ recipient~~population and written no higher than an eighth grade reading level reflecting cultural competence and linguistic abilities~~.

E. DISEASE MANAGEMENT INTERVENTIONS

1. The ~~CMO must establish and implement a~~HCGP has programs targeted to ~~the~~ recipients with chronic ~~population with such~~ diseases such as cardiac arterial disease, chronic heart failure, chronic obstructive pulmonary disease, diabetes mellitus and asthma.~~ These conditions are long-lasting and the CMO's management strategy must be appropriate based on the enrollee's age and severity of the underlying conditions based on risk stratification required in Section 3803.8.b.~~

2. The ~~CMO must~~HCGP uses, to the extent available, ~~h~~Health ~~i~~Information ~~t~~Technology (HIT) and ~~h~~Health ~~i~~Information ~~e~~Exchange (HIE), claims, eligibility and other non-administrative sources of data (like self-reported information from ~~enrollees~~recipients) to create information on various gaps-in-care, such as medication non-adherence, screening/testing non-compliance~~,~~ and prevent~~at~~ive care ~~like~~ including physician visits annually for covered chronic conditions.

~~2.~~3. The ~~CMO must~~ HCGP coordinates with the ~~enrollee~~ recipient and the ~~enrollee's~~ recipient's PCPs and/or other responsible providers to address these gaps. ~~in care identified, including medication non-adherence.~~

4. The ~~CMO must~~HCGP provides health coaching to facilitate behavioral changes by the ~~enrollees~~ recipients to address underlying health risks such as obesity or weight management. The HCGP provides one-to-one health coaching using licensed clinical professionals, and may also use online coaching tools~~,~~ to set up targets and intervention actions that can lead to fulfillment of ~~enrollee~~recipient goals.

~~3. The CMO must provide one-to-one health coaching using licensed clinical professionals, and may also use online coaching tools, to set up targets and intervention actions that can lead to fulfillment of enrollee goals.~~

~~g. Care Management Interventions~~

F. CARE MANAGEMENT INTERVENTIONS

1. The ~~CMO must establish and implement a program of~~ HCGP provides a clinical care management intervention~~s due to~~program for the escalating acute care needs of ~~people~~ recipients with high risks. This ~~must include typical co-morbid conditions. The CMO must provide~~ nurse-intensive intervention~~s~~ is provided over a defined period of time to resolve exacerbation from co-morbid conditions impacting ~~enrollee~~ recipient health care issues.

2. This service will be documented in the recipient's care plan and care notes. ~~The CMO must document, in detail to the DHCFP, how it provides care management interventions, including: the criteria for which enrollees receive this service; the minimum frequency of contact by risk level and manner by which the CMO is intervening with the enrollees; the co-morbid conditions being addressed; the expected duration of services; and, how the CMO is collaborating with various provider types, including PCPs, specialists and other providers in the provision of these services.~~

~~h. Complex Condition Management~~

G. COMPLEX CONDITION MANAGEMENT

1. The ~~CMO must establish and implement~~HCGP provides a program for ~~enrollees~~ recipients with certain types of conditions such as transplants, burns~~,~~ and other high-cost (often exceeding $100,000 per year), high-risk and/or rare conditions. ~~Enrollees must be~~Recipients are targeted early enough in their disease or condition to improve their health outcomes and reduce or prevent further progression of the disease or condition. The HCGP identifies recipients for this program and educates them regarding various options which may lead to equal or better outcomes for the recipient. ~~The management of these enrollees is very nurse-intensive and addresses not only relatively rare types of conditions, but also those enrollees which involve a very high treatment cost, often exceeding $100,000 per year.~~

~~2.~~ ~~The CMO may identify enrollees for this program who are contemplating more invasive procedures or treatments which do not have well-documented treatment protocols and represent significant variations in care for such treatments. The CMO may educate enrollees regarding various options which may lead to equal or better outcomes than the one that the enrollee is contemplating.~~

~~i.~~ a. Oncology Management Program

1. The ~~CMO must identify enrollees for this program that can be only managed in a program which focuses on specific cancer related treatment protocols. This program may refer patients to certain defined facilities or networks of providers. The CMO must work intensively~~HCGP provides oncology management program interventions. The HCGP works with identified ~~enrollees~~ recipients through ~~multiple interactions conducted by~~ a nurse expert in oncology treatment protocol and specialty.

~~2. The CMO must document, in detail, how it provides oncology management program interventions, including: the criteria for which enrollees receive this service; the minimum frequency of contact by~~

~~risk level and manner by which the CMO Health Care Team is intervening with the enrollees; how the CMO Health Care Team is collaborating with various provider types in the provision of these services; and how the CMO Health Care Team has established a defined network of facilities and providers for referral and coordination.~~

~~j.~~ b. Chronic Kidney Disease Program

1. The ~~CMO must identify enrollees~~HCGP team identifies recipients with Chronic Kidney Disease (CKD) for case management. Case management is expected to ~~retard the progression of the disease and~~ delay the need for dialysis or transplant~~,~~ and help to prepare ~~enrollees~~ recipients for dialysis therapy in the least costly setting. The ~~CMO shall~~HCGP implements interventions to include education with regard to options for treatment, diet, lifestyle changes and preparation for dialysis including dialysis access placement and in-patient or home dialysis options, standardized evidence-based care pathways and coordinated care processes and protocols which may be accomplished through referrals to, and coordination with, a defined network of providers. The HCGP care manager documents, in detail, how it provides CKD program interventions.

~~2. The CMO must document, in detail, how it provides CKD program interventions, including: the criteria for which enrollees receive this service; the minimum frequency of contact by risk level and manner by which the CMO is intervening with the enrollees; how the CMO is collaborating with various provider types in the provision of these services; and how the CMO has established a defined network of facilities and providers for referral and coordination.~~

~~a.~~c. Mental Health Program

The ~~CMO must identify enrollees for this program who have~~HCGP assesses and facilitates treatment for recipients with mental health conditions as follows:

1. Identification of recipients with a serious and persistent mental health condition, acute mental health problems or mental health co-morbidity associated with acute and/or chronic conditions.

2. ~~The CMO Health Care Team must complete~~Completion of an initial assessment and ~~provide~~ provision of follow-up management for behavioral issues ~~like~~ including depression and other psychiatric problems that hamper ~~patients'~~ recipient's ability to cope with acute and chronic conditions effectively.

3. ~~For individuals who have a mental health condition, the CMO Health Care Team shall promote~~Enhanced communication between PCPs and behavioral health providers to help ensure that services are coordinated, that duplication is eliminated~~,~~ and that coordination supports primary care based management of psychiatric medications as medically appropriate.

4. ~~The CMO Health Care Team shall take affirmative steps~~Measures to ensure the prevention of readmission to hospitals of ~~enrollees~~ recipients with a mental health condition. ~~These approaches and activities must be documented, in detail.~~

5. ~~The CMO Health Care Team shall take affirmative steps~~Measures to ensure that ~~enrollees~~ recipients with ~~a~~ mental health conditions have access to evidence-based mental health treatment and mental health rehabilitative services, such as Assertive Community Treatment (ACT) and other models supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) through the establishment of referral protocols and treatment guidelines.

~~6.~~ ~~The CMO must document, in detail, how it provides: mental health program interventions, including the criteria for which enrollees receive this service; the minimum frequency of contact by risk level and manner by which the CMO Health Care Team is intervening with the enrollees; how the CMO Health Care Team is collaborating with various provider types, including PCPs, behavioral health providers and other providers in the provision of these services; how the CMO is promoting coordination and integration of medical and behavioral health care; and how it is promoting access to evidence-based behavioral health services.~~

~~a.~~d. Maternity and Neo-Natal Program

1. The State ~~may identify enrollees~~identifies recipients in order to manage pregnant mothers in the earliest trimester(s) to manage risk factors for a better outcome both before and after the birth. The

~~CMO shall~~HCGP implement~~s~~ interventions to reduce incidence and severity of preterm births through pre-natal education, pre-natal care management and education and proactive case management of pregnancies. The program assists ~~enrollees~~ recipients by facilitating access to maternal and child health programs.

~~m. Enrollee Education~~

~~1. The CMO must have a health education system that includes programs, services, functions and resources necessary to provide health education, health promotion and patient education.~~

~~2.1. The CMO must provide health education, health promotion and patient education for all enrollees which, at a minimum, shall include, but may not be limited to, the following:~~

~~1.a. Assistance and education about appropriate use of health care services;~~

~~2.a. Assistance and education about health risk reduction and healthy lifestyle including tobacco cessation;~~

~~3.a. Education to encourage use of the CMO's nurse call services;~~

~~4.a. Assistance and education about self-care and management of health condition, including coaching;~~

~~5.a. Assistance and education about EPSDT, for Title XIX enrollees under age 21 and Title XXI enrollees through the age of 18;~~

~~6.a. Assistance and education about teen pregnancy, maternity care programs and services for pregnant women; and~~

~~7.a. Assistance and education about any new services the DHCFP implements.~~

~~3.1. The CMO must establish and maintain an internet website at which the enrollees can access health information and evidence-based health education.~~

4. ~~The CMO must provide health education materials in formats easily understood by the client population and written no higher than an eighth grade reading level reflecting cultural competence and linguistic abilities.~~

~~5. The CMO shall use, to the greatest extent practical, existing materials from state disease councils and coalitions where applicable (such as the U.S. Department of Health and Human Services, the Agency for Healthcare Research and Quality).~~

~~6. The CMO must track the number of educational materials mailed to enrollees, as well as the number of returned items. The CMO must have mechanisms to address new/corrected address information for enrollees, recognizing that the DWSS may not update enrollee address information in the Nevada Operations of Multi-Automated Data System (NOMADS) or Medicaid Management Information System (MMIS).~~

~~n. Nurse Triage and Nurse Advice Call Services~~

H. NURSE TRIAGE AND NURSE ADVICE CALL SERVICES

~~Nurse Triage is the assessment and disposition of symptom-based calls. Nurse Triage call services do not involve making diagnoses by telephone. Nurses do not diagnose but rather collect sufficient data related to the presenting problem and medical histories, recognize and match symptom patterns to those in the protocol and assign acuity. Nurses provide for the safe, timely disposition of health-related problems. Nurse Triage aids in getting the enrollees to the right Level of Care (LOC) with the right provider in the right place at the right time by assessing the severity of the enrollee's symptoms and then guiding the enrollee to the appropriate LOC.~~

Nurse Advice is a telephonic information service that offers answers to general healthcare questions~~. Nurse Advice call services provide~~ providing an opportunity to engage ~~enrollees~~ recipients one-on-one about their health by providing general health information and self-care instructions, as well as guidance on whether to see a doctor ~~and referrals to other appropriate health services.~~ or alternative, appropriate health service. Nurses do not diagnose but rather collect sufficient data to provide for the safe, timely disposition of health-related problems. Nurse Triage aids in getting the enrolled recipients to the right Level of Care (LOC) with the right provider in the right place at the right time by assessing the severity of the recipient's symptoms and then guiding the recipient to the appropriate LOC.

~~The CMO must document the system of nurse call services, including clinically based protocols and mechanisms for physician backup. The CMO must document how nurse triage is distinguished from other nurse advice call services. The CMO must specify qualifications for nurse triage/nurse advice staff and include position descriptions for each type of nurse triage/nurse advice position that is employed.~~

1. The ~~CMO must establish and implement a system to~~HCGP provides nurse call services 24 hours/7 days a week, including holidays, through a toll-free number accessible to all ~~enrollees~~ recipients enrolled in the ~~service area~~program.

~~2. The CMO shall have a properly functioning toll free telephone number for enrollees to call to access nurse triage and nurse advice call services, and access other enrollee services and resources specified in Section 3803.8.q. Recipients shall not incur a charge for placing a call, other than those applicable for local calls.~~

~~3. The CMO must staff its call center with licensed Registered Nurses (RNs) who use clinically based protocols for triage services provided to enrollees, including call back for all referrals made by the CMO's triage staff to self-care, urgent care, emergency room or 911. The CMO must provide physician access and back up for call center nurses at all times.~~

~~4. The CMO shall have sufficient and appropriate staff to handle all calls and provide nurse triage services in a timely, responsive and courteous manner. The staffing shall be adequate to fulfill the following standards of promptness and quality:~~

~~a. Ninety percent (90%) of telephone calls shall be answered within five rings;~~

~~b. A call pick-up system that places the calls in queue shall be used;~~

~~c. Blocked call rate (busy signal received) of five percent or less on an average daily basis; and~~

~~d. Ninety percent (90%) of calls in the queue shall be answered by a live operator in less than two minutes and measured on a daily basis.~~

~~5. The CMO shall install and maintain a functioning Automatic Call Distribution system (ACD) and call reporting system that records and aggregates the following information, at a minimum, on an hourly, daily, weekly and monthly basis for the call center as a whole and for individual operators:~~

~~a. Total number of incoming calls;~~

~~b. Number of answered calls by the CMO staff;~~

~~c. Average call wait time;~~

~~d. Maximum call wait time;~~

~~e. Percentage of calls answered by a live operator in under two minutes;~~

~~f. Average talk time;~~

~~g. Number of calls placed on hold and length of time on hold;~~
~~h. Number of abandoned calls and length of time until call is abandoned;~~

~~i. Number of outbound calls; and~~

~~j. Number of available operators by time.~~

~~This system should have the capability of automatically routing calls to back-up part-time operators when target wait times are exceeded. The CMO must document automatic call distribution system processes for monitoring and enforcing call center standards.~~

~~6. The CMO shall develop operational procedures, manuals, forms and reports necessary for the smooth operation of the nurse triage and nurse advice call services. A demonstration of the CMO's telephone system and staffing capability is required as part of the readiness review prior to the effective date of any CMO contract implementation.~~

~~7. The CMO shall develop a complete monitoring, supervision, and enforcement plan to ensure that nurse triage and nurse advice call services performance and customer service standards are maintained. The DHCFP must have the ability to monitor calls on a random basis to ensure quality service is being offered. Callers will be notified that calls may be monitored.~~

~~E. Continuity of Care Transitions~~
I. CONTINUITY OF CARE TRANSITIONS

1. The ~~CMO must establish and implement programs that facilitate~~ HCGP is responsible for facilitating specific transitions, which occur when information about or accountability for some aspect of a~~n~~ ~~enrollee's~~ recipient's care is transferred between two or more health care entities. Facilitation of such transitions by the ~~CMO~~ HCGP Health Care Team ~~must be~~is achieved through activities designed to ensure timely and complete transmission of information or accountability.

2. The ~~CMO must~~HCGP conduct~~s~~ provider outreach that ~~shall~~ target~~s~~ providers from the entire spectrum of medical care, including hospitals, PCPs, pharmacies and specialists ~~in order~~ to establish relationships and develop referral processes with, but not necessarily limited to, PCPs, discharge planners, facility staff and community agencies.

3. The ~~CMO~~ HCGP Health Care Team ~~must~~ coordinates with hospital discharge planning ~~that includes~~staff, including post-discharge transition services ~~designed~~ to prevent avoidable re-hospitalization. ~~s by improving care coordination at the interfaces between care settings.~~

4. The ~~CMO must~~HCGP initiates care transition services no later than 24 hours prior to discharge and must establish and maintain mechanisms to encourage and track PCP follow-up within seven business days of discharge. ~~and within 30 days of discharge.~~

~~5. The CMO must provide care transition services that are grounded on an evidence-based care transition model that, at a minimum, provides for:~~

~~a. Timely, culturally and linguistically competent post-discharge education regarding symptoms that may indicate additional health problems or a deteriorating condition;~~

~~b. Assistance to ensure timely and productive interactions between enrollees, the enrollee's PCP and other post-acute and outpatient providers;~~

~~c. Patient-centered self-management support and relevant information specific to the enrollee's condition; and~~

~~d.~~ a. ~~Comprehensive medication review and management including if appropriate, counseling and self-management support.~~

~~6.~~5. The ~~CMO must~~HCGP documents their care transitions programs, including provider outreach, collaboration in discharge planning and processes for encouraging and tracking follow-up PCP visits. The ~~CMO must also specify~~HCGP specifies evidence-based care transition interventions (e.g. Care Transitions Intervention, Transitional Care Model, other) to be used. The ~~CMO must~~HCGP identifies its approach to identifying facilities targeted for out-posted staff and specify the degree to which care management staff is out-posted. ~~at hospitals or other facilities and the CMO's approach to identifying targeted facilities and establishing outposted staff.~~

~~p. Emergency Department Redirection Management~~

J. EMERGENCY DEPARTMENT REDIRECTION MANAGEMENT

The ~~CMO must establish and implement programs that redirect inappropriate~~HCGP redirects recipients who inappropriately use ~~from~~ hospital Emergency Departments (EDs) for ~~enrollees accessing EDs for~~ non-emergent care ~~that can be addressed in a primary care setting~~. The ~~CMO's~~ HCGP's management of these ~~enrollees must~~recipients includes

linking ED users to PCPs, with appropriate follow-up and monitoring access patterns to primary care.

1. The ~~CMO must~~HCGP document~~s, in detail,~~ how it provides ED redirection management programs, including~~:~~
   a. ~~the c~~Criteria for which ~~enrollees~~ recipients receive this service~~,~~;
   b. ~~t~~Targeted communications to ~~enrollees~~ recipients after identification of ED visits~~,~~;
   c. ~~m~~Methods for linking ~~enrollees~~ recipients to PCPs for primary care~~,~~;
   d. ~~a~~Appropriate referral to disease, case or behavioral health management programs; and~~,~~
   ~~a.~~e. ~~h~~How the ~~CMO~~ HCGP's Health Care Team ~~will~~ collaborates with various provider types, including PCPs and hospitals' EDs in the provision of these services. ~~The CMO must specify the degree to which care management staff are outposted at hospital EDs and the CMO's approach to identifying targeted facilities and establishing outposted staff.~~

~~E. Linking to Community Resources~~
K. LINKING TO COMMUNITY RESOURCES

~~1.~~ The ~~CMO must~~HCGP provides information on the availability of and, if necessary, coordinat~~ione~~ of services with additional resources available within the community that may help support the ~~enrollees'~~ recipient's health and wellness or meet their care goals.

1. The ~~CMO must~~HCGP develops and maintains a directory of community resources available to assist ~~enrollees~~recipients. Community resources are services or programs outside the health care system that may support ~~enrollees'~~ the recipient's health and wellness. The ~~CMO must have~~HCGP maintains an approach to linking ~~enrollees~~recipients to community resources, including processes for ~~indentifying~~identifying ~~additional~~ resources ~~available~~ in the community that may benefit ~~enrollees~~recipients, maintaining and/or utilizing a directory of community resources (such as teaching and facilitating the use of Nevada 2-1-1, a community resource lifeline)~~., and assisting enrollees in accessing non-Medicaid covered services.~~

~~2. The CMO must establish and maintain mechanisms to assist enrollees with coordinating care for non-Medicaid covered services, which include determining the need for non-covered services and referring enrollees for intake and assessment, as appropriate.~~

~~3.1. The CMO must have an approach to linking enrollees to community resources, including processes for indentifying additional resources available in the community that may benefit enrollees, maintaining and/or utilizing a directory of community resources (such as teaching and facilitating the use of Nevada 2-1-1, a community resource lifeline), and assisting enrollees in accessing non-Medicaid covered services.~~

a. The HCGP maintains procedures to assist recipients in coordinating care for non-Medicaid covered services, which include determining the need for non-covered services and referring recipients for intake and assessment, as appropriate.

~~r. Advance Directives Requirements~~

~~1. The CMO must have written policies and procedures consistent with Section 1902(w)(1) of the Social Security Act and the Patients Self-Determination Act of 1990, with respect to Advance Directives (AD) for all adult enrollees receiving care management from the CMO. Specifically, the CMO's policies and procedures must provide for:~~

~~a. Written information to each enrollee at the time of enrollment concerning the enrollee'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 ADs;~~

~~b. Documentation in the enrollee's medical record whether the enrollee has executed an advance directive;~~

~~c. Not conditioning the provision of care of otherwise discriminating against an individual based on whether or not the individual has executed an advance directive;~~

~~d. Ensuring compliance with requirements of State laws regarding advance directives, including informing enrollees that any complaints concerning the advance directives requirements may be filed with the appropriate State agency which regulates the CMO; and~~

~~e. Educating CMO staff, PCPs and the community on issues concerning ADs, at least annually.~~

~~2. Sample AD policies, procedures and forms, as well as patient information concerning Nevada law are available on the DHCFP's website: http://dhcfp.state.nv.us/advancedirectives.htm.~~

~~3. The CMO must have processes in place for informing enrollees of ADs and documenting whether enrollees have executed ADs.~~

~~s. Enrollee Services Department~~

~~1. The CMO shall maintain an Enrollee Services Department (AKA Member Services Department) that is adequately staffed with qualified individuals who shall assist enrolled recipients, enrolled recipients' family members or other interested parties (consistent with HIPAA compliance and laws on confidentiality and privacy) in obtaining information and services.~~

~~2. At a minimum, Enrollee Services Department staff must be responsible for the following:~~

~~a. Explaining the operation of the CMO;~~

~~b. Assisting enrollees in selecting and/or changing PCPs;~~

~~c. Explaining care management services and covered benefits;~~

~~d. Assisting enrollees to make appointments and obtain services;~~

~~e. Resolving, recording and tracking enrollee grievances in a prompt and timely manner; and~~

~~f. Responding to enrollee inquiries.~~

~~3. While the Enrollee Services Department will not be required to operate after business hours, the CMO must provide for phone coverage 24 hours per day, seven days per week. The CMO must have written policies and procedures describing how to respond to enrollees in need of urgent care and emergency services after business hours and on weekends.~~

~~4. The Enrollee Services Department is to be operated at least during the hours of 8:00 AM to 5:00 PM (Pacific Time) Monday-Friday except national holidays. The CMO must specify the regular business hours for their Enrollee Services Department (at a minimum of 8:00 AM to 5:00 PM Pacific Time). The CMO may propose alternative hours, subject to approval of the DHCFP for operation of the Enrollee Services Department.~~

~~5. The CMO will work with the DHCFP to educate stakeholders, government agencies, providers and the community across the state of the CMO's program, both prior to enrolling recipients in the program and throughout the life of the contract.~~

~~The DHCFP may accompany the CMO's representative on any or all of these meetings.~~

~~The CMO must submit a comprehensive provider and community outreach communication plan to the DHCFP for approval. The outreach plan must identify and include outreach activities to include:~~

~~a. Individual and Group Providers;~~
~~b. Community organizations including those who directly work with the target enrollee population;~~
~~c. Hospitals;~~

~~d. Health fairs;~~

~~e. Public agencies; and~~

~~f. Key stakeholders.~~

~~The outreach plan must include a detailed timeline for these activities which must include a combination of formal presentations and individual provider, organization and association meetings as well as targeted meetings with key stakeholders, public agencies and interested stakeholders. The CMO will develop this schedule in coordination with the DHCFP. The CMO must submit quarterly reports on the outreach program as well as plan for continued education to the DHCFP.~~

3803.~~9~~7 PROVIDER SERVICES

~~A. Provider Policy and Procedures~~
A. PROVIDER POLICY AND PROCEDURES

~~1. The CMO must prepare, subject to the approval of the DHCFP, a Provider Manual. The CMO shall document the approval of the Provider Manual by the CMO's Medical Director and shall maintain documentation verifying that the Provider Manual is reviewed and updated at least annually. The Provider Manual and subsequent updates must be approved by the DHCFP prior to distribution.~~

~~2.~~1. The ~~CMO will also~~HCGP publishes the Provider Manual on the ~~CMO's~~ HCGP's provider portal internet website and ~~will~~ updates the website, as needed, to keep the Provider Manual current. The manual ~~shall~~ includes, at a minimum, the following information:

a. The ways (policies ~~and~~/ procedures) ~~to be implemented by~~in which the ~~CMO~~ HCGP Health Care Team ~~that~~ impacts ~~or require~~providers and

requires coordination ~~with providers~~from them to help coordinate recipient care;

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

b. The ways in which recipient's participation in the HCGP are verified and providers are notified of HCGP recipients, including how providers can refer their recipients into the program;

c. ~~The b~~Benefits and limitations available to ~~enrollees~~ recipients under the Care Management Program; and

d. ~~Policies and procedures to be implemented by the CMO to~~ Ways in which the HCGP has promoted quality improvement and cost-effective ~~enrollee~~ recipient service utilization.

~~3.~~2. The ~~CMO must~~HCGP gives each provider written notice of any significant change, as defined by the DHCFP, in any of the ~~enumerations~~ items noted above. The ~~CMO shall~~HCGP issues updates to the Provider Manual as directed by the DHCFP when there are material changes that will affect coordination with providers and information about the Care Management Program.

~~B. Provider Announcements and Notices~~

B. PROVIDER ANNOUNCEMENTS AND NOTICES

1. ~~The CMO may, subject to the prior review and approval of the DHCFP,~~The HCGP publishes announcements, notices, newsletters or other information of use to providers. Any announcements, notices or newsletters ~~must be~~ are published on the ~~CMO's~~ HCGP's provider portal website.

2. The ~~CMO must~~HCGP provides a draft copy of all announcements, notices and newsletters to the DHCFP for approval prior to publication and distribution. ~~The DHCFP must prior approve all provider announcements, notices and newsletters, regardless of method of dissemination. If the DHCFP does not respond within 20 days the information will be considered approved.~~

~~C. Provider Education~~

C. REAL TIME REFERRAL

A Real Time Referral (RTR) is provided for health care providers, facilities, social workers and other entities who are working directly with HCGP eligible recipients who wish to refer a recipient into the HCGP.

1. Referral may be done in two different ways:

   a. Verbally over the phone to telephone number 1 (855) 606-7875; and

   b. By filling out the RTR form and securely faxing it to 1 (800) 542-8074.

2. The RTR form is located on the DHCFP website at the following link: http://dhcfp.nv.gov/Pgms/BLU/HCGP/. This form is also located within the HCGP provider handbook and on the HCGP website.

D. PROVIDER EDUCATION

1. The ~~CMO must~~HCGP conducts comprehensive outreach and ongoing education campaigns reaching providers on utilizing current guidelines for prevention and treatment of chronic diseases in support of a Chronic Care Model. The ~~CMO's~~ HCGP's education and training system for providers on use of evidence-based practice guidelines must, at a minimum, include:

   a. Developing and/or disseminating guidelines to providers; and

   b. Resource tools to facilitate the use of evidence-based practice guidelines by the providers.

2. The ~~CMO must~~HCGP uses designated practice guidelines and protocols mutually agreeable to the ~~CMO~~ HCGP and the DHCFP. ~~Prior to the dissemination of any guidelines, the CMO shall identify the practice guidelines it intends to use and submit such guidelines to the DHCFP for approval. The DHCFP shall accept or reject within ten business days of receipt.~~

3. The ~~CMO must~~HCGP adopts practice guidelines and protocols which:

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

   b. Considers the needs of the ~~CMO's enrollees~~HCGP's recipients;

   c. Are adopted in consultation with participating PCPs and other health care professionals in Nevada; and

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

~~4. The CMO, subject to the DHCFP's approval, may develop and implement a program of practice facilitation for providers identified as at risk for non-compliance with evidence-based care guidelines.~~

~~5.~~4. The ~~CMO's~~ HCGP's education and training system for providers ~~must~~ includes:

~~a. Provider education on various types of chronic conditions and disabilities prevalent among Medicaid clients;~~

~~b. Provider education on physical, sensory, communication disabilities, developmental or mental health needs;~~

~~c.~~ a. Provider education on evaluation and appropriate treatment or referral of mental health issues;

~~d.~~ b. Provider education on Medicaid services authorization request processes;

~~e.~~ c. Provider education on identification and utilization of community resources;

~~f.~~ d. Provider education on scope of benefits, including how to refer people to services covered by other state agencies; and

~~g.~~ e. Provider education on disability, cultural competency and sensitivity training.

~~6. The CMO must have a system for provider outreach and education, including approaches to offering Continuing Medical Education (CME) to providers. The CMO must specify educational material and other resource tools to promote evidence-based practice guidelines.~~

~~7.~~5. The ~~CMO must have~~HCGP maintains tools and resources that will help providers educate clients about self-management and empowerment.

~~D. Provider Feedback/Profiling~~

E. PROVIDER FEEDBACK

~~1. The CMO must establish and implement a performance-based program for assessing the professional behaviors of individual practitioners using established clinical guidelines. Provider profiling must be designed to influence future care patterns and to enhance health outcomes of individuals accessing services through reports and data on service utilization.~~

~~2. The CMO Health Care Team must provide feedback on gaps between recommended care and actual care received by the enrollees attributed to an identified PCP.~~

~~3.~~1. The ~~CMO~~ HCGP Health Care Team ~~must~~ provides feedback to the PCP regarding the ~~enrollee's~~ recipient's adherence to the care plan developed by the ~~enrollee's~~ recipient's Health Care Team. The PCP also provides feedback to the DHCFP when requested by the DHCFP or when the PCP feels it is beneficial.

~~4. The CMO must measure PCP's improvement of adherence to clinical guidelines and performance on a key process and outcome measures relative to chronic care management.~~

~~5. The CMO must identify and recognize providers with best practices and the best performance on use of clinical guidelines and achievement on key process and outcome measures relative to chronic care management.~~

~~6. The CMO Health Care Team must identify, through assessment of utilization and other indicators, provider performance that suggests patterns of potential inappropriate utilization.~~

~~7. The CMO, subject to the DHCFP's approval, may develop and implement pay-for-performance payment mechanisms to PCPs.~~

~~E.~~2. The ~~CMO must~~ HCGP specifies~~y~~ the degree to which care management staff is out posted at primary care practices to help manage ~~enrollee~~ recipient care and the approach and activities used to identify targeted practices and establish out posted staff.

~~1. The CMO may maintain a program of practice facilitation for providers identified as at risk for non-compliance with evidence-based care guidelines. If such a program is implemented, the CMO must document the qualification of practice facilitators; the approach to identifying targeted practices; the frequency and duration of interventions and the extent of activities to assist practices such as, enhancing documentation and delivery of clinical interventions, particularly preventive services, developing reminder systems for recalling and tracking patients, developing evidence-based behavioral interventions and implementing Health Information Technology (HIT). This program will require the DHCFP's approval prior to implementation.~~

~~2. The CMO may maintain pay-for-participation program(s) with payment mechanisms to PCPs for certain activities such as enrollee care plan input and/or approval. The CMO may maintain a pay-for-performance program(s) with payment~~

mechanisms to PCPs that encourage the achievement of quality targets. If such a program is implemented, the CMO must document the structure of such programs, who is eligible for incentives under such programs and the performance required to receive an incentive payment under such programs. This program will require the DHCFP's approval prior to implementation.

3.1. The CMO shall operate a Management Information System (MIS) capable of maintaining, providing, documenting and retaining information sufficient to substantiate and report the CMO's compliance with the contract requirements. The CMO must facilitate the meaningful use of HIT and Health Information Exchange and make use of resources such as the Electronic Health Record (EHR) incentive program, Health Insight as Nevada's federally designated EHR Regional Extension Center and the Department of Health and Human Services' Office of Health IT, as appropriate.

3803.10 PAYMENT

Consideration shall be paid in a manner negotiated with the CMO. The DHCFP will review and may revise the rates periodically.

3803.11 MEDICAL/HEALTH HOME INFRASTRUCTURE ADMINISTRATION

A. The CMO shall support and assist the DHCFP in its efforts to develop Patient-Centered Medical Homes (PCMHs) and comprehensive Medicaid health homes. CMS approval is required prior to the implementation of any PCMH program under the CMO. PCMHs are an approach to providing accessible, continuous, coordinated and comprehensive primary care that facilitates partnerships between individual members and their personal providers and, when appropriate, the member's family. The focus in this person-centered approach is on the person who has a disease or illness, and how the disease or illness impacts their life, rather than on the illness or disease itself. If implemented successfully, this approach results in better informed enrollees who are better able to participate in their care, ultimately leading to better clinical outcomes. The provision of medical homes may allow better access to health care, increase satisfaction with care and improve health. Health Homes are medical home providers who meet higher standards for care coordination and also function as comprehensive care management providers across behavioral, social and long-term care systems.

B. The CMO shall support and assist the DHCFP in its efforts to develop PCMHs and comprehensive Medicaid health homes. CMS approval is required prior to the implementation of any PCMH program under the CMO. PCMHs are an approach to providing accessible, continuous, coordinated and comprehensive primary care that facilitates partnerships between individual members and their personal providers, and when appropriate, the member's family. The focus in this person-centered approach is on

~~the person who has a disease or illness and how the disease or illness impacts their life, rather than on the illness or disease itself. If implemented successfully, this approach results in better informed enrollees who are better able to participate in their care, ultimately leading to better clinical outcomes. The provision of medical homes may allow better access to health care, increase satisfaction with care and improve health. Health Homes are medical home providers who meet higher standards for care coordination and also function as comprehensive care management providers across behavioral, social and long-term care systems:~~

~~1. Provide quality-driven, cost-effective, culturally appropriate and person and family-centered health home services;~~

~~2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;~~

~~3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;~~

~~4. Coordinate and provide access to mental health and substance abuse services;~~

~~5. Coordinate and provide access to comprehensive care management, care coordination and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;~~

~~6. Coordinate and provide access to chronic disease management including self-management support to individuals and their families;~~

~~7. Coordinate and provide access to individual and family supports including referral to community, social support and recovery services;~~

~~8. Coordinate and provide access to long-term care supports and services;~~

~~9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health care related needs and services;~~

~~10. Demonstrate a capacity and use HIT to link services, facilitate communication among team members and between the health team, individual and family caregivers and provide feedback to practices as feasible and appropriate; and~~

~~11. Establish a continuous quality improvement program, collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes and experience of care outcomes and quality of care outcomes at the population level.~~

3803.8 INFORMATION REQUIREMENT

A. GENERAL INFORMATION REQUIREMENTS

The HCGP maintains written information about its services and access to services available upon request to recipients and potential recipients.

This written information must also be available to recipients with limited English proficiency and in accordance with Title VI of the Civil Rights Act of 1964 (Title VI). The HCGP will also provide oral translation services to recipients in accordance with that act. All written material directed to recipients and potential recipients must be approved by the DHCFP prior to distribution.

The HCGP must abide by all marketing regulations outlined in 42 CFR 438.104.

B. NOTICE OF ENROLLMENT

The HCGP will send a Notice of Enrollment/Welcome Letter prior to initiation of services for all newly enrolled recipients.

C. ENROLLEE/BENEFICIARY HANDBOOK

The HCGP will provide all enrollees with an Enrollee Beneficiary Handbook. The HCGP's written material to recipients and potential recipients use an easily understood format, not to exceed an eighth-grade reading level.

1. Provision of Handbook

   a. The HCGP furnishes the written handbook to all recipients via mail within five business days of receiving notice of the recipient's enrollment;

   b. The HCGP notifies all recipients of their right to request and obtain this information at least once per year or upon request;

   c. The HCGP publishes the Enrollee Beneficiary Handbook on the HCGP's recipient's internet website and will update the website, as needed, to keep the Enrollee Beneficiary Handbook current;

   d. The HCGP will provide each recipient written notice of any significant change in the Handbook, as defined by the DHCFP, at least 30 calendar

days in advance of the intended effective date of the change, in any of the enumerations noted above; and

e. The HCGP will issue updates to the Enrollee Handbook as directed by the DHCFP when there are material changes made to the handbook.

2. At a minimum, the information below is included in the handbook:

a. Explanation of services;

b. The role of the PCP and description of the HCGP's process for confirmation of the enrolled recipient's selection of a PCP, and the process for assisting the enrolled recipient in finding a PCP;

c. Recipient disenrollment rights and protections;

d. Information on procedures for recommending changes in policies and services; and

e. Enrollee/Beneficiary Handbook must include a distinct section for eligible recipients which:

i. Explains the EPSDT program and includes a list of all the services available to children; and

ii. A statement that services are free and a telephone number which the recipient can call to receive assistance in scheduling an appointment.

D. ENROLLEE/RECIPIENT SERVICES DEPARTMENT

1. The HCGP shall maintain an Enrollee Services Department (AKA Recipient Services Department) that is adequately staffed with qualified individuals who shall assist enrolled recipients, enrolled recipient's family members or other interested parties (consistent with HIPAA compliance and laws on confidentiality and privacy) in obtaining information and services.

2. At a minimum, Enrollee Services Department staff must be responsible for the following:

a. Explaining the operation of the HCGP;

b. Assisting recipients in selecting and/or changing PCPs;

c. Explaining care management services and covered benefits;

d. Assisting recipients to make appointments and obtain services;

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

f. Responding to recipient inquiries; and

g. Maintaining operations of their Enrollee/Recipient Services Department Monday through Friday, except national holidays, and at a minimum the regular business hours must be 8:00 AM to 5:00 PM Pacific Time.

3803.~~12~~9 ~~PROGRAM~~ OPERATION AND REPORTING REQUIREMENTS~~AND REVIEWS~~

A. MANDATORY REPORTS

The ~~CMO~~ HCGP must provide the DHCFP with uniform utilization, cost, quality assurance~~,~~ and recipient satisfaction ~~and grievance~~ data on a regular basis. It must also cooperate with the DHCFP in carrying out data validation steps. The data for the program includes, but is not limited to, the following:

1. ~~Enrollee~~ Recipient Stratification Reporting;

~~The CMO must provide the DHCFP with monthly reports documenting the CMO's initial claims-based risk assignment of the Membership File showing a comprehensive stratification of the enrolled population. The content of these reports are pursuant to guidelines established by the CMO, the DHCFP and the DHCFP's contractors, including the DHCFP's contracted actuary and/or External Quality Review Organization (EQRO), as well as those components identified in the current CMO contract. The CMO must submit these reports to the DHCFP in a timely manner pursuant to current CMO contract requirements, in addition to the other reports required by the current CMO contract. The CMO must obtain the DHCFP's approval of the format and content of the Enrollee Stratification report prior to development of the first such report.~~

2. ~~Enrollee~~ Recipient Contact Reporting;

~~The CMO must provide the DHCFP with monthly reports documenting the CMO's case management services rendered and encounters for all enrollees. The content of these reports are pursuant to guidelines established by the CMO, the DHCFP and the DHCFP's contractors, including the DHCFP's contracted actuary and/or EQRO, as well as those components identified in the current CMO contract. The CMO must submit these reports to the DHCFP in a timely manner pursuant to~~

~~current CMO contract requirements, in addition to the other reports required by the current CMO contract. The CMO must obtain the DHCFP's approval of the format and content of the Enrollee Encounter report prior to development of the first such report.~~

3. Call Center and Nurse Triage Reporting;

~~The CMO must provide the DHCFP with monthly reports documenting the CMO's call center statistics. The content of these reports are pursuant to guidelines established by the CMO, the DHCFP and the DHCFP's contractors, including the DHCFP's contracted actuary and/or EQRO, as well as those components identified in the current CMO contract. The CMO must submit these reports to the DHCFP in a timely manner pursuant to current CMO contract requirements in addition to the other reports required by the current CMO contract. The CMO must obtain the DHCFP's approval of the format and content of the Call Center Statistical report prior to development of the first such report.~~

4. Provider Engagement Reporting;

~~The CMO must provide the DHCFP with monthly reports documenting the CMO's engagement with providers regarding care coordination for enrollees. The content of these reports are pursuant to guidelines established by the CMO, the DHCFP and the DHCFP's contractors, including the DHCFP's contracted actuary and/or EQRO, as well as those components identified in the current CMO contract. The CMO must submit these reports to the DHCFP in a timely manner pursuant to the current CMO contract requirements in addition to the other reports required by the current CMO contract. The CMO must obtain the DHCFP's approval of the format and content of the Provider Engagement report prior to development of the first such report.~~

5. Summary ~~Enrollee~~ Recipient Utilization Reporting;

~~The CMO must provide the DHCFP with annual reports documenting the patterns of health care service utilization among enrollees. The content of these reports are pursuant to guidelines established by the CMO, the DHCFP and the DHCFP's contractors, including the DHCFP's contracted actuary and/or EQRO, as well as those components identified in the current CMO contract. The CMO must submit these reports to the DHCFP in a timely manner pursuant to current CMO contract requirements, in addition to the other reports required by the current CMO contract. The CMO must obtain the DHCFP's approval of the format and content of the Enrollee Service Utilization report prior to development of the first such report~~.

6. Provider Profiling Report;

~~The CMO must provide the DHCFP with quarterly reports documenting the patterns of professional behaviors of individual practitioners using established clinical guidelines as required in Section 3803.9.D.~~

7. Quality Assurance Reporting;

~~Quality-related studies will be performed by the contracted CMO pursuant to guidelines established jointly by the CMO, the DHCFP and the DHCFP's contracted EQRO, as well as those identified in the current CMO Contract. In addition, the CMO must provide outcome-based clinical reports and management reports as may be requested by the DHCFP. The CMO must submit these reports to the DHCFP in a timely manner pursuant to current CMO contract requirements, in addition to the other reports required by the current CMO contract. Should the CMO fail to provide such reports in a timely manner, the DHCFP will require the CMO to submit a Plan of Correction (POC) to address contractual requirements regarding timely reporting submissions. The CMO must obtain the DHCFP's approval of the format and content of all Quality Assurance reports prior to development of the first such reports.~~

8. ~~Grievance,~~ Complaint and Dispute Resolution Reporting;

~~The CMO must provide the DHCFP with quarterly reports documenting the number and types of enrollee grievances, provider complaints and disputes received by the CMO Health Care Team. The content of these reports are pursuant to guidelines established by the CMO, the DHCFP and the DHCFP's contractors, including the DHCFP's contracted actuary and/or EQRO, as well as those components identified in the current CMO contract. The CMO must submit these reports to the DHCFP in a timely manner pursuant to current CMO contract requirements in addition to the other reports required by the current CMO contract. The CMO must obtain the DHCFP's approval of the format and content of the grievance and the complaint and dispute resolution report prior to development of the first such report. Comprehensive records pertaining to enrollee grievances, provider complaints and dispute information, including but not limited to, specific outcomes, shall be retained for each occurrence for review by the DHCFP.~~

9. Satisfaction Reporting;

~~a. The CMO must collect and submit to the DHCFP a statistically valid uniform data set measuring recipient satisfaction in a timeline that meets CMS reporting requirements, unless the requirement is waived by the DHCFP due to an EQRO performed survey. This may be done in conjunction with the CMO's own satisfaction survey. The DHCFP may~~

~~request a specific sample, and/or survey tool. Survey results must be disclosed to the State and, upon request, disclosed to enrollees.~~

~~b. The CMO must monitor enrollees and providers regarding satisfaction including completion of annual satisfaction surveys.~~

10. Fraud and Abuse Reporting;

~~The CMO is responsible for informing the DHCFP of any suspected recipient fraud or abuse. The CMO must provide immediate notification to DHCFP Business Lines Unit and Surveillance and Utilization Review (SUR) Unit regarding all suspected recipient and provider fraud and abuse pursuant to 42 CFR 455.17. These reporting requirements shall be included in all CMO subcontracts.~~

11. Disenrollment Reporting;

~~The CMO must submit a monthly report to the DHCFP on the number of program disenrollments and the reasons for disenrollment.~~

12. Non-Compliance Reporting; and

~~The CMO must submit a monthly report to the DHCFP on the number of recipients who have been categorized as noncompliant.~~

13. Re-Assessment Reporting.

~~The CMO must complete a demonstration eligibility re-assessment for beneficiaries already enrolled in the CMO at least annually. The CMO must report to the DHCFP the names of all individuals for whom a re-assessment is completed. The CMO must report to the DHCFP all individuals not referred for enrollment and the reason the individual was not referred.~~

~~14. Other Reporting~~

~~The CMO shall be required to comply with additional reporting requirements upon the request of the DHCFP. Additional reporting requirements may be imposed on the CMO if the DHCFP identifies any area of concern with regard to a particular aspect of the CMO's performance under the CMO Contract or if CMS requires any additional reports. Such reporting would provide the DHCFP with the information necessary to better assess the CMO's performance.~~

~~3803.13 OPERATIONAL REQUIREMENTS~~

~~A. Operating Structure and Staffing~~

~~1. The CMO must assure the DHCFP that the organization is adequately staffed with experienced, qualified personnel. The CMO shall provide the DHCFP with an updated organizational chart, every six months or whenever a significant change in the organization occurs. The organizational chart must follow guidelines established by the CMO and the DHCFP, as well as those components identified in the current CMO contract.~~

~~2. The CMO must have in place the organizational, management and administrative systems capable of fulfilling all contract requirements.~~

~~B. Subcontractors~~

~~The CMO must abide by all requirements related to subcontractors in the current CMO contract. The DHCFP reserves the right to review the form of all subcontracts, including administrative services. All subcontracts shall be submitted to the DHCFP for approval prior to their effective date.~~

B. ~~3803.14~~ MANAGEMENT INFORMATION SYSTEM (MIS)

The HCGP operates an ~~Management Information System (~~MIS~~)~~ capable of maintaining, providing, documenting and retaining information sufficient to operate their care management program and substantiate and report the ~~CMO~~HCGP's compliance with the current HCGP contract requirements. ~~The CMO must facilitate the meaningful use of HIT and Health Information Exchange and make use of resources such as the Electronic Health Record (EHR) incentive program, Health Insight as Nevada's federally designated EHR Regional Extension Center and the Department of Health and Human Services' Office of Health IT, as appropriate.~~

1. The ~~CMO shall have an~~HCGP's MIS is capable of documenting administrative and clinical procedures while maintaining the privacy and confidentiality requirements pursuant to HIPAA. The ~~CMO shall~~HCGP provides the DHCFP with aggregate performance and outcome data, as well as ~~its policies for transmission of~~providing data to and from participating providers. ~~The CMO shall submit its work plan or readiness survey assessing its ability to comply with HIPAA mandates in preparation for the standards and regulations.~~

~~2. The CMO shall have internal procedures to ensure that data reported to the DHCFP are valid and to test validity and consistency on a regular basis.~~

~~1. The CMO shall ensure that the operation of its systems and handling of confidential information is performed in accordance with state and federal regulations related to~~

security and confidentiality, and meet all privacy and security requirements of HIPAA and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH). All Protected Health Information (PHI) that is accessed, used, stored or transmitted shall be in accordance with HIPAA. Furthermore, all social security numbers, employer taxpayer identification numbers, drivers license numbers and any other numbers or information that can be used to access a person's financial resources are "personal identifying information" that must be protected in accordance with NRS.

3. Eligibility and Claims Data

C. ELIGIBILITY AND CLAIMS DATA

1. The DHCFP or its fiscal agent will exchange eligibility, and claims data and disenrollment data with the CMOHCGP. The CMO is required to establish and maintain an MIS that accurately captures recipient and provider data and that the operation of its systems and handling of confidential information is performed in accordance with state and federal regulations related to security and confidentiality, and meet all privacy and security requirements of HIPAA and the HITECH. All PHI that is accessed, used, stored or transmitted shall be in accordance with HIPAA.

2. The CMO willHCGP utilize uses data maintained in its MIS to help determine what the care management services are appropriate for each enrollee enrolled recipient. to receive and those enrollees and associated providers who should receive outreach services.

3. The CMO's MIS shall be capable of linking records for the same enrolled recipient that are associated with different Medicaid identification numbers; (e.g., recipients who are re-enrolled and assigned new numbers).

4. The CMO shall update its MIS whenever enrolled recipients change names, phone numbers, and/or addresses and maintain such changes in its MIS.

5. The CMO's MIS must capture and store the provider, recipient, prior authorization, and claims data that is sent from the MMIS and/or other systems by the DHCFP or its fiscal agent.

6.3. The CMO's HCGP's MIS system will stores service utilization data regarding each enrolleerecipient/provider and performs analysis on the data that is captured and provides the DHCFP, and when applicable providers, with analysis results via reports required in Section 3803.12.

E. Services and Contact Records

D. RECIPIENT SERVICES AND CONTACT RECORDS

1. ~~The CMO is required to establish and maintain an MIS that enables it to administer and manage the functions required in the current CMO contract. The CMO's MIS shall have an~~The HCGP maintains an electronic tracking application ~~that has the capability to~~which tracks each contact made with an ~~enrollee~~enrolled recipient, ~~enrollee's~~ enrolled recipient's authorized designee or provider, including phone calls, care management activities, clinical interventions and outcomes, profiling and education information, linkages and care coordination across providers and referrals.

~~2. The CMO's MIS must not overlay previous entries for tracking contact data. Once an entry has been captured [saved], any additional information must be treated as a new entry or additional comment. Each contact incident must be date/time stamped to create an audit trail.~~

~~3.~~2. The ~~CMO's~~ HCGP's MIS shall identify/capture services provided to each ~~enrollee~~ recipient (such as case management, disease management, care coordination, etc.) and transmit and report information to the appropriate parties.

~~4.~~3. The ~~CMO's~~ HCGP's MIS ~~must be~~is capable of sharing health information with providers to ensure that all involved parties have a comprehensive picture of a~~n enrollee's~~ recipient's health status.

~~5.~~4. The ~~CMO's~~ HCGP's MIS ~~shall be capable of generating~~generates reports to the DHCFP~~ as described in Section 3803.12~~. ~~The system must also have the functionality to provide ad hoc reports.~~

~~6. The CMO must document MIS reporting capabilities to include description of all standard reports available and processes for defining and producing ad hoc reports.~~

E. MEDICAL RECORDS

1. Documentation of Care Management Interventions – The HCGP provides adequate evidence of individual encounters, at a minimum:

   a. Plan of Care (POC);

   b. Assessment and periodic reassessment;

   c. Consultation with the PCP and other members of the Health Care Team;

   d. Education and other targeted interventions directly with the recipient;

~~a.~~ e. Referrals and results thereof; and

f. All other aspects of care management, including ancillary services.

2. The HCGP maintains the confidentiality of all medical records and shares medical records when an enrolled recipient changes PCPs or transfers between managed care and FFS programs.

3. The HCGP assists the enrolled recipient or the parent/legal guardian of the enrolled recipient in obtaining a copy of the enrolled recipient's medical records pursuit to NRS 629.061 and provisions of HIPAA.

4. The HCGP maintains organized, legible and complete medical records in conformance with the DHCFP's standards.

3804 GRIEVANCES, APPEALS AND FAIR HEARINGS

A. RECIPIENT GRIEVANCES

The ~~Care Management Organization (CMO) shall establish a system for enrollees, which~~HCGP includes a grievance process. ~~The appeal process and access to the State Fair Hearing system is administered by the Division of Health Care Financing and Policy (DHCFP). The CMO shall establish a similar system to resolve disputes with providers.~~ The ~~CMO must~~HCGP provides information about ~~these systems~~this process to ~~enrollees~~ recipients at the time of enrollment and to providers and subcontractors. ~~The CMO must submit to the DHCFP quarterly reports that document the grievance activities. The CMO is required to maintain records of grievances, complaints and disputes, which the State will review as part of the State's quality strategy.~~

~~a. Enrollee Grievances~~

~~1.~~ A grievance is an expression of dissatisfaction ~~about any matter~~. Possible issues for grievances include, but are not limited to, access to services, quality of services, interpersonal relationships between the ~~CMO~~ HCGP staff and ~~enrollees~~ recipients and failure to respect a~~n enrollee's~~ recipient's rights.

~~The CMO's enrollee grievance system must be in writing and submitted to the DHCFP for review and approval at the time the CMO's Policies and Procedures are submitted and at anytime thereafter when the CMO's enrollee grievances policies and procedures have been revised or updated (not including grammatical or readability revisions or updates). The CMO may not implement any policies and procedures concerning its enrollee grievance system without first obtaining the written approval of the DHCFP. Grievances are not eligible for referral to the State Fair Hearing process.~~

1. An ~~enrollee~~ HCGP recipient may file a grievance either orally or in writing to the HCGP. If a grievance is filed orally, the ~~CMO~~ HCGP is required to document the contact for tracking purposes and to establish the earliest date of receipt. ~~There is no requirement to track routine telephone inquiries. For tracking purposes, an oral grievance is differentiated from a routine telephone inquiry by the content of the inquiry.~~

   a. In an instance of grievance regarding a request for disenrollment response, the recipient will follow the grievance process through the HCGP. Once this is completed, the HCGP will report the resolution to the DHCFP, the DHCFP will make the determination on the recipient's request for disenrollment. If the DHCFP determines the disenrollment request does not need to be pursued through the grievance process, the DHCFP will provide a NOD within thirty (30) calendar days. If the request for disenrollment is

approved by the DHCFP, the DHCFP will notify the recipient the effective date of disenrollment from the HCGP via mail within thirty (30) calendar days.

2. Grievances are not eligible for referral to the State Fair Hearing process.

~~2.~~3. An enrollede recipient or ~~an enrollee's~~their representative (including a provider on behalf of an enrollede recipient) may file a grievance directly with the DHCFP. However, such grievances~~ will be referred to the ~~CMO~~ HCGP for resolution. In the event a provider files a grievance on the enrollee's behalf, the provider must first obtain the enrollee's written permission.

~~3.~~4. In handling grievances, the HCGP will: ~~CMO must meet the following requirements:~~

a. Acknowledge receipt of each grievance;

b. Ensure that the individuals who make decisions on grievances were not involved in any previous level of review or decision-making; and

c. Ensure that the individuals who make decisions on grievances have the necessary levels of experience and authority.

~~4. In handling grievances, the CMO must meet the following requirements:~~

~~a.~~d. ~~The CMO is required to d~~Dispose of, and resolve, each grievance within ~~the State's established timeframes specified as follows:~~Standard disposition of ~~grievances: The CMO is allowed no more than~~ 90 calendar days from the date of receipt of the grievance.

~~a.d. Standard disposition of grievances: The CMO is allowed no more than 90 days from the date of receipt of the grievance.~~

~~b. An enrollee or an enrollee's representative (including a provider on behalf of an enrollee) may file a grievance directly with the DHCFP. However, such grievances will be referred to the CMO for resolution. In the event a provider files a grievance on the enrollee's behalf, the provider must first obtain the enrollee's written permission.~~

~~c.~~ d. ~~The CMO must k~~Keep a written or electronic record of each filed grievance to include a description of the issue, the date filed, the dates and nature of actions taken and the final resolution.

~~b. Notice of Decision/Handling of Appeals~~

B. NOTICE OF DECISION/HANDLING OF APPEALS

The HCGP does not modify any Medicaid benefits for recipients, outside of the additional coordination benefits provided by the HCGP itself. As the HCGP does not make any changes to a recipients Medicaid benefits, it does not complete appeals regarding the exclusion, addition or modification of a recipients HCGP services. The DHCFP provides a written NOD ~~notice of action~~ to the ~~enrollee~~ recipient when the DHCFP takes a negative action or makes an adverse determination affecting the ~~enrollee~~recipient, per ~~Medicaid Services Manual (~~MSM~~)~~ Chapter 100, ~~"~~Medicaid Program~~"~~.

~~For certain actions, an enrollee may have the right to appeal. Information on the appeals process is located in MSM Chapter 3100, "Hearings,".~~

~~c. Handling of Provider Complaints and Disputes~~

~~The CMO must document how they have established and maintained a system for addressing provider complaints and disputes, including processes for accepting, tracking and disposing of complaints and disputes from providers.~~

C. PROVIDER COMPLAINTS AND DISPUTES

~~1.~~ The ~~CMO must establish and~~HCGP maintains a process to resolve any provider complaints and disputes that are separate from, and not a party to, grievances submitted by providers on behalf of ~~enrollees~~recipients. The ~~CMO must~~HCGP accepts written or oral complaints and disputes that are submitted directly by the provider, as well as those that are submitted from other sources, including the DHCFP. The ~~CMO must~~HCGP staffs a provider services unit to handle provider complaints and disputes. Eighty percent of all written, telephone or personal contacts must be resolved within 30 calendar days of the date of receipt and one hundred percent of all written, telephone or personal contacts must be resolved within 90 calendar days of the date of receipt.

~~2. Written procedures must be included, for review and approval, at the time the CMO policies and procedures are submitted to the DHCFP and at anytime thereafter when the CMO's provider complaint and dispute policies and procedures have been revised or updated. The CMO may not implement any policies and procedures concerning its provider complaint and dispute system without first obtaining the written approval of the DHCFP.~~

~~3.~~1. ~~The CMO must accept written or oral complaints and disputes that are submitted directly by the provider as well as those that are submitted from other sources,~~

~~including the DHCFP. The CMO must staff a provider services unit to handle provider complaints and disputes.~~

~~4. The CMO must keep a written or electronic record in the form of a file or log for each provider complaint or dispute to include the nature of it, the date filed, dates and nature of actions taken and final resolution.~~

~~5. The CMO must resolve eighty percent (80%) of written, telephone or personal contacts within 30 calendar days of the date of receipt.~~

~~6. The CMO must resolve one hundred percent (100%) of written, telephone or personal contacts within 90 calendar days of the date of receipt.~~

~~d. Enrollee Rights~~

D. RECIPIENT RIGHTS

The vendor ~~must~~ maintains policies and procedures regarding ~~enrollee~~ recipient rights and protections. The vendor must demonstrate a commitment to treating recipients in a manner that acknowledges their rights and responsibilities. This must include the ~~enrollee's~~ recipient's right to be treated with respect and due consideration for his or her dignity and privacy, as well as their right to receive information on their health options in a manner appropriate to the ~~enrollee's~~ recipient's condition and ability to understand.