

MEDICAID SERVICES MANUAL  
TRANSMITTAL LETTER

June 26, 2018

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 make the chapter obsolete effective July 1, 2018, as the program is ending June 30, 2018.

Entities Financially Affected: AxisPoint Health (APH), the vendor contracted to provide the care management services.

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

These changes are effective July 1, 2018.

**MATERIAL TRANSMITTED**

CL 31933  
MSM 3800 Care Management Organization

**MATERIAL SUPERSEDED**

MTL 19/17  
MSM 3800 Care Management Organization

<b>Manual Section</b>	<b>Section Title</b>	<b>Background and Explanation of Policy Changes, Clarifications and Updates</b>
<b>3800</b>	<b>Introduction</b>	Obsolete – the program is ending June 30, 2018.
<b>3801</b>	<b>Authority</b>	Obsolete – the program is ending June 30, 2018.
<b>3802</b>	<b>Reserved</b>	Obsolete – the program is ending June 30, 2018.
<b>3803</b>	<b>Policy</b>	Obsolete – the program is ending June 30, 2018.
<b>3803.1</b>	<b>Covered Services</b>	Obsolete – the program is ending June 30, 2018.

<b>Manual Section</b>	<b>Section Title</b>	<b>Background and Explanation of Policy Changes, Clarifications and Updates</b>
3803.2	<b>Eligibility and Enrollment</b>	Obsolete – the program is ending June 30, 2018.
3803.3	<b>Change in a Recipient's Status</b>	Obsolete – the program is ending June 30, 2018.
3803.4	<b>Transitioning Recipient's into Care Management</b>	Obsolete – the program is ending June 30, 2018.
3803.5	<b>Transferring Recipient's Between Managed Care/Other Entities</b>	Obsolete – the program is ending June 30, 2018.
3803.6	<b>Recipient Services</b>	Obsolete – the program is ending June 30, 2018.
3803.7	<b>Provider Services</b>	Obsolete – the program is ending June 30, 2018.
3803.8	<b>Information Requirement</b>	Obsolete – the program is ending June 30, 2018.
3803.9	<b>Operation and Reporting Requirements</b>	Obsolete – the program is ending June 30, 2018.
3804	<b>Grievances, Appeals and Fair Hearings</b>	Obsolete – the program is ending June 30, 2018.

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3800 ——— INTRODUCTION

~~The Division of Health Care Financing and Policy (DHCFP) recognizes that there are many individuals at increased risk for hospitalization due to chronic conditions. The DHCFP has developed a Care Management Organization (CMO) under the Nevada Comprehensive Care Waiver (NCCW) to assist this at risk population in connecting with preventative care. The CMO is part of the NCCW 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 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 program. The program 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.~~

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~~3801 ——— AUTHORITY~~

~~Under the provisions of Nevada Revised Statute (NRS) 422 and under Section 1115(a) of the Social Security Act (SSA), 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” is intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. Under Section 1115(a), Nevada received approval to implement Nevada’s CMO program, known as the HCGP, under the NCCW. This project is funded under Title XIX of the SSA.~~

~~The HCGP must meet all requirements of the NCCW, as approved by Centers for Medicare and Medicaid Services (CMS).~~

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~~3802~~ ——— ~~RESERVED~~

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~~3803 POLICY~~

~~3803.1 COVERED SERVICES~~

~~HCGP enrollees remain in the Medicaid FFS delivery model and therefore will receive all services in the current Nevada State Plan under FFS.~~

~~The HCGP provides coordination of medical, behavioral health and social services for targeted recipients in the Nevada Medicaid FFS program. The HCGP performs integrated medical, behavioral and social case management with enrollees. The 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~~

~~Eligibility and enrollment for all forms of Medicaid (MCO and FFS) are the responsibility of the DHCFP and the Division of Welfare and Supportive Services (DWSS).~~

~~1. HCGP Enrollment Process~~

~~The HCGP receives a monthly master recipient list from the DHCFP, and then uses a predictive algorithm to identify recipients who meet eligibility criteria. The HCGP completes the enrollment process.~~

~~2. Non-Discrimination in Enrollment~~

~~The HCGP accepts recipients eligible for enrollment in the order in which they become eligible for the program, without restriction, up to the limits set under the waiver. The HCGP will not, on the basis of health status or need for health services, discriminate against recipients eligible to enroll. The HCGP will not deny enrollment nor discriminate against any Medicaid recipients eligible to enroll on the basis of race, color, national origin, religion, sex, age, disability or any other class status protected by federal or state law or regulation by programs receiving Federal Financial Participation (FFP).~~

~~B. ELIGIBLE GROUPS~~

~~MANDATORY HCGP PROGRAM ENROLLEES~~

~~The following categories of Medicaid eligible recipients, not enrolled in an MCO, are accepted into the HCGP:~~

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1. ~~Parents and caretakers;~~
2. ~~Pregnant Women;~~
3. ~~Aged, Blind and Disabled (ABD);~~
4. ~~Infants and Children under age 19;~~
5. ~~Former Foster Care Children; and~~
6. ~~Transitional Medical and Post Medical assistance groups in the FFS populations.~~

The HCGP screens these populations 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 HCGP utilizes the current version of the ICD 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, spondylosis, disc displacement, Schmorl's Nodes, disc degeneration, disc disorder with and without myelopathy, postlaminectomy syndrome, cervical disorders;~~

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~~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.~~

~~C. RE ENROLLMENT 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 3803.2G.~~

~~2. A recipient who is disenrolled from the HCGP solely because he or she loses Medicaid eligibility will be re-enrolled with the HCGP once the recipient regains Medicaid eligibility, as long as 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 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 SSA;~~

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

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

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

~~6. Recipients enrolled in an MCO;~~

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

~~8. Recipients receiving emergency Medicaid;~~



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~~8.9. Residents of Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID); and~~

~~10. Recipients newly eligible for Medicaid and Childless Adults according to the Affordable Care Act (ACA).~~

~~E. VOLUNTARILY ENROLLED RECIPIENTS:~~

~~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.~~

~~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 number 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, telephone or face to face contact depending on risk level.~~

~~G. DISENROLLMENT REQUIREMENTS AND LIMITATIONS~~

~~The HCGP abides by all provisions outlined in 42 CFR §438.56 under the authority of 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 telephone, in person or mail;~~

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- ~~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;~~
- ~~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). Refer to Section 3804.~~

~~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;~~~~

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~~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 the determination.~~

### ~~3. DISENROLLMENT DETERMINATIONS~~

~~The DHCFP will determine all disenrollments on a case-by-case basis, except those disenrollment requests by AI/ANs. If a Nevada Medicaid eligible AI/AN elects to disenroll from the HCGP, the disenrollment will commence the first day of the month following the determination.~~

### ~~3803.3 CHANGE IN A RECIPIENT'S STATUS~~

~~The HCGP requires that a recipient report any changes in the recipient's status immediately to the DWSS eligibility worker, including family size and residence. Within seven calendar days of becoming aware of any changes in a recipient's status, the HCGP 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 TRANSITIONING RECIPIENTS INTO CARE MANAGEMENT~~

~~Upon enrolling recipients into the program, the HCGP will:~~

~~A. 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 telephonic assessment and develop a recipient care plan;~~

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- ~~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 TRANSFERRING RECIPIENTS BETWEEN MANAGED CARE/OTHER ENTITIES~~

~~When a recipient transfers from the HCGP to another case management system or managed care program, the HCGP will transfer relevant recipient/patient information, medical records and other pertinent materials. This data includes:~~

- ~~A. Verification with the accepting provider to confirm the transferring of information regarding the recipient to include:
 
  - ~~1. The nature of the recipient's chronic illness;~~
  - ~~2. The nature of care management services received through the HCGP;~~
  - ~~3. The HCGP care manager's name and phone number;~~
  - ~~4. The recipient's Primary Care Physician's (PCP) name and phone number; and~~
  - ~~5. 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;~~~~~~

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- ~~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/or~~
- ~~n. Receiving durable medical equipment or currently using rental equipment.~~

#### ~~3803.6 RECIPIENT SERVICES~~

##### ~~A. CLIENT IDENTIFICATION AND PRIORITIZATION~~

- ~~1. The HCGP maintains a system for prioritizing the target population by risk and level of need to determine how to tailor care intervention.~~
- ~~2. The HCGP uses a predictive modeling algorithm to assign a risk score to prioritize recipients. This methodology includes, but is not limited to, the following:
 
  - ~~a. Diagnostic classification methods that assign primary and secondary chronic conditions to enrollees;~~
  - ~~b. Predictive models that identify recipients at risk for future high utilization, adverse events and/or costs; and~~
  - ~~c. Stratification of recipients that incorporates health risk assessment into predictive modeling to tier recipients into high need categories for intensive/face-to-face intervention.~~~~

##### ~~B. PRIMARY CARE PROVIDER SELECTION~~

- ~~1. The HCGP establishes a source of primary care for all recipients. Upon initial assessment, the HCGP validates the recipient's PCP or facilitates the selection of a PCP if the recipient does not have a routine source of primary care.~~
- ~~2. The HCGP provides recipients who do not have a routine source of primary care information about the importance of establishing a PCP.~~

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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 with whom recipients have previously received services, as evidenced by 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 provide primary care to other family members as appropriate;~~
  - d. ~~Providers who are experienced in treating the chronic condition(s) known by the 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 HCGP sends written confirmation of the recipient PCP selection to the recipient within five business days of verification. The HCGP also provides notice to each PCP, either electronically, telephonically or by mail, within five business days of the HCGP verification of PCP selection. The HCGP informs each PCP about all recipients that have selected the provider as their PCP on at least a monthly basis.~~
5. ~~An enrolled recipient may change a PCP for any reason. The HCGP notifies enrolled recipients of the procedures necessary to notify the HCGP of PCP changes within the 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.~~
6. ~~In cases where the HCGP has been informed that a PCP has been terminated by the DHCFP, the HCGP will notify enrolled recipients in writing of this termination in order to facilitate selection of another PCP within 10 business days of being made aware of PCPs termination.~~

~~C. CARE PLAN DEVELOPMENT~~

~~The HCGP develops a care plan for recipients.~~

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- ~~1. The Health Care Team establishes and maintains a care plan which outlines the recipient's current and expected needs and goals for care, and identifies coordination gaps. The care plan anticipates routine needs and tracks current progress toward recipient goals.~~
- ~~2. The Health Care Team consists of a multi-disciplinary care planning team which, at a minimum, includes:
 
  - ~~a. The recipient and/or the recipient's personal representative, including designated family members and/or legal guardians if recipient is a minor;~~
  - ~~b. A care manager, assigned by the HCGP to the recipient to oversee and coordinate chronic care management activities;~~
  - ~~c. The recipient's identified PCP;~~
  - ~~d. A Nevada licensed psychiatrist, psychologist or a Nevada licensed/certified mental health specialist based on identified recipient needs;~~
  - ~~e. A pharmacist based on identified recipient needs;~~
  - ~~f. A nutritionist based on identified recipient needs; and~~
  - ~~g. Other key clinicians and caregivers identified as necessary to the recipient's care.~~~~
- ~~3. The care plan must document:
 
  - ~~a. The process used for the care plan development and monitoring, including the composition of a multi-disciplinary care planning team. It must 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.~~
  - ~~b. Any maintenance mechanisms for the recipient and/or the recipient's personal representative and care team to be actively involved in and participate fully in decision making regarding the recipient's care. The HCGP follows a patient-centered care model, with the care plans reflecting this approach.~~~~
- ~~4. Appropriate care referrals and scheduling assistance for the recipient, including specialty health care or transportation services.~~
- ~~5. The tracking and monitoring of the referrals and follow-up of the recipient's needs.~~



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- ~~6. The provision of tracking and monitoring of reminders to recipients and the recipient's PCP and/or other treating provider(s).~~
- ~~7. The provision of feedback to the recipient's PCP and/or other treating provider(s) regarding the recipient's adherence to the care plan. This includes medication monitoring in its approach to care plan monitoring and reassessment for all recipients. This also includes any gaps between recommended care and actual care received by the recipient to the recipient's PCP and/or other treating provider(s).~~
- ~~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.~~

~~D. RECIPIENT EDUCATION~~

- ~~1. The 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 HCGP provides health education, health promotion and patient education for all recipients which, at a minimum, shall include, but may not be limited to, the following:
 
  - ~~a. Assistance and education regarding:
 
    - ~~1. Appropriate use of health care services;~~
    - ~~2. Health risk reduction and healthy lifestyle including tobacco cessation;~~
    - ~~3. Use of the HCGP's nurse call services;~~
    - ~~4. Self care and management of health condition, including coaching;~~
    - ~~5. Assistance and education about Early Periodic Diagnostic Screening and Treatment (EPSDT), for recipients under age 21;~~
    - ~~6. Teen pregnancy, maternity care programs and services for pregnant women; and~~
    - ~~7. Any new services the DHCFP implements.~~~~~~



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- ~~3. The HCGP maintains an internet website at which the enrolled recipients can access health information and evidence-based health education.~~
- ~~4. The HCGP provides health education materials in formats easily understood by the recipient.~~

~~E. DISEASE MANAGEMENT INTERVENTIONS~~

- ~~1. The HCGP has programs targeted to recipients with chronic diseases such as cardiac arterial disease, chronic heart failure, chronic obstructive pulmonary disease, diabetes mellitus and asthma.~~
- ~~2. The HCGP uses, to the extent available, Health Information Technology (HIT) and Health Information Exchange (HIE), claims, eligibility and other non-administrative sources of data (like self reported information from recipients) to create information on various gaps in care, such as medication non adherence, screening/testing non compliance and preventive care including physician visits annually for covered chronic conditions.~~
- ~~3. The HCGP coordinates with the recipient and the recipient's PCPs and/or other responsible providers to address these gaps.~~
- ~~4. The HCGP provides health coaching to facilitate behavioral changes by the 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 recipient goals.~~

~~F. CARE MANAGEMENT INTERVENTIONS~~

- ~~1. The HCGP provides a clinical care management intervention program for the escalating acute care needs of recipients with high risks. This nurse intensive intervention is provided over a defined period of time to resolve exacerbation from co-morbid conditions impacting recipient health care issues.~~
- ~~2. This service will be documented in the recipient's care plan and care notes.~~

~~G. COMPLEX CONDITION MANAGEMENT~~

- ~~1. The HCGP provides a program for 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. Recipients are targeted early enough in their disease or condition to improve their health outcomes and reduce or prevent further~~

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~~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.~~

~~a. Oncology Management Program~~

- ~~1. The HCGP provides oncology management program interventions. The HCGP works with identified recipients through a nurse expert in oncology treatment protocol and specialty.~~

~~b. Chronic Kidney Disease Program~~

- ~~1. The HCGP team identifies recipients with Chronic Kidney Disease (CKD) for case management. Case management is expected to delay the need for dialysis or transplant and help to prepare recipients for dialysis therapy in the least costly setting. The 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.~~

~~c. Mental Health Program~~

~~The 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 comorbidity associated with acute and/or chronic conditions.~~
- ~~2. Completion of an initial assessment and provision of follow up management for behavioral issues including depression and other psychiatric problems that hamper recipient's ability to cope with acute and chronic conditions effectively.~~
- ~~3. Enhanced communication between PCPs and behavioral health providers to help ensure that services are coordinated, that duplication is eliminated and that coordination supports primary~~

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~~care-based management of psychiatric medications as medically appropriate.~~

~~4. Measures to ensure the prevention of readmission to hospitals of recipients with a mental health condition.~~

~~5. Measures to ensure that recipients with 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.~~

~~d. Maternity and Neo Natal Program~~

~~1. The State 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 HCGP implements 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 recipients by facilitating access to maternal and child health programs.~~

#### ~~H. NURSE TRIAGE AND NURSE ADVICE CALL SERVICES~~

~~Nurse Advice is a telephonic information service that offers answers to general healthcare questions, providing an opportunity to engage 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 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.~~

~~1. The HCGP provides nurse call services 24 hours/7 days a week, including holidays, through a toll-free number accessible to all recipients enrolled in the program.~~

#### ~~I. CONTINUITY OF CARE TRANSITIONS~~

~~1. The HCGP is responsible for facilitating specific transitions, which occur when information about or accountability for some aspect of a recipient's care is transferred between two or more health care entities. Facilitation of such transitions~~

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~~by the HCGP Health Care Team is achieved through activities designed to ensure timely and complete transmission of information or accountability.~~

- ~~2. The HCGP conducts provider outreach that targets providers from the entire spectrum of medical care, including hospitals, PCPs, pharmacies and specialists to establish relationships and develop referral processes with, but not necessarily limited to, PCPs, discharge planners, facility staff and community agencies.~~
- ~~3. The HCGP Health Care Team coordinates with hospital discharge planning staff, including post-discharge transition services to prevent avoidable re-hospitalization.~~
- ~~4. The 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.~~
- ~~5. The HCGP documents their care transitions programs, including provider outreach, collaboration in discharge planning and processes for encouraging and tracking follow-up PCP visits. The HCGP specifies evidence-based care transition interventions (e.g. Care Transitions Intervention, Transitional Care Model, other) to be used. The HCGP identifies its approach to identifying facilities targeted for outposted staff and specify the degree to which care management staff is outposted.~~

#### ~~J. EMERGENCY DEPARTMENT REDIRECTION MANAGEMENT~~

~~The HCGP redirects recipients who inappropriately use hospital Emergency Departments (EDs) for non-emergent care. The HCGP's management of these recipients includes linking ED users to PCPs, with appropriate follow-up and monitoring access patterns to primary care.~~

- ~~1. The HCGP documents how it provides ED redirection management programs, including:
 
  - ~~a. Criteria for which recipients receive this service;~~
  - ~~b. Targeted communications to recipients after identification of ED visits;~~
  - ~~c. Methods for linking recipients to PCPs for primary care;~~
  - ~~d. Appropriate referral to disease, case or behavioral health management programs; and~~
  - ~~e. How the HCGP's Health Care Team collaborates with various provider types, including PCPs and hospitals' EDs in the provision of these services.~~~~

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~~K. LINKING TO COMMUNITY RESOURCES~~

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

~~1. The HCGP develops and maintains a directory of community resources available to assist recipients. Community resources are services or programs outside the health care system that may support the recipient's health and wellness. The HCGP maintains an approach to linking recipients to community resources, including processes for identifying resources in the community that may benefit 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).~~

~~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.~~

~~3803.7 PROVIDER SERVICES~~

~~A. PROVIDER POLICY AND PROCEDURES~~

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

~~a. The ways (policies/procedures) in which the HCGP Health Care Team impacts providers and requires coordination from them to help coordinate recipient care;~~

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

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

~~d. Ways in which the HCGP has promoted quality improvement and cost-effective recipient service utilization.~~

~~2. The HCGP gives each provider written notice of any significant change, as defined by the DHCFP, in any of the items noted above. The HCGP issues updates to the~~

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~~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~~

- ~~1. The HCGP publishes announcements, notices, newsletters or other information of use to providers. Any announcements, notices or newsletters are published on the HCGP's provider portal website.~~
- ~~2. The HCGP provides a draft copy of all announcements, notices and newsletters to the DHCFP for approval prior to publication and distribution.~~

~~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://dhefp.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 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 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.~~~~

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- ~~2. The HCGP uses designated practice guidelines and protocols mutually agreeable to the HCGP and the DHCFP.~~
- ~~3. The HCGP adopts practice guidelines and protocols which:
 
  - ~~a. Are based on valid and reliable clinical evidence;~~
  - ~~b. Considers the needs of the 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 HCGP's education and training system for providers includes:
 
  - ~~a. Provider education on evaluation and appropriate treatment or referral of mental health issues;~~
  - ~~b. Provider education on Medicaid services authorization request processes;~~
  - ~~c. Provider education on identification and utilization of community resources;~~
  - ~~d. Provider education on scope of benefits, including how to refer people to services covered by other state agencies; and~~
  - ~~e. Provider education on disability, cultural competency and sensitivity training.~~~~
- ~~5. The HCGP maintains tools and resources that will help providers educate clients about self-management and empowerment.~~

~~E. PROVIDER FEEDBACK~~

- ~~1. The HCGP Health Care Team provides feedback to the PCP regarding the recipient's adherence to the care plan developed by the 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.~~



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~~2. The HCGP specifies the degree to which care management staff is outposted at primary care practices to help manage recipient care and the approach and activities used to identify targeted practices and establish outposted staff.~~

### ~~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. 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~~



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~~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;~~

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- ~~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.~~

### ~~3803.9 — OPERATION AND REPORTING REQUIREMENTS~~

#### ~~A. — MANDATORY REPORTS~~

~~The HCGP must provide the DHCFP with uniform utilization, cost, quality assurance and recipient satisfaction 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. — Recipient Stratification Reporting;~~
- ~~2. — Recipient Contact Reporting;~~
- ~~3. — Call Center and Nurse Triage Reporting;~~
- ~~4. — Provider Engagement Reporting;~~
- ~~5. — Summary Recipient Utilization Reporting;~~
- ~~6. — Provider Profiling Report;~~
- ~~7. — Quality Assurance Reporting;~~
- ~~8. — Complaint and Dispute Resolution Reporting;~~
- ~~9. — Satisfaction Reporting;~~
- ~~10. — Fraud and Abuse Reporting;~~
- ~~11. — Disenrollment Reporting;~~
- ~~12. — Non-Compliance Reporting; and~~

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~~13. — Re-Assessment Reporting.~~

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

~~The HCGP operates an MIS capable of maintaining, providing, documenting and retaining information sufficient to operate their care management program and substantiate and report the HCGP's compliance with the current HCGP contract requirements.~~

- ~~1. — The HCGP's MIS is capable of documenting administrative and clinical procedures while maintaining the privacy and confidentiality requirements pursuant to HIPAA. The HCGP provides the DHCFP with aggregate performance and outcome data, as well as providing data to and from participating providers.~~

~~C. — ELIGIBILITY AND CLAIMS DATA~~

- ~~1. — The DHCFP or its fiscal agent exchange eligibility, claims and disenrollment data with the HCGP.~~
- ~~2. — The HCGP uses data maintained in its MIS to determine the care management services appropriate for each enrolled recipient.~~
- ~~3. — The HCGP's MIS system stores service utilization data regarding each recipient/provider and performs analysis on the data that is captured and provides the DHCFP, and when applicable providers, with analysis results.~~

~~D. — RECIPIENT SERVICES AND CONTACT RECORDS~~

- ~~1. — The HCGP maintains an electronic tracking application which tracks each contact made with an enrolled recipient, 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 HCGP's MIS shall identify/capture services provided to each recipient (such as case management, disease management, care coordination, etc.) and transmit and report information to the appropriate parties.~~
- ~~3. — The HCGP's MIS is capable of sharing health information with providers to ensure that all involved parties have a comprehensive picture of a recipient's health status.~~
- ~~4. — The HCGP's MIS generates reports to the DHCFP.~~

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~~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;~~
  - ~~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 pursuant 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.~~

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~~3804 ——— GRIEVANCES, APPEALS AND FAIR HEARINGS~~

~~A. ——— RECIPIENT GRIEVANCES~~

~~The HCGP includes a grievance process. The HCGP provides information about this process to recipients at the time of enrollment and to providers and subcontractors.~~

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

~~1. ——— An HCGP recipient may file a grievance either orally or in writing to the HCGP. If a grievance is filed orally, the HCGP is required to document the contact for tracking purposes and to establish the earliest date of receipt.~~

~~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 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 30 calendar days.~~

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

~~3. ——— An enrolled recipient or their representative (including a provider on behalf of an enrolled recipient) may file a grievance directly with the DHCFP. However, such grievances will be referred to the 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.~~

~~4. ——— In handling grievances, the HCGP will:~~

~~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.~~

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~~d. — Dispose of, and resolve, each grievance within 90 calendar days from the date of receipt of the grievance.~~

~~e. — 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~~

~~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 to the recipient when the DHCFP takes a negative action or makes an adverse determination affecting the recipient, per MSM Chapter 100, Medicaid Program.~~

~~C. — PROVIDER COMPLAINTS AND DISPUTES~~

~~The 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 recipients. The 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 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.~~

~~D. — RECIPIENT RIGHTS~~

~~The vendor maintains policies and procedures regarding 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 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 recipient's condition and ability to understand.~~