MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

October 12, 2010

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3600 – MANAGED CARE ORGANIZATION

## BACKGROUND AND EXPLANATION

The changes to chapter 3600 will allow optional payment method for Obstetrics.

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.

These policy changes are effective October 13, 2010.

| MATERIAL TRANSMITTED | MATERIAL SUPERSEDED |
|---|---|
| MTL 42/10<br>CHAPTER 3600 – MANAGED CARE ORGANIZATION | MTL 37/03, 24/07, 04/09, 25/09, 14/10<br>CHAPTER 3600 – MANAGED CARE ORGANIZATION |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| **3602** | **Definitions** | Removed definition numbering. |
| **3603.5** | **Special Requirements For Selected Covered Services** | Policy was added to allow MCO's to use a negotiated rate for pregnancy related CPT codes.<br><br>Clarification was added to state that under no circumstance will visits not covered by Medicaid or Nevada Check Up be applied toward the minimum number of visits required for a global payment. |
| **3605** | **References and Cross References** | Chapter titles were updated. |

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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MANAGED CARE ORGANIZATION

# 3600 INTRODUCTION

In 1992, the Nevada State Department of Human Resources initiated the development of a fully capitated, risk based managed care program. The capitated, risk-based managed care program was implemented under Section 1915(b) Waiver which established a mandatory managed care program, serving recipients in Clark County and Washoe County. The mandatory program became effective on January 1, 1996 and served eligible recipients in the programs that were then known as "Aid to Families with Dependent Children and related programs as well as the Child Health Assurance Program and other child welfare programs". On April 1, 1997, the voluntary Medicaid Managed Care program was also implemented in Nevada.

Subsequent to the close of the 1997 Nevada Legislature, the U.S. Congress passed the Balanced Budget Act (BBA) of 1997. Under the BBA, states are given the ability to implement managed care programs without a waiver. This generally simplified approval at the federal level. On October 1, 1998, Nevada's managed care program was approved by the Centers for Medicare and Medicaid Services (CMS) which was formerly known as the Health Care Financing Administration (HCFA) as a state plan amendment.

The State of Nevada Division of Health Care Financing and Policy (DHCFP – aka Nevada Medicaid) oversees the administration of all Medicaid MCO's in the state. Nevada Medicaid operates a fee-for-service and a managed care reimbursement and service delivery system with which to provide covered medically necessary services to its eligible population. MCO contracts are comprehensive risk contracts and are paid a risk-based capitated rate for each eligible, enrolled recipient on a Per-Member, Per-Month (PMPM) basis. These capitated rates are certified to be actuarially sound. There is also a formula for stop loss when costs of care exceed a threshold during a specified time period.

The mandatory Managed Care Program is currently available to Medicaid and Nevada Check Up (NCU) recipients in urban Clark and Washoe counties. DHCFP may, at a future date, designate other geographical locations as mandatory managed care areas in accordance with NAC 695C.160.

All MCO's must be in compliance with all applicable Nevada Revised Statutes (NRS), Nevada Administrative Code (NAC), the Code of Federal Regulations (CFR), the United States Code, and the Social Security Act (SSA) which assure program and operational compliance as well as assuring services that are provided to Medicaid and NCU recipients enrolled in an MCO are done so with the same timeliness, amount, duration, and scope as those provided to fee-for-service (FFS) Medicaid and NCU recipients.

Participating MCOs shall provide to enrolled Medicaid and NCU recipients a benefits package covering inpatient and outpatient hospital care, ambulatory care, physician services, a full range of preventive and primary health care services, and such other services as the DHCFP determines to be in the best interests of the State and eligible recipients to include in benefits package. The

MCO is responsible for reimbursing claims of eligible enrollees for services covered under the contract or for services the MCO has prior authorized for each month a capitated payment is made. The Division will continue to provide, on a fee-for-service basis, certain services that are not contained in the MCO contracts or the capitated benefits package.

Currently, Health Maintenance Organizations (HMO) are the only MCO with which the DHCFP contracts. Enrollment in an MCO is mandatory for Temporary Assistance for Needy Families (TANF) (Section 1931) and Child Health Assurance Program (CHAP) (poverty level pregnant women, infants, and children) recipients when there is more than one MCO option from which to choose in a geographic service area. Enrollment in an MCO is mandatory for all NCU recipients when there is at least one MCO option in the recipient's geographic service area. The eligibility and aid code determination functions for the Medicaid applicant and eligible population are the responsibility of the Division of Welfare and Supportive Services (DWSS) whereas the eligibility function for the NCU applicant and eligible population is the responsibility of the DHCFP. The enrollment function is the responsibility of Medicaid Management Information System (MMIS).

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for NCU, with the exception of the four areas where Medicaid and NCU policies differ as documented in the NCU Manual Chapter 1000.

# 3601 AUTHORITY

The rules set forth below are intended to supplement, and not to duplicate, supersede, supplant or replace other requirements that are otherwise generally applicable to Medicaid managed care programs as a matter of federal statute, regulation, or policy, or that are generally applicable to the activities of Managed Care Organizations (MCO) and their providers under applicable laws and regulations. In the event that any rule set forth herein is in conflict with any applicable federal law or regulation, such federal law or regulation shall control. Such other applicable requirements include, but are not limited to:

a. Federal contract and procurement requirements applicable to risk comprehensive contracts with an MCO, as set forth in 42 CFR 438 for MCOs and Primary Care Case Management (PCCM); 42 CFR 434.6 of the general requirements for contracts; 42 CFR 438.6 (c) of the regulations for payments under any risk contracts; 42 CFR 447.362 for payments under any non-risk contracts Section 1903 (m) of the Act, for MCOs and MCO contracts; 45 CFR 74 for procurement of contracts and, Part 2 of the State Medicaid Manual, Center for Medicare and Medicaid Services (CMS) Publication 45-2;

b. Section 1932 (including Section (a)(1)(A)) of the Act, for the State's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities;

c. MCO licensure and financial solvency requirements, as set forth in Title XIX of the Social Security Act, Part 2 of the State Medicaid Manual, CMS Publication 45-2, and the Nevada Revised Statutes (NRS);

d. Independent external quality review requirements, as set forth in Part 2 of the State Medicaid Manual, CMS Publication 45-2, and 42 CFR 438;

e. Restrictions on payments by MCOs of incentives to physicians to restrict or limit services, as set forth in 42 CFR §§ 417.479(d)-(g) and (i) and § 434.70;

f. Composition of enrollment requirements for MCOs, as set forth in 42 CFR 438 and Part 2 of the State Medicaid Manual, CMS Publication 45-2;

g. The requirement that MCOs maintain written policies and procedures with respect to advance directives, as set forth in 42 CFR 438 and Section 1902(w)(1);

h. Requirements for screening, stabilization, and appropriate transfer of persons with an emergency medical condition, as set forth in the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. §1395dd and 42 CFR 438;

i. The requirement that certain entities be excluded from participation, as set forth in §1128 and §1902(p) of the Social Security Act and Part 2 of the State Medicaid Manual, CMS Publication 45-2;

j. The requirement of prior CMS approval for risk comprehensive contracts, as set forth in 42 CFR 438 and Part 2 of the State Medicaid Manual, CMS Publication 45-2;

k. The requirements of access to and reimbursement for federally qualified health center services, as set forth in §4704(b) of the Omnibus Budget Reconciliation Act of 1990 and Part 2 of the State Medicaid Manual, CMS Publication 45-2;

l. Confidentiality and privacy requirements as set forth in 42 CFR Parts 160 and 164;

m. The requirement of freedom of choice for family planning services and supplies, as set forth in 42 CFR 431.51 and as defined in Section 1905 (a)(4)(C) and Part 2 of the State Medicaid Manual, CMS Publication 45-2;

n. The Nevada Title XIX and Title XXI State Plans;

o. The requirements to operate as an HMO/MCO in Nevada as set forth in NRS 695C and 695G;

p. Any other requirements that are imposed as a matter of applicable federal statutes or regulations, or under applicable CMS requirements with respect to Medicaid managed care programs.

These rules are issued pursuant to the provisions of NRS Chapter 422. The Nevada State Department of Health and Human Services (DHHS), acting through the Nevada Division of Health Care Financing and Policy (DHCFP) has been designated as the single state agency responsible for administering the Nevada Medicaid program under delegated federal authority pursuant to 42 CFR 431. Accordingly, to the extent that any other state agency rules are in conflict with these rules, the rules set forth herein shall control.

3602 DEFINITIONS

ACCESS

A recipient's ability to obtain medical care. The ease of access is determined by components such as the availability of medical services and their acceptability to the recipient, the location of health care facilities, transportation, hours of operation and cost of care.

ADMINISTRATIVE COSTS

There are two separate cost components in administrative costs:

a. Non-Medical Administrative Costs: Those costs (both direct and indirect) necessary to administer the Medicaid managed care program.

1. Direct Expenses: Those expenses that can be charged directly as a part of the overall administrative costs; and,

2. Indirect Expenses: Those elements of costs necessary in the performance of administering the program that are of such a nature that the amount applicable to the program cannot be determined accurately or readily (i.e., rent, heat, electrical power, salaries and benefits of management personnel which are allocated to different programs, etc.).

b. Medical Administrative Costs

Costs, either direct or indirect, related to recipient medical care management (i.e., development of physician protocols for disease management, utilization review activities, case management costs, and medical information management systems).

Division of Health Care Financing and Policy (DHCFP) will review Medical Administrative Costs for reasonability and in the context of the benefit received by the client and DHCFP (i.e., is the cost of developing physician protocols for disease management less than or equal to the fiscal and health outcome benefit received).

c. Non-Medical Costs

The following are not considered administrative costs. They are, however, included in the overall percentage of non-medical costs, and will be reviewed for reasonableness by DHCFP:

1. Profit: The percentage of profit which the Contractor anticipates receiving after expenses (net income, revenues less expenses, divided by total revenues received

from DHCFP); and

2. Risk and contingencies: That amount which the Contractor anticipates setting aside (as a percentage of the revenues received) for potential unknown risks and contingencies.

ADMINISTRATIVE CUT-OFF DATE

A date each month selected by DHCFP. Changes made to the Medicaid recipient eligibility system prior to this date are effective the next month and are shown on the recipient's Medicaid card. Changes made to the computer system after this date become effective the first day of the second month after the change was made.

AGE/SEX RATES

A set of rates for a given group product in which there is a separate rate for each grouping of age and sex categories.

APPEAL

A request for review of an action as "action" is defined in 42 CFR 438.

BENEFIT

A service authorized by the plan.

CAPITATION PAYMENT

A payment the State agency makes periodically to a contractor on behalf of each recipient enrolled under a contract for the provision of medical services under the State Plan. The State agency makes the payment regardless of whether the particular recipient receives services during the period covered by the payment.

COLD-CALL MARKETING

Any unsolicited personal contact by the Managed Care Organization (MCO) or contractor with the potential enrollee for the purpose of marketing as defined in this section.

CONTRACT

A legal agreement entered into between DHCFP, based on the Request for Proposals (RFP) and on the MCO's response to the RFP.

CONTRACT PERIOD

The State-certified contract period will be the defined effective and termination dates of the contract inclusive of any renewal period.

CONTRACTOR

Pursuant to the CFRs, an MCO is any entity that contracts with the State agency under the State Plan, in return for a payment to process claims, to provide or pay for medical services, or to enhance the State agency's capability for effective administration of the program. For the purposes of this RFP, a contractor must be a MCO as defined in the Medicaid State Plan which holds a certificate of authority from the Insurance Commissioner for the applicable contract period and throughout the contract period, or has a written opinion from the Insurance Commissioner that such a certificate is not required, who has a risk-basis contract with DHCFP.

DAYS

Refers to calendar days, unless otherwise specified.

DENIED SERVICE

Any medical service requested by a provider for a Medicaid or Nevada Check Up (NCU) recipient for whom the Contractor denies approval for payment.

DENTAL DIRECTOR

The Contractor's director of dental services, who is required to be a Doctor of Dental Science or a Doctor of Medical Dentistry and licensed by the Nevada Board of Dentistry, designated by the Contractor to exercise general supervision over the provision of dental services by the Contractor.

DENTAL RELATED SERVICES

These may include radiology, physician, anesthesiologist, outpatient facility and pharmacy related to a covered medically necessary dental services or procedures.

DENTAL SERVICES

These include covered diagnostic, preventive or corrective services or procedures for treatment of the teeth and associated structures of the oral cavity for disease, injury or impairment that may affect the oral or general health of the recipient up to age 21 years and eligible NCU recipients through their 18$^{th}$ year; and dentures, emergency extractions and Palliative care for 21 years and older. The MCO is responsible for covered dental services as described in Chapter 1000 of the Medicaid Services Manual (MSM).

DISENROLLMENT

Process of terminating individuals or groups from enrollment with a Managed Care Plan. Except where expressly required by federal or state regulations, disenrollment may not occur mid-month. Under most circumstances, requests for disenrollment are effective the first day of the month following receipt of the request, provided that the request is within policy/contract guidelines and is submitted before the administrative cutoff date.

EMERGENCY MEDICAL CONDITION

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

EMERGENCY SERVICES

Emergency services means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a provider qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition. The Contractor must not require the services to be prior or post-authorized.

ENCOUNTER

A covered service or group of services delivered by a provider to a recipient during a visit, or as a result of a visit (e.g., pharmacy) between the recipient and provider.

ENCOUNTER DATA

Data documenting a contact or service delivered to an eligible recipient by a provider for any covered service.

ENROLLEE

A Medicaid or NCU recipient who is enrolled in a managed care program.

ESSENTIAL COMMUNITY PROVIDERS

A healthcare provider that (a) has historically provided services to underserved populations and demonstrates a commitment to serve low-income, underserved populations who make up a significant portion of its patient population or, in the case of a sole community provider, serves

underserved patients within its clinical capability; and (b) waives charges or charges for services on a modified sliding fee scale based on income and does not restrict access or services because of a client's financial limitations.

EXISTING PROVIDER-RECIPIENT RELATIONSHIP

This relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through State records of previous managed care enrollment or fee-for-service experience or through contact with the recipient.

EXTERNAL QUALITY REVIEW ORGANIZATION (EQRO)

An independent entity which performs annual external reviews of the quality of services furnished under State contracts with MCO to render Medicaid services.

GEOGRAPHIC SERVICE AREA

The MCO can elect to offer health care services to recipients residing in any or all towns, cities, and/or counties in Nevada for which the MCO has been certified by the Nevada State Insurance Commissioner. The MCO must meet the requirements of NAC 695C.160.

GRIEVANCE

Any oral or written communications made by an enrollee, or a provider acting on behalf of the enrollee with the enrollee's written consent, to any DHCFP managed care health plan employee or its providers expressing dissatisfaction with any aspect of the Medicaid managed care health plan or provider's operations, activities or behavior, regardless of whether the communication requests any remedial actions.

HEALTH CARE PLAN

An arrangement whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services, and at least part of the arrangement consists of arranging for, or the provision of, health care services paid for by, or on behalf of, the recipient on a periodic prepaid basis (according to NRS 695C.030.4).

HEALTH CARE PROFESSIONAL

A physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified register nurse anesthetist, and certified nurse midwife) licensed clinical social

worker, registered respiratory therapist, and certified respiratory therapy technician. States may, at their sole discretion, expand this list to include other health care professionals.

HEALTH CARE SERVICES

Any services included in the furnishing to any natural person of medical or dental care or hospitalization or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person any other services for the purpose of preventing, alleviating, curing or healing human illness or injury (according to NRS 695C.030.5).

HEALTH MAINTENANCE ORGANIZATION (HMO)

A Health Maintenance Organization, by Nevada Medicaid standards, is an entity that must provide its Medicaid or NCU enrollees inpatient hospital, outpatient hospital, laboratory, x-ray, family planning, physician, dental and home health services. The HMO provides these services for a premium or capitation fee, whether or not the individual enrollee receives services.

HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS)

Health Plan Employer Data and Information Set (HEDIS) consists of a standardized set of measures to assess and continuously improve the performance of managed care organizations and allow comparison of Contractors.

MANAGED CARE

A system of health care delivery that influences utilization and cost of services and measures performance. The goal is a system that delivers value by giving people access to quality, cost–effective health care.

MANAGED HEALTH PLAN

Provides one or more products which:

a. integrate financing and management with delivery of health care services to an enrolled population;

b. employ or contract with an organized provider network which delivers services and (as a network or individual provider) shares financial risk or has some incentive to deliver quality, cost-effective services; and,

c. use an information system capable of monitoring and evaluating patterns of covered persons' uses of medical services and the cost of those services.

MARKETING

Any communication from the MCO, including its employees, affiliated providers, agents or contractors, to a Medicaid or NCU recipient who is not enrolled with the MCO that can reasonably be interpreted as intended to influence the recipient to enroll with the MCO or either not to enroll in or to disenroll from another MCO's plan.

MARKETING MATERIAL

Materials that are produced in any medium by or on behalf of the MCO and can reasonably be interpreted as intended to market to potential enrollees.

MATERNITY KICK PAYMENT (SOBRA)

The Maternity Kick Payment is payment made to an MCO which is intended to reimburse the health plan for costs associated specifically with covered delivery costs and postpartum care.

MEDICAL HOME

Refers to inclusion of a program recipient on the patient panel of a Primary Care Physician and the ability of the recipient to rely on the PCP for access to and coordination of their medical care.

NEVADA HEALTH NETWORK (NHN)

Division of Health Care Financing and Policy's official name for its collective Managed Care Programs.

OUT-OF-NETWORK PROVIDER

These are certain types of providers with whom formal contracts may not be in place with the Contractor. However, the Contractor benefit package includes Medicaid services for which the Contractor will reimburse for specific services. The Contractor must, at a minimum, pay qualified out-of-network providers for family planning, emergency services, out-of-network obstetrical and gynecological providers for recipients within the last trimester of pregnancy, and prior-authorized specialty services rendered to its recipients at the rate paid by DHCFP according the Medicaid fee for service rate schedule.

PERFORMANCE INDICATORS

Performance indicators are preset criteria which involve the recipient or provider and show the outcomes and impact level of Contract performance on specified sets of the population.

PLAN OF CORRECTION (POC)

A detailed written plan describing the actions and/or procedures to remedy deviation from the stated standard(s) or contractual and/or legal mandates.

POST-STABILIZATION SERVICES

Covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.

PREPAID BENEFIT PACKAGE

The set of health care-related services for which plans will be capitated and responsible to provide.

PRIMARY CARE CASE MANAGEMENT (PCCM)

A managed care health delivery system. Primary Care Case Management refers to an alternative health care case management system allowed for State Medicaid programs under the statutory authority provided by section 1915 (a) (1) and 1915 (a) (1) (A) of the Social Security Act. These systems, in general, provide for health care financing and delivery structures, which increase the responsibility of primary care physicians for the overall management of their patient's care, and make the physicians more aware of the financial implications of their health delivery decisions. In establishing this increased responsibility, recipients are restricted to their care manager as long as they are enrolled, except in an emergency, for obtaining primary care and for authorization to receive certain other services.

PRIMARY CARE PROVIDER (PCP)

Physicians who practice general medicine, family medicine, general internal medicine, general pediatrics, or osteopathic medicine. Physicians who practice obstetrics and gynecology may function as PCPs for the duration of the health plan member’s pregnancy.

PRIMARY CARE SITE (PCS)

A location, usually a clinic, where a recipient chooses to access primary health care. The recipient’s medical record is maintained at this location, and a rotating staff of physicians manages and coordinates the recipient’s medical needs.

PRIVATE DUTY NURSING

Nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility.

PROVIDER DISPUTE

A request to the Contractor by any provider who provides services to Medicaid or NCU recipients for the Contractor to review and make a decision to change or uphold a Contractor decision regarding, but not limited to, quality of plan service, policy and procedure issues, denied claims, claim processing time, or other disputes.

QUALITY ASSURANCE (QA)

A formal set of activities to review and affect the quality of services provided. Quality assurance includes quality assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services.

QUALITY IMPROVEMENT

A continuous process that identifies problems in organizational systems, including health care delivery systems which tests solutions to those problems and constantly monitors the solutions for improvement.

REASONABLE PROMPTNESS/TIMELINESS

All service authorization request determinations will be issued within a reasonable promptness by Nevada Medicaid and its contractors. Reasonable promptness means Nevada Medicaid and its contractors will take action to approve, deny, terminate, reduce or suspend service(s) within 14 calendar days from the date the service authorization request is received.

REFERRAL

The recommendation by a physician, dentist and/or Contractor, and in certain instances, the recommendation by a parent, legal guardian and/or authorized representative, for a covered recipient to receive medically necessary care from a different provider.

REINSURANCE

Insurance purchased by a Contractor, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the

process of honoring the claims of its participating providers, policy holders, or employees and covered dependents.

RISK CONTRACT

Means under which the contractor assumes risk for the costs of the services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the contract.

RURAL HEALTH CLINIC (RHC)

Rural Health Clinic (RHC), defined in 42 CFR 491.2, is a clinic that is located in a rural area designated as a shortage area. It is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.

SERVICE AREA

The geographic area served by the Contractor as approved by State regulatory agencies and/or as detailed in the certificate of authority issued by the Nevada State Department of Insurance (DOI).

SERVICE AUTHORIZATION REQUEST (SAR)

A managed care enrollee's request for the provision of a service. The request may be made by the enrollee, a provider, or some other entity or individual acting on behalf of the enrollee. A SAR may be made either in writing or orally.

SERVICE LEVELS

Service levels are various measurable requirements that pertain to the delivery system structure of the contract and are used for evaluating contract performance and compliance.

SPECIAL CHILDREN'S CLINIC (SCC)

Clinics operating to serve children, from birth to their third birthday, providing early intervention services for children with known or suspected developmental delays or disabilities. These clinics receive Title V funding.

SUBCONTRACTOR

Third party not directly employed by the MCO who will provide services identified in the MCO contract.

SUPPLEMENTAL OMNIBUS BUDGET RECONCILIATION ACT OF 1996 (SOBRA)

Legislation of the Omnibus Budget Reconciliation Act (OBRA) of 1986.

TARGETED CASE MANAGEMENT

Targeted case management is a service that refers to the identification of a "target" group for whom case management services will be provided. This targeting may be done by age, type or degree of disability, illness or condition, or another identifiable characteristic or combination thereof. These services are defined as "services which assist an individual, eligible under the plan, in gaining access to needed medical, social, educational and other service." The intent of these services is to allow States to reach beyond the usual bounds of the Medicaid program to coordinate a broad range of activities and services necessary to the optimal functioning of the Medicaid recipient.

URBAN

A geographic area of service in a county having a population of 30,000 or more and has a radius of not more than 25 miles between recipients and the managed care organizations network providers and hospitals.

UTILIZATION

The extent to which the recipients of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. It is usually expressed as the number of services used per year or per 100 or one 1,000 persons eligible for the service.

# 3603 POLICY

## 3603.1 ELIGIBLE GROUPS

A. Mandatory Managed Care Program Recipients:

The State of Nevada Managed Care Program requires the mandatory enrollment of recipients found eligible for Medicaid program coverage under the following Medicaid eligibility categories when there are two or more Managed Care Organizations (MCOs) in the geographic service area:

1. Temporary Assistance for Needy Families (TANF);
2. Two parent TANF;
3. TANF – Related Medical Only;
4. TANF – Post Medical (pursuant to Section 1925 of the Social Security Act (the Act);
5. TANF – Transitional Medical (under Section 1925 of the Act);
6. TANF Related (Sneede vs. Kizer);
7. Child Health Assurance Program (CHAP)
8. Child Health Insurance Program (CHIP); and
9. Aged Out Foster Care (Young adults who have “aged out” of foster care)

B. Mandatory Managed Care Exempt Program Recipients:

The State of Nevada Managed Care Program exempts the following Medicaid program recipients from mandatory enrollment in the managed care program:

1. Recipients who are eligible for Medicare;
2. Children under the age of 19 years, who are eligible for Supplemental Security Income under Title XVI;
3. Children under the age of 19 years who are eligible under section 1902(e)(3) of the Act;

4. Children under the age of 19 years who are foster care or other out-of-the-home placement;

5. Children under the age of 19 years who are receiving foster care or adoption assistance under Title IV-E;

6. TANF and CHAP adults diagnosed as Seriously Mentally Ill (SMI);

7. TANF and CHAP children diagnosed as Severely Emotionally Disturbed (SED); and

8. Recipients with comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any insurance purchased from another organization or agency which cannot be billed by an MCO are exempt from mandatory enrollment.

C. Voluntarily Enrolled Managed Care Program Recipients:

The State of Nevada Managed Care Program allows that although the following Medicaid recipients are exempt from mandatory enrollment, they are allowed to voluntary enroll in a MCO if they choose:

1. Indians who are members of federally recognized tribes 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;

2. Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs (also known as Children with Special Health Care Needs – CSHCN);

3. TANF and CHAP adults diagnosed as SMI; and

4. TANF and CHAP children diagnosed as SED.

## 3603.2 GEOGRAPHIC AREA

The State assures individuals will have a choice of at least two MCOs in each geographic area. When fewer than two MCOs are available for choice in the geographic areas listed, the managed care program will be voluntary.

## 3603.3 COVERED SERVICES

No enrolled recipient shall receive fewer services in the managed care program than they would receive in the current Nevada State Plans, except as contracted or for excluded services noted in Section 3603.4 below.

Any new services added or deleted from the Medicaid benefit package will be analyzed for inclusion or exclusion in the MCO benefit package.

## 3603.4 EXCLUDED SERVICES AND/OR COVERAGE LIMITATIONS

The following services are either excluded as an MCO covered benefit or have coverage limitations. Exclusions and limitations are identified as follows:

a. All services provided at IHS Facilities and Tribal Clinics

Native Americans may access and receive covered medically necessary services at IHS facilities and Tribal Clinics. If a Native American voluntarily enrolls with a MCO and seeks covered services from IHS, the MCO should request and receive medical records regarding those covered services/treatments provided by IHS. If treatment is recommended by IHS and the enrollee seeks the recommended treatment through the MCO, the MCO must either provide the service or must document why the service is not medically necessary. The documentation may be reviewed by Division of Health Care Financing and Policy (DHCFP) or other reviewers. The MCO is required to coordinate all services with IHS. If a Native American recipient elects to disenroll from the MCO, the disenrollment will commence no later than the first day of the second administrative month and the services will then be reimbursed by Fee-For-Service (FFS).

b. Non-emergency transportation

A contracted vendor will authorize and arrange for all medically necessary non-emergency transportation. The MCO must verify medical appointments upon request by DHCFP or their designee.

c. All Nursing Facility stays over 45 days

The MCO is required to cover the first 45 days of a nursing facility admission, pursuant to the Medicaid Services Manual (MSM). The MCO is also required to collect any patient liability (pursuant to 42 CFR 435.725) for each month a capitated payment is received, pursuant to the MSM. The MCO shall notify DHCFP by the 40th day of any nursing facility stay admission expected to exceed 45 days. The enrollee will be disenrolled from the MCO and the stay will be covered by FFS commencing on the 46th day of the facility stay.

d. Swing bed stays in acute hospitals over 45 days

The MCO is required to cover the first 45 days of a swing bed admission pursuant to the MSM. The MCO is also required to collect any patient liability (pursuant to 42 CFR 435.725) for each month a capitated payment is received, pursuant to the MSM. The MCO shall notify DHCFP by the 40th day of any swing bed stay expected to exceed 45 days. The enrollee will be disenrolled from the MCO and the stay will be covered by FFS commencing on the 46th day of the facility stay.

e. School Based Child Health Services (SBCHS)

DHCFP has an agreement with several school districts to provide selected medically necessary covered services through SBCHS to eligible Title XIX Medicaid and Title XXI Nevada Check Up (NCU) recipients.

Eligible Medicaid enrollees, who are three years of age and older, can be referred to a school based child health service for an evaluation by their private physician, school physician, special education teacher, school nurse, school counselor, parent or guardian, or social worker. If the child is found eligible for these services, then an Individual Education Plan (IEP) is developed for the child. The IEP specifies services needed for the child to meet educational goals. A copy of the IEP will be sent to the child's Primary Care Physician (PCP) within the managed health care plan, and maintained in the enrollee's medical record.

The school districts provide, through school district employees or contract personnel, the majority of specified medically necessary covered services. Medicaid reimburses the school districts for these services in accordance with the school district contract. The MCO will provide covered medically necessary services beyond those available through school districts, or document why the services are not medically necessary. The documentation may be reviewed by DHCFP or its designees. Title XIX Medicaid and Title XXI NCU eligible children are not limited to receiving health services through the school districts. Services may be obtained through the MCO rather than the school district, if requested by the parent/legal guardian. The MCO case manager shall coordinate with the school district in obtaining any services which are not covered by the plan or the school district.

f. Intermediate Care Facility for the Mentally Retarded (ICF/MR)

Residents of ICF/MR facilities are not eligible for enrollment with the MCO. If a recipient is admitted to an ICF/MR after MCO enrollment, the recipient will be disenrolled from the MCO and the admission, bed day rate, and ancillary services will be reimbursed through FFS.

g. Residential Treatment Center (RTC) Limitations

It is the MCO's responsibility to provide reimbursement for all ancillary services (i.e., physician services, optometry, laboratory, dental and x-ray services, etc.) for enrollees under the Title XXI, NCU. These enrollees will remain enrolled with the MCO throughout their RTC stay. The RTC bed day rate will be covered by FFS for NCU enrollees.

Enrollees who are covered under Title XIX Medicaid will be disenrolled from the MCO in the month following the RTC admission. The RTC admission, bed day rate, and ancillary services will be reimbursed through FFS thereafter for Title XIX Medicaid recipients.

h. Hospice

Recipients who are receiving Hospice Services are not eligible for enrollment with the MCO. Once admitted into hospice care, Medicaid and NCU members will be disenrolled immediately.

i. Institutions for Mental Diseases (IMDs)

Federal regulations stipulate that Medicaid can only reimburse for services to IMD/psychiatric hospital patients who are 65 years of age or older or under the age of 21 years. Residents of IMD facilities who are 21 years of age through 64 years of age are not eligible for enrollment with the MCO. If a recipient is admitted to an IMD after MCO enrollment, the recipient will be disenrolled.

j. Adult Day Health Care

Recipients who are receiving Adult Day Health Care (Provider Type 39) services are not eligible for enrollment with the MCO. If a recipient is made eligible for Adult Day Health Care after MCO enrollment, the recipient will be disenrolled and the Adult Day Health Care will be reimbursed through FFS.

k. Home and Community Based Waiver (HCBW) Services

Recipients who are receiving HCBW Services are not eligible for enrollment with the MCO. If a recipient is made eligible for HCBW Services after MCO enrollment, the recipient will be disenrolled and the HCBW Services will be reimbursed through FFS.

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

Conducting a PASRR and LOC will not prompt MCO disenrollment, however, if the recipient is admitted to a nursing facility as the result of a PASRR and LOC, the MCO is responsible for the first 45 days of admission (see #C above).

m. SED/SMI

The MCO must ensure enrollees who are referred for evaluation for SED/SMI or who have been determined SED/SMI by the health plan are obtaining the medically necessary evaluations and that enrollees are transitioned, as necessary, to another provider in order to obtain their mental health services if such services are not available within the network. The MCO is required to notify DHCFP if a Title XIX Medicaid recipient elects to disenroll from the MCO following the determination of SED/SMI and forward the enrollee's medical records to the provider from whom the enrollee will receive the covered mental health services. However, in the event the Medicaid enrollee who has received such a determination chooses to remain enrolled with the MCO, the MCO will be responsible for providing all patient care.

The MCO is required to adhere to MSM Chapter 400 and 2500 for all SED and SMI referrals and determinations and must reimburse providers of these services pursuant to the referenced MSM Chapters. Such services include, but are not limited to: case management; lab work; prescription drugs; acute in-patient; and, other ancillary medical and mental health services required by the plan of treatment. Title XIX Medicaid eligible recipients have the option of disenrolling from the MCO, if determined to be SED or SMI. Title XXI, NCU recipients must remain enrolled with the MCO who is responsible for on-going patient care. If a Title XIX eligible recipient elects to disenroll from the MCO following a determination of SED or SMI, the disenrollment will commence no later than the first day of the second administrative month and the services will then be reimbursed by FFS.

## 3603.5 SPECIAL REQUIREMENTS FOR SELECTED COVERED SERVICES

A. Out-of-Network Providers

When it is necessary for enrolled recipients to obtain services from out-of-network providers (e.g., the enrollee needs to see a specialist for which the MCO has no such specialist in its network) the MCO must:

1. Coordinate with out-of-network providers with respect to payment;

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

3. Negotiate a contract to determine the rate prior to services being rendered.

B. Emergency Services

The MCO must cover and pay for emergency services regardless of whether the provider who furnished the services has a contract with the MCO. The MCO must pay the out-of-network provider for emergency services applying the "prudent layperson" definition of an emergency, rendered at a rate limited to the amount that would have been paid if the service had been provided under the state's FFS Medicaid program, unless a lower amount is mutually agreed to between the MCO and the party(ies) rendering service. Pursuant to 1932 (b)(2)(D) of the Social Security Act, a non-contracting provider of emergency services must accept as payment in full no more than it would receive if the services were provided under the state's FFS Medicaid program. This rule applies whether the non-contracting provider is within the State or outside of the State in which the managed care entity has a contract.

No prior or post-authorization can be required for emergency care provided by network or out-of-network providers. The MCO may not deny payment for treatment obtained when the enrollee has an emergency medical condition and seeks emergency services, applying the "prudent layperson" definition of an emergency; this includes the prohibition against denying payment in those instances in which the absence of immediate medical attention would not have resulted in placing the health of the enrollee in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily part or organ. The MCO may not deny payment for emergency services treatment when a representative of the MCO instructs the enrollee to seek emergency services care.

Pursuant to 42 CFR 438.114, the MCO may not limit what constitutes an emergency medical condition as defined in this section on the basis of lists of diagnoses or symptoms nor refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's PCP, MCO, or the DHCFP of the enrollee's screening and treatment within ten calendar days of the presentation for emergency services.

An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. The attending physician or the provider actually treating the enrollee is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge and that determination is binding on the MCO.

C. Post-Stabilization Services

The MCO is financially responsible for:

1. Post-stabilization services obtained within or outside the network that are pre-approved by a network provider or MCO representative;

2. Post-stabilization services obtained within or outside the network that are not pre-approved by a network provider or other organization representative, but administered to maintain the enrollee's stabilized condition within one hour of a request to the MCO for pre-approval of further post-stabilization care services;

3. Post-stabilization care services obtained within or outside the network that are not pre-approved by a network provider or other MCO representative but administered to maintain, improve, or resolve the enrollee's stabilized condition if the MCO does not respond to a request for pre-approval within one hour or the MCO cannot be contacted or the MCO and the treating physician cannot reach an agreement concerning the enrollee's care and a network provider or other organization representative is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the enrollee until a network physician is reached or one of the criteria in 42 CFR 422.113(c)(3) is met.

   Pursuant to 42 CFR 422.113(c)(3), the MCO's financial responsibility for post-stabilization care it has not pre-approved ends when a network physician with privileges at the treating hospital assumes responsibility for the enrollee's care or a network physician assumes responsibility for the enrollee's care through transfer or the MCO and the treating physician reach an agreement concerning the enrollee's care or the enrollee is discharged.

D. Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC)

The MCO must pay for services provided by a FQHC or a RHC. MCOs may enter into contracts with FQHCs or RHCs, provided that payments must be at least equal to the amount paid other providers for similar services and no lower than the Medicaid FFS rates. If the MCO does not have a contract with an FQHC or RHC, the MCO must pay at a rate equivalent to that paid by the DHCFP FFS rate schedule. This does not apply to out of network providers of emergency services. See Section 3603.5.b. The MCO must make a good faith effort to negotiate a contract with these providers. The MCO must report to DHCFP payments and visits made to FQHCs and/or RHCs.

E. Out-Of-State Providers

When it is necessary for recipients to obtain services from an Out-Of-State (OOS) provider, the MCO must negotiate a contract to determine the rate prior to services being rendered. The MCO must inform the provider to accept the MCO's reimbursement as payment in full. The only exception is for Third-Party Liability (TPL). The provider must not bill, accept or retain payments from Medicaid or NCU recipients. Out-of-state providers of emergency services must accept as payment in full no more than it would

receive if the services were provided under the State's FFS Medicaid program, pursuant to 1932(b)(2)(D) of the Social Security Act.

F. Obstetrical/GYN Services

1. Care Coordination for Certain Pregnant Women

The MCO is responsible for the identification and medical management of women identified as having a risk of preterm birth or poor pregnancy outcome.

A pregnancy is defined as "high risk" when there is a likelihood of an adverse outcome to the woman and/or her baby that is greater than the incidence of that outcome in the general pregnant population.

It is the responsibility of the MCO to assess the risk status of all enrolled pregnant women.

Subsequently, the MCO is responsible for providing medical case management to all enrolled women who have been identified as having a high risk pregnancy.

The MCO is also responsible for referring enrolled pregnant women identified with specified social needs to the DHCFP District Office (DO) care coordination staff. The primary social needs are hunger, homelessness and domestic violence issues. The DO care coordination staff is available to provide information to the enrollee regarding available community support programs and limited case management to enrollees identified as experiencing any of the specified high risk social issues. The MCO is responsible to promote coordination and communication between the DO care coordination staff and the MCO's case managers. DHCFP will verify that appropriate coordination and communication by the MCO case managers/staff with DO care coordination staff is occurring and that such coordination and communication is effective in intervening on behalf of these enrollees.

2. Obstetrical Global Payment

Global obstetrical payments are not mandatory for MCO. MCOs may either pay using the global rate or a negotiated rate for pregnancy related CPT codes. If a global model is used, the following will apply:

Length of time that the pregnant woman is enrolled in the health plan is not a determining factor in payment to the obstetrician. Payment to the delivering obstetrician for a normal routine pregnancy shall be based upon the services and number of visits provided by the obstetrician to the pregnant woman through the

course of her pregnancy. Payments are determined by CPT codes submitted by the provider. The MCO must provide separate payment for covered medically necessary services required as a result of a non-routine pregnancy.

A Global Payment will be paid to the delivering obstetrician, regardless of network affiliation, when the enrollee has been seen seven or more times. If the obstetrician has seen the enrollee less than seven times, the obstetrician will be paid according to the Medicaid FFS visit-by-visit schedule.

a. Network Providers

For all cases, the MCO must have policies and procedures in place for transitioning the Medicaid or NCU eligible pregnant recipient to a network provider. A network obstetrician will be reimbursed by the MCO at the full FFS rates for obstetrical services.

b. Non-network Providers

The MCO may reimburse a non-network provider at a negotiated rate less than the FFS rates established for pregnancy-related CPT codes.

c. New Enrollees within the Last Trimester of Pregnancy

A pregnant woman who is enrolled with the MCO within the last trimester of pregnancy must be allowed to remain in the care of a non-network provider, if she so chooses. The MCO must have policies and procedures for this allowance.

d. Prior Authorization

The MCO's prior authorization policies and procedures must be consistent with the provision of prenatal care in accordance with community standards of practice. DHCFP, at its discretion, may require removal of the prior authorization requirement for various procedures based on reported approval data and any other relevant information. The MCO is required to provide written notification to all affected network providers within 30 days of end of reported quarter regarding the elimination of the prior authorization requirement.

Under no circumstance will visits not covered by Medicaid or NCU be applied toward the minimum number of visits required for a global payment.

3. Certified Nurse Midwife Services

The MCO must make certified nurse midwife services available to enrollees, if such services are available in the MCO's service area. If the MCO does not have a contract for said services, the MCO must pay the certified nurse midwife provider according to the Medicaid FFS schedule for services rendered to the recipient.

4. Maternity Kick Payment (aka SOBRA payment)

The MCO will receive a maternity kick payment from the DHCFP to cover the maternity costs of any birth, still born, or miscarriage occurring in the third trimester of pregnancy for which an obstetrical payment has been made. The third trimester commences at 27 weeks of gestation. Maternity kick payments will be generated upon submission of encounter data confirming the delivery.

The maternity kick payment is intended to reimburse the health plans for costs associated specifically with covered delivery and postpartum care. Antepartum care is included in the capitation rate paid for the mother. Costs of care for the newborn are included in the capitation rate.

5. Family Planning Services

Federal regulations grant the right to any enrollee of child-bearing age to receive family planning services from any qualified provider, even if the provider is not part of the MCO’s provider network. The MCO may not require family planning services to be prior authorized. Family planning services are provided to enrollees who want to control family size or prevent unwanted pregnancies. Family planning services may include education, counseling, physical examinations, birth control devices, supplies and Norplant.

Pursuant to MSM Chapter 600, tubal ligations and vasectomies are a covered benefit for recipients 21 years of age or older. Tubal ligations and vasectomies to permanently prevent conception are not covered for any recipient under the age of 21 or any recipient who is adjudged mentally incompetent or is institutionalized.

The MCO must, at a minimum, pay qualified out-of-network providers for family planning services rendered to its enrollees at the FFS rate paid by DHCFP. The MCO will be responsible for coordinating and documenting out-of-network family planning services provided to its recipients and the amounts paid for such services.

6. Coordination of Care

Pursuant to 42 CFR 438.208(b)(2, 3, and 4) the MCO is required to implement procedures to coordinate services it may provide to the enrollee with the services the enrollee may receive from any other MCO and implement procedures to share with other MCO serving the enrollee the results of its identification and assessment of any CSHCN to ensure services are not duplicated. The MCO must implement procedures to ensure that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR 160 and 164. The MCO case managers will be responsible for coordinating services with appropriate non-Medicaid programs. This coordination includes referral of potentially eligible enrollees, including women with high risk pregnancies, to appropriate community resources and social service programs.

## 3603.6 ADDITIONAL PREVENTIVE SERVICES

The MCO is encouraged to offer additional preventive or cost-effective services to enrolled recipients, if the services do not increase the cost to the State.

## 3603.7 DENTAL SERVICES

Dental services are included in the MCO benefit package in geographic areas designated as mandatory managed care areas. The MCO will be responsible for all covered medically necessary dental services pursuant to MSM Chapter 1000 and the State Plan, Section 3.1-A.

## 3603.8 PRIVATE DUTY NURSING

Private duty nursing services are included in the MCO package for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided:

a. by a registered nurse or a licensed practical nurse;

b. under the directions of the recipient's physician; and

c. at the State's option, to a recipient in one or more of the following locations:

1. his or her own home;

2. a hospital; or

3. a nursing facility.

For additional information, reference MSM Chapter 900.

## 3603.9 PHARMACY SERVICES

Pharmacy services are included in the MCO benefit package. The MCO may design its own pharmacy formulary based on clinical guidelines. Medications not covered in the MCO's formulary must be available through a non-formulary request process based on physician certification and justification of medical necessity. Pharmacy coverage benefits are based on the State Plan.

The MCO may use generic substitutions unless the physician/dentist justifies the medical necessity of the brand name pharmaceutical.

The MCO must have a policy for transitioning a recipient's prescriptions from FFS, or another MCO, to the MCO. The MCO will not be allowed to terminate a current prescription without first conducting a medical examination of the recipient. The MCO then must document why a drug is not medically necessary, if a current prescription is terminated.

The DHCFP shall approve the MCO's formulary prior to implementation. The MSM Chapter 1200 stipulates the conditions with which a prescriber must comply to certify that a specific brand of medication is medically necessary for a particular patient. The physician should document in the patient's medical record the need for the brand name product in place of the generic form. The procedure of the certification must comply with the following: certification must be in the physician's own handwriting; and, certification must be written directly on the prescription blank and a phrase indicating the need for a specific brand is required (an example would be "Brand Medically Necessary"). Substitution of generic drugs prescribed by brand name must also comply with NRS 639.2583.

## 3603.10 CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) AND MENTAL HEALTH SERVICES FOR ADULTS

The MCO benefit package includes certain services for CSHCN and mental health services for adults for which the MCO must reimburse certain types of providers with whom formal contracts may not be in place and coordinate these services with other services in the MCO benefit package.

The MCO must implement mechanisms to assess each enrollee, identified to the MCO as an individual with special health care needs, in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.

The MCO must produce a treatment plan for enrollees with special health care needs who are determined through an assessment to need a course of treatment or regular care monitoring. The treatment plan must be:

a. Developed by the enrollee's primary care provider (PCP) with enrollee participation, and in consultation with any specialists caring for the enrollee;

b. Approved by the MCO in a timely manner, if approval is required by the MCO; and,

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

For children with special health care needs who are determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow these enrollees access to a specialist, through a standing referral or an approved number of visits, as appropriate for the enrollee's condition and identified needs.

The MCO is required to adhere to MSM 400 and 2500 for all SED and SMI referrals and determinations and must reimburse providers of these services pursuant to the referenced MSM Chapters. Title XIX Medicaid eligible recipients have the option of disenrolling from the MCO, if determined to be SED or SMI. Title XXI NCU recipients must remain enrolled with the MCO who is responsible for ongoing patient care.

## 3603.11 TRANSPLANTATION OF ORGANS AND TISSUE, AND RELATED IMMUNO SUPPRESSANT DRUGS

These services are covered, with limitations, when medically necessary. Coverage limitations for these services are defined in the Title XIX State Plan. DHCFP via its Title XIX State Plan Attachment 3.1.E covers corneal, kidney, liver and bone marrow transplants and associated fees for adults. For children up to age 21 any medically necessary transplant that is not experimental will be covered. The health plan may claim transplant case reimbursement from DHCFP for in-patient medical expenses above the threshold of $100,000 in a one-year period (State Fiscal Year). 75% of the expenses above $100,000 are reimbursed to the health plan.

At the discretion of DHCFP administration, an enrollee may be assigned to another MCO at any time and DHCFP may reimburse the MCO for claims and waive stop loss. DHCFP may also assign an otherwise FFS child to the MCO for care management. The MCO will be expected to administer these fee for service payments with no added markup.

3603.12 TARGETED CASE MANAGEMENT (TCM)

TCM has a specific meaning for Nevada Medicaid and NCU. TCM, as defined by MSM, Chapter 2500, is carved out of the managed care contracts. Case management, which differs from TCM, is required from the contracted MCO.

3603.13 IMMUNIZATIONS

The MCO shall require its network providers to enroll in the Vaccines for Children Program (VFC) which is administered by the Nevada State Health Division. Providers licensed by the state to prescribe vaccines may request to be enrolled in the Nevada State Health Division's VFC Program. The immunization program will review and approve provider enrollment requests. The MCO shall require VFC enrolled providers to cooperate with the Nevada State Health Division for purposes of performing orientation and monitoring activities regarding VFC Program requirements.

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

The MCOs shall require VFC enrolled network providers to participate in the Nevada State Health Division's Immunization Registry to ensure the DHCFP's goal to fully immunize children up to the age of two years. The MCO shall provide appropriate technical support in instances where the provider does not have the capability to meet these requirements. The MCO must work within the Health Division to interface directly with the Immunization Registry.

3603.14 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

The MCO is required to conduct Early Periodic Screening Diagnostic and Treatment (EPSDT) screenings of its enrolled recipients under the age of 21 years. The screening must meet the EPSDT requirements found in the MSM as well as 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Social Security Act, and 42 CFR 441.50 through 441.62. The MCO must conduct all interperiodic screening on behalf of eligible enrolled recipients, as defined in the MSM.

Medically necessary screening, diagnostic and treatment services identified in an EPSDT periodic or interperiodic screening must be provided to eligible children under the age of 21 years if the service is listed in 42 U.S.C. § 1396 d(a). The MCO is responsible for reimbursement of all medically necessary services under EPSDT whether or not the service is in the State Plan. The MCO is responsible for the oral examination component of the EPSDT physical exam and referral to a dental provider, as per the dental periodicity schedule or when medically necessary. The MCO is responsible for the coordination of care in order to ensure all medically necessary coverage is being provided under EPSDT.

The services which need to be provided through the MCO include, but are not limited to the following in accordance with 1905(r) of the Social Security Act and the MSM:

a. Screening services which include a comprehensive health and developmental history (including assessment of both physical and mental health development);

b. A comprehensive, unclothed physical exam;

c. Age appropriate immunizations (according to current American Committee On Immunization Practices – ACIP - schedule);

d. Laboratory tests (including blood lead level assessment appropriate to age and risk as directed by current federal requirements);

e. Health education;

f. Vision services;

g. Dental services;

h. Hearing services; and,

i. Such other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Medicaid Plan.

The MCO is not required to provide any items or services which are determined to be unsafe or ineffective, or which are considered experimental. Appropriate limits may be placed on EPSDT services based on medical necessity.

The MCO is required to provide information and perform outreach activities to eligible enrolled children for EPSDT services. These efforts may be reviewed and audited by DHCFP or its designee.

## 3603.15 ENROLLMENT AND DISENROLLMENT REQUIREMENTS AND LIMITATIONS

The eligibility and enrollment functions are the responsibility of DHCFP and the Division of Welfare and Supportive Services (DWSS). The MCO shall accept each recipient who is enrolled in or assigned to the MCO by DHCFP and/or its enrollment sections. The first date a Medicaid or NCU eligible recipient will be enrolled is not earlier than the applicable date in the MCO's specified contract.

The MCO must accept recipients eligible for enrollment in the order in which they apply without restriction, up to the limits set under the contract. The MCO acknowledges that enrollment is mandatory except in the case of voluntary enrollment programs that meet the conditions set forth in 42 CFR 438.50(a). The MCO will not, on the basis of health status or need for health services, discriminate against recipients eligible to enroll. The MCO will not deny the enrollment nor discriminate against any Medicaid or NCU recipients eligible to enroll on the basis of race, color or national origin and will not use any policy or practice that has the effect of discrimination on the basis of race, color or national origin. If the recipient was previously disenrolled from the MCO as the result of a grievance filed by the MCO, the recipient will not be re-enrolled with the MCO unless the recipient wins an appeal of the disenrollment. The recipient may be enrolled with another MCO.

The MCO is not financially responsible for any services rendered during a period of retroactive eligibility. However, as described in Section 3603.14 (B)(1) herein, the MCO is responsible for Medicaid newborns as of the date of birth. The MCO is responsible for NCU newborns pursuant to Section 3603.14 (B)(2) of this chapter.

The MCO must notify a recipient that any change in status, including family size and residence, must be immediately reported by the recipient to the DWSS eligibility worker. The MCO must provide DHCFP with weekly electronic notification of all births and deaths.

a. Enrollment of Pregnant Women

The eligibility of Medicaid applicants is determined by the DWSS. DWSS notifies the state's fiscal agent who enrolls the applicant. Letters are sent to the new recipients requiring them to select an MCO or an MCO will be automatically assigned. The MCO will be notified of the pregnant woman's choice by the State's fiscal agent. The MCO shall be responsible for all covered medically necessary obstetrical services and pregnancy related care commencing on the date of enrollment.

b. Enrollment of Program Newborns

The MCO must have written policies and procedures for newborns of enrolled recipients. The MCO is required to electronically report births on a weekly basis to the DHCFP via the Provider Supplied Data file located on the File Transfer Protocol (FTP). The MCO will be responsible for all covered medically necessary services included in the MCO benefit package to the qualified newborn.

Enrollment requirements for program newborns are as follows:

1. Medicaid Eligible Newborns

   All Title XIX Medicaid eligible newborns born to enrolled recipients are enrolled effective the date of birth if the mother of the newborn was enrolled with the MCO as of the newborn's date of birth.

2. NCU Newborns

   The head of household/mother must notify the MCO and NCU of the pregnancy prior to and within 14 days following the delivery in order to qualify to receive coverage from the date of birth. For all qualified newborns, the MCO shall receive a capitation payment for the month of birth and for all subsequent months that the child remains enrolled with the MCO. If notification is not received as required herein, the newborn will be enrolled as of the first day of the next administrative month from the date of notification.

   If the MCO receives notification of a pregnancy or a birth, they must provide a weekly electronic report to the DHCFP. The report must contain the following information for reporting a pregnancy:

   a. Mother's Name;

   b. Estimated Date of Confinement (EDC); and,

   c. Family ID Number or Mother's Billing Number.

   If reporting a birth, the transfer file must contain the following information:

   d. Mother's Name;

   e. Child's (newborn's) Name;

   f. Family ID Number or Mother's billing Number;

   g. Child's Date of Birth;

   h. Sex;

   i. Ethnicity;

   j. Social Security Number of Child (if available); and

k. Any changes in resident address and/or telephone number.

If the mother has other health insurance coverage that provides for 30 days of coverage of the newborn and she has other children enrolled in the NCU program, the newborn will be enrolled in the MCO as of the first day of the next administrative month.

3. Auto Assignment Process

For Medicaid recipients who do not select a MCO, DHCFP will assign the recipient to an MCO based upon federally required enrollment default criteria that include:

a. The maintenance of existing provider individual relationships or relationships with traditional Medicaid providers; and,

b. Distributing the recipients among the contracted MCOs based upon an algorithm developed by DHCFP when maintaining such relationships is not possible.

4. Automatic Re-enrollment

A recipient who has been disenrolled solely because he or she loses Medicaid or NCU eligibility for a period of two months or less will be auto-assigned to their last known MCO once they are redetermined eligible before or in the third month.

5. Disenrollment Requirements and Limitations

a. Disenrollment at the Request of the Enrollee

An enrollee may request disenrollment from the MCO without cause at any time during the first 90 days of enrollment. The enrollee is required to notify the DHCFP fiscal agent by mail of his/her decision to disenroll and, if he/she is a mandatory recipient, must select another MCO. The effective date of change in the MCO will be based on the monthly administrative cutoff date but not later than the first day of the second month following the month in which the enrollee makes the request to disenroll. After the first 90 days of enrollment, the enrollee will be locked into an MCO for the remainder of the current open enrollment period. There will be one open enrollment period annually. If the enrollee wishes to disenroll at any time during the lock-in period, they must contact the appropriate MCO and provide good cause for doing so. The MCO will determine if it is good cause as defined in 42 CFR 438.56.

NCU enrollees may request disenrollment from the MCO without cause during the first 90 days of enrollment and are required to contact the NCU office if they request disenrollment from the MCO and if he/she is a mandatory recipient, must select another MCO. After the first 90 days of enrollment, the enrollee will be locked into an MCO for the remainder of the current open enrollment period. There will be one open enrollment period annually. If the enrollee wishes to disenroll at any time during the 12 month lock-in period, they must contact the appropriate MCO and provide good cause for doing so. The MCO will determine if it is good cause using the same criteria as for Medicaid.

b. Disenrollment at the Request of the MCO

The MCO may request disenrollment of a recipient if the recipient has been seen by at least three of the MCO's PCPs and each PCP provides a written statement to DHCFP confirming their inability to treat the enrollee due to the enrollee's serious behavioral non-compliance or disruptive behavior. In addition, the MCO must confirm the enrollee has been referred to the MCO'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. The MCO may also request disenrollment of an enrollee if the MCO can provide documentation the enrollee has, on at least three separate occasions, demonstrated serious behavioral non-compliance or disruptive behavior toward the MCO's or subcontractor's staff. Prior approval by DHCFP of a MCO's request for the enrollee's disenrollment is required. If approval is granted, the enrollee will be given notice by the MCO that disenrollment will occur effective the first day of the next month following administrative cut off.

The MCO may request disenrollment of an enrollee for a combination of PCP and MCO serious, behavioral non-compliance or disruptive behavior by an enrollee for a total of at least three separate instances. The same documentation and procedure applies as in the separate PCP or MCO instances. Prior approval of these disenrollments by DHCFP is required.

DHCFP reserves the right to review and act upon an MCO's request for disenrollment without the recipient exhibiting the serious, behavioral non-compliance or disruptive behavior three times. DHCFP will make a determination on such a request within five days. If approval is granted, the enrollee will be given notice by the MCO that disenrollment will occur effective the first day of the next month following administrative cut off.

An MCO may not request disenrollment of an enrollee for any of the following reasons:

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

2. Pre-existing medical condition;

3. The enrollee'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 an enrollee seriously impairs the MCO's ability to furnish services to either this particular enrollee or other enrollees);

6. An enrollee's attempt to exercise his/her grievance or appeal rights; or,

7. Based on the enrollee's national origin, creed, color, sex, religion, age, pursuant to Section 2.2 of the DHCFP Managed Care contract and applicable CFRs.

Pursuant to 42 CFR 438.56(b)(3) in those circumstances in which the MCO requests disenrollment of an enrollee, the MCO must provide the DHCFP with written assurances that it is not requesting disenrollment for any reason(s) other than those permitted under the DHCFP Managed Care contract.

c. Disenrollment Pursuant to a finding of SED or SMI Status:

See Section 3603.4 (m) of this MSM.

6. Enrollment, Disenrollment and Other Updates

The MCO must have written policies and procedures for receiving monthly updates from DHCFP of recipients enrolled in, and disenrolled from, the MCO, and other updates pertaining to these recipients. The updates will include those newly enrolled with the MCO. The MCO must incorporate these updates into its management information system.

7. Enrollment Interface

Upon initiation of the implementation process, the MCO must furnish the technical means by which the DHCFP Enrollment Sections can:

a. Determine the number of recipients each enrolled PCP will accept as new patients; and,

b. Transmit beneficiary elections regarding PCP assignment for the forthcoming month.

8. Provider Enrollment Roster Notification

The MCO must establish and implement a mechanism to inform each PCP about any newly MCO enrolled recipients assigned to the PCP on at least a monthly basis. Written or electronic notice to each PCP regarding patient rosters effective for each month must be provided to the provider within five business days of the MCO receiving the recipient file from the enrollment sections. The enrollment sections will pass the membership file through the system for verification of eligibility prior to distribution to the MCO, who will in turn be responsible for keeping individual participating providers informed. The MCO may elect to update its membership file more frequently to keep PCPs informed of the enrollment activity, but this must be done with the understanding that only the membership file that has been confirmed through the DHCFP eligibility system is the accurate version.

## 3603.16 CHANGE IN A RECIPIENT'S STATUS

Within seven calendar days of becoming aware of any changes in a recipient's status, including changes in family size and residence, the MCO must electronically report the change(s) to DHCFP.

## 3603.17 TRANSITIONING/TRANSFERRING OF RECIPIENTS

A. Transitioning Recipients into MCOs

The MCO will be responsible for recipients as soon as they are enrolled and the MCO is aware of the enrollee in treatment. The MCO must have policies and procedures for transitioning recipients currently receiving services in the FFS program into the MCO’s plan.

The MCO must have policies and procedures including, without limitation, the following to ensure a recipient's smooth transition from FFS to the MCO:

1. Recipients with medical conditions such as:

   a. Pregnancy (especially if high risk);

   b. Major organ or tissue transplantation services in process

   c. Chronic illness;

   d. Terminal illness; and/or,

   e. Intractable pain.

2. Recipients who, at the time of enrollment, are receiving:

   a. Chemotherapy and/or radiation therapy;

   b. Significant outpatient treatment or dialysis;

   c. Prescription medications or durable medical equipment (DME); and/or,

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

3. 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,

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

B. Transferring Recipients Between MCOs

It may be necessary to transfer a recipient from one MCO to another or to FFS for a variety of reasons. When notified by DHCFP that an enrollee has been transferred to another plan or to FFS, the MCO must have written policies and procedures for

transferring/receiving relevant patient information, medical records and other pertinent materials to the other plan or current FFS provider. Prior to transferring a recipient, the MCO (via their subcontractors when requested by the MCO) must send the receiving plan or provider information regarding the recipient's condition. This information shall include, without limitation, whether the recipient is:

1. Hospitalized;

2. Pregnant;

3. Receiving dialysis;

4. Chronically ill (e.g., diabetic, hemophilic, etc.);

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

6. On an apnea monitor;

7. Receiving behavioral or mental health services;

8. Receiving Nevada early intervention services in accordance with an Individualized Family Service Plan (IFSP) provides a case manager who assists in developing a plan to transition the child to the next service delivery system. For most children this would be the school district and services are provided for the child through an IEP.

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

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

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

12. Name and contact information of Assigned PCP;

13. Referred to a Specialist(s);

14. Receiving substance abuse treatment for recipients 21 and older;

15. Receiving prescription medications;

16. Receiving durable medical equipment or currently using rental equipment ;

17. Currently experiencing health problems; or

18. Receiving case management (including the case manager's name and phone number).

When a recipient changes MCOs or reverts to FFS while hospitalized, the transferring MCO shall notify the receiving MCO, the receiving provider, or the DHCFP Quality Improvement Organization (QIO-like vendor) as appropriate, of the change within five calendar days.

3603.18 INFORMATION REQUIREMENTS

The MCO 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 MCO 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.

The MCO is required to notify all enrollees and potential enrollees that oral interpretation services are available for any language and written information is available in English and all prevalent non-English languages. The MCO must notify all enrollees and potential enrollees how to access this information.

The MCO's written material must use an easily understandable format. The MCO 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 MCO will be responsible for effectively informing Title XIX Medicaid enrollees who are eligible for EPSDT services, regardless of any thresholds.

If the MCO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover to the State with its application for a Medicaid contract and whenever it adopts the policy during the term of the contract. The information provided must be consistent with the provisions of 42 CFR 438.10 and must be provided to potential enrollees before and during enrollment.

Such information must also be provided within 90 days after adopting the policy with respect to any particular service.

a. Enrollee Handbook

The MCO 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 MCO and the Enrollee."

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

The MCO must furnish the handbook to all recipients 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 MCO will also publish the Enrollee Handbook on the MCO's internet website upon contract implementation and will update the website, as needed, to keep the Enrollee Handbook current at least monthly.

At a minimum the information enumerated below must be included in the handbook:

1. Explanation of benefits and how to obtain benefits, including out-of-plan benefits, and how to access them, the address and telephone number of the MCO's office or facility and the days that the office or facility is open and services are available;

2. The role of the PCP and a confirmation of the enrolled recipient's selection of a PCP, if a PCP was designated at the time of enrollment;

3. A list of current network PCPs who are and who are not accepting new patients in the enrollee's service area, with their board certification status, addresses, telephone numbers, availability of evening or weekend hours, all languages spoken and information on PCPs, specialists, and hospitals;

4. Any restrictions on the enrollee's freedom of choice among network providers;

5. Procedures for changing a PCP;

6. Enrollee rights and protections as specified in 42 CFR 438.100;

7. The amount, duration and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled;

8. Procedures for obtaining benefits, including authorization requirements;

9. The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers;

10. Procedures for disenrollment;

11. The extent to which, and how, after hours and emergency coverage are provided including: what constitutes an emergency medical condition, emergency and post stabilization services with reference to the definitions in 42 CFR 438.114; the fact that prior authorization is not required for emergency services; the process and procedures for obtaining emergency services, including the 911-telephone system or its local equivalent; the locations of any emergency settings and other locations at which providers and hospitals furnish emergency and post stabilization services under the contract; the fact that, subject to regulatory limitations, the enrollee has a right to use any hospital or other setting for emergency care;

12. Explanation of procedures for urgent medical situations, non-emergency transportation services and how to utilize services in other circumstances, including the recipient services telephone number; clearly define urgent care, emergency care, and emergency transportation, and clarify the appropriate use of each;

13. Policy on referrals for specialty care and for other benefits not furnished by the enrollee's PCP, including explanation of authorization procedures;

14. How and where to access any benefits that are available under the Title XIX and Title XXI State plans but are not covered under the contract, including any cost sharing, and how transportation is provided.

    For a counseling or referral service that the MCO does not cover because of moral or religious objections, the MCO need not provide the information on how or where to obtain the service. The MCO must notify the State regarding services that

meet this criteria and in those instances, the State must provide the information on where and how to obtain the service;

15. Procedures for accessing emergency and non-emergency services when the recipient is in and out of the MCO service area;

16. Information on grievance, appeals, and fair hearing procedures and information as specified in 42 CFR 438.10(g);

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

18. The MCO 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 90 days after the change. The MCO must ensure that a signed copy of 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.nv.gov/advancedirectives.htm);

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

20. The MCO is also required to provide, to the enrollee upon request, information on the structure and operation of the MCO and information about physician incentive plans as set forth in 42 CFR 438.6(h);

21. 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;

22. Information regarding prescription coverage;

23. Notification of the enrollee's responsibility to report any on-going care corresponding to a plan of care at the time of enrollment and their right to continue that treatment under the MCO on a transitional basis;

24. Notification of the enrollee's responsibility to report any third party payment service to the MCO and the importance of doing so; and

25. How to report Fraud and Abuse.

The MCO must give each enrollee written notice of any significant change, as defined by the State, in any of the enumerations noted above. The MCO shall issue updates to the Enrollee Handbook on a monthly basis when there are material changes that will affect access to services and information about the Managed Care Program; this includes additions and changes to the provider network.

The MCO shall also provide such notices in its semi-annual recipient newsletters and shall maintain documentation verifying handbook updates.

The MCO must give written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination notice. This notice shall be provided to each enrollee who received his/her primary care from, or was seen on a regular basis by, the terminated provider.

b. Identification Cards

The MCO may choose to issue an identification card to enrollees. The identification card must clearly state that the card does not constitute evidence of insurance coverage or eligibility. The card may include the following information: enrollee's billing number; the MCO's name and member services department telephone number; and, date of issue. The MCO must educate its providers regarding the card issued to enrolled recipients. The MCO may, at its discretion, include a unique member identification number on the card. The MCO must annotate on the card that the number is to be used by its network providers only.

c. Information for Potential Enrollees

The MCO must provide information regarding contracted MCOs to potential enrollees. The information is to be furnished at the time the potential enrollee first becomes eligible to enroll in a voluntary program or is first required to enroll in a mandatory program and, at that time, must be provided within a timeframe which enables the potential enrollee to use the information in choosing among available MCOs. The information for potential enrollees will be provided to the MCO by DHCFP and will include:

1. General information about the basic features of managed care, including which populations are excluded, subject to mandatory enrollment, or free to enroll voluntarily in the program, and the responsibilities for coordination of enrollee care;

2. Information specific to each MCO operating in a potential enrollee's service area and a summary of the following information:

   a. Benefits covered;

b. Service area;

c. Names, locations, telephone numbers of and non-English languages spoken by current network providers, and including identification of providers that are not accepting new patients;

d. Information on PCPs, specialists, and hospitals;

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

f. Benefits that are available under the State Plan but are not covered under the contract, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided. For a counseling or referral service that the MCO does not cover because of moral or religious objections, the State will provide information about where and how to obtain the service.

The State is responsible for providing more detailed information to potential enrollees upon request.

## 3603.19 MEDICAL PROVIDER REQUIREMENTS

A. PCP or Primary Care Site (PCS)

The MCO shall allow each enrolled recipient the freedom to choose from among its participating PCPs and change PCPs as requested.

Each enrolled recipient must be assigned to a PCP or PCS, within five business days of the effective date of enrollment. The MCO may auto-assign a PCP or PCS to an enrolled recipient who does not make a selection at the time of enrollment. If the enrolled recipient desires, the MCO shall allow him or her to remain with his or her existing PCP if the PCP is a member of MCO's primary care network.

B. Assignment of a PCP or PCS

If an enrolled recipient does not choose a PCP, the MCO shall match enrolled recipients with PCPs by one or more of the following criteria:

1. Assigning enrolled recipients to a provider from whom they have previously received services, if the information is available;

2. Designating a PCP or PCS who is geographically accessible to the enrolled recipient per NAC 695C.160;

3. Assigning all children within a single family to the same PCP; and/or,

4. Assigning a CSHCN to a practitioner experienced in treating that condition, if the MCO knows of the condition.

The MCO shall ensure that enrolled recipients receive information about where they can receive care during the time period between enrollment and PCP selection/assignment. The MCO shall notify the enrolled recipient of his or her assigned PCP within five business days of assignment.

C. Changing a PCP or PCS

1. An enrolled recipient may change a PCP or PCS for any reason. The MCO shall notify enrolled recipients of procedures for changing PCPs. The materials used to notify enrolled recipients shall be approved by DHCFP prior to publication and/or distribution.

2. In cases where a PCP has been terminated, the MCO must notify enrolled recipients in writing and allow recipients to select another primary care provider, or make a re-assignment within 15 business days of the termination effective date, and must provide for urgent care for enrolled recipients until re-assignment.

3. The MCO may initiate a PCP or PCS change for an enrolled recipient under the following circumstances:

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

   b. The enrolled recipient's residence has changed such that distance to the PCP is greater than 25 miles. Such change will be made only with the consent of the enrollee;

   c. The PCP ceases to participate in the MCO's network; or,

   d. Legal action has been taken against the PCP which excludes provider participation.

   The recipient will be given the right to select another PCP or PCS within the MCO network.

4. The MCO shall document the number of requests to change PCPs and the reasons for such requests.

3603.20 PROVIDER DIRECTORY

The MCO will publish their provider directory via an internet website upon contract implementation and will update the website on a bi-weekly basis for all geographic service areas. The MCO will provide DHCFP with the most current provider directory upon contract award for each geographic service area. Thereafter, the MCO will provide monthly electronic updates (including additions/deletions to the network) to DHCFP.

3603.21 NETWORK MAINTENANCE

A. Maintenance of the network includes, but is not limited to:

1. Initial and ongoing credentialing;

2. Adding, deleting, and periodic contract renewal;

3. Provider education; and,

4. Discipline/termination, etc.

B. The MCO must have written policies and procedures for monitoring its network providers, and for disciplining those who are found to be out of compliance with the MCO's medical management standards.

C. The MCO must take appropriate action related to dual FFS and managed care network providers, as follows:

1. Upon the MCO's awareness of any disciplinary action, sanction taken against a network provider, or any suspected provider fraud or abuse, the MCO shall immediately inform DHCFP.

2. If the MCO is notified that the OIG, DHCFP or another state Medicaid agency has taken an action or imposed a sanction against a network provider, the MCO shall review the provider's performance related to the DHCFP Managed Care Contract and take any action or impose any sanction, including disenrollment from the MCO's Provider Network.

## 3603.22 RETRO-CAPITATION AND CAPITATION RECONCILIATION

Capitation payments are subject to several types of error. Most often, a capitation payment error is introduced due to an inaccuracy in eligibility or enrollment status. Some errors are corrected automatically by the Medicaid Management Information System (MMIS), others by manual financial transaction. Depending upon the nature of the error in a particular instance, capitation may be paid or recovered from the MCO. Capitation is also reconciled periodically, typically for a three-month period.

a. Errors automatically corrected by the MMIS

The MMIS automatically adjusts up to three months of capitation for newborns when updated Welfare eligibility data for the current month also includes previously unreported eligibility.

In those instances where an eligibility agent has corrected an estimated date of birth forward in time, the MMIS automatically recovers the incorrectly paid capitation.

Should an error extend beyond three months, the instance must be researched and corrected manually by financial transaction.

b. Errors Corrected Manually by Financial Transaction

The MCO, in order to recover unpaid capitation, is required to submit such instances on a periodic basis via the process described in the Contract (Forms and Reporting Guide).

The Business Lines unit reconciles and authorizes payment of these retro-capitation payment requests on a quarterly basis with sufficient lag time (typically three months) to allow automated MMIS corrections to occur.

The Business Lines unit also reconciles and authorizes capitation recovery in instances where it is discovered that capitation has been incorrectly paid. This may occur on either a periodic or per-instance basis.

c. Reconciliation of Capitation Payments

The Business Lines unit determines the validity of retro-capitation requests or may use an appropriate sample for a large number of payment requests.

## 3603.23 THIRD-PARTY LIABILITY (TPL) AND SUBROGATION

TPL refers to any individual, entity (e.g., insurance company) or program (e.g., Medicare) including group health plans, as defined in Section 607(1) of the Employee Retirement Income

Security Act of 1974 (29 USC and 1167 (1)) service benefits plans, and MCOs that are or may be liable for all or part of a recipient's health coverage. Under Section 1902(a)(25) of the Social Security Act, DHCFP is required to take all reasonable measures to identify legally liable third parties and treat verified TPL as a resource of the Medicaid recipient.

The MCO shall act as the State's authorized agent for the limited purpose of TPL collection, within the limitation of the Fair Debt Collection Practices Act, 15 USC § 1692, of all third-party liability (TPL) pursuant to 42 CFR § 433.135 et seq and 42 CFR 433.147. The MCO's capitated payments include an offset in the rates for these collections. The MCO shall vigorously pursue billing prior resources and report their TPL and subrogation collection results to the DHCFP quarterly, as these amounts are considered part of their capitation.

MCOs are required to secure signed acknowledgements from enrolled Medicaid recipients or their authorized representative for any prior resources (Medicare, private insurance, etc.). The MCO must also determine if casualty claims are filed and recover costs through subrogation. The MCO must determine the third party and seek payment. If the third party refuses to pay, all information on the third party and collection attempts are to be reported to DHCFP on the Third Party Quarterly Report Form.

The DHCFP will monitor and evaluate the MCO's TPL and subrogation collection reports to validate collection activities and results over the first year following contract implementation. The state will establish a valid managed care baseline target using the data as reported by the MCO. The validated report data will establish the MCO's baseline target data. This amount will be built into future rates. The MCO will then be required to meet or exceed this baseline target over the balance of the contract period. If the MCO does not meet or exceed projected collections, DHCFP will conduct a review to determine if there is a legitimate reason. If there is no legitimate reason, the projected collections will be deducted from the MCO's costs before the data is used to set future rates. DHCFP will prospectively adjust capitation rates downward to account for expected TPL collections.

## 3603.24 MANAGEMENT INFORMATION SYSTEM (MIS)

A. The MCO shall operate an MIS capable of maintaining, providing, documenting, and retaining information sufficient to substantiate and report MCO's compliance with the contract requirements.

B. The MCO shall have an MIS capable of documenting administrative and clinical procedures while maintaining the privacy and confidentiality requirements pursuant to Health Insurance Portability and Accountability Act (HIPAA). The MCO shall provide DHCFP with aggregate performance and outcome data, as well as its policies for transmission of data from network providers. The MCO shall submit its work plan or readiness survey assessing its ability to comply with HIPAA mandates in preparation for the standards and regulations.

C. The MCO shall have internal procedures to ensure that data reported to DHCFP are valid and to test validity and consistency on a regular basis.

D. Eligibility Data

1. The MCO enrollment system shall be capable of linking records for the same enrolled recipient that are associated with different Medicaid and/or NCU identification numbers; e.g., recipients who are re-enrolled and assigned new numbers.

2. At the time of service, the MCO or its subcontractors shall verify every enrolled recipient's eligibility through the current electronic verification system.

3. The MCO shall update its eligibility database whenever enrolled recipients change names, phone numbers, and/or addresses, and shall notify DHCFP of such changes.

4. The MCO shall notify DHCFP of any enrolled recipients for whom accurate addresses or current locations cannot be determined and shall document the action that has been taken to locate the enrolled recipients. The MCO shall immediately notify DHCFP of the births and known deaths of all enrolled recipients.

E. Encounter and Claims Records

1. The encounter data reporting system should be designed to assure aggregated, unduplicated service counts provided across service categories, provider types, and treatment facilities. The MCO shall use a standardized methodology capable of supporting CMS reporting categories for collecting service event data and costs associated with each category of service.

2. The MCO shall collect and submit service specific encounter data in the appropriate CMS 1500, UB04 and the appropriate ADA Dental Claim format or an alternative format if prior approved by DHCFP. The data shall be submitted in accordance with the requirements set forth in the Reporting Guide of the current DHCFP Managed Care Contract. The data shall include all services reimbursed by Medicaid.

F. EPSDT Tracking System

The MCO shall operate a system that tracks EPSDT activities for each enrolled Medicaid eligible child by name and Medicaid identification number. The system shall allow the MCO to report annually on the CMS 416 reporting form. This system shall be enhanced, if needed, to meet any other reporting requirements instituted by CMS or DHCFP.

3603.25 REPORTING

Adequate data reporting capabilities are critical to the ability of CMS and DHCFP to effectively evaluate the DHCFP's managed care programs. The success of the managed care program is based on the belief that recipients will have better access to care, including preventive services, and will experience improved health status, outcomes, and satisfaction with the health care delivery system. To measure the program's accomplishments in each of these areas, the MCO must provide DHCFP and/or its contractors with uniform utilization, cost, quality assurance, and recipient satisfaction and grievance/appeal data on a regular basis. It must also cooperate with DHCFP in carrying out data validation steps.

The MCO is required to certify the data including, but not limited to, all documents specified by the State as required in the Reporting Guide of the current DHCFP Managed Care Contract, enrollment information, encounter data, and other information contained in contract proposals, as provided in 42 CFR 438.606. The data must be certified by the MCO's Chief Executive Officer (CEO), the MCO's Chief Financial Officer (CFO) or an individual who has delegated authority to sign for, and who reports directly to, the MCO's CEO or CFO. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data**.**

The MCO must meet all reporting requirements and timeframes as required in the Reporting Guide of the current DHCFP Managed Care Contract unless otherwise agreed to in writing by both parties. Failure to meet all reporting requirements and timeframes as contractually required and all attachments thereto may be considered to be in default or breach of said contract.

a. Encounter Reporting

Contracted MCOs must submit encounter data in accordance with the requirements in the Reporting Guide of the current DHCFP Managed Care Contract, to include any revisions or additions which contain information regarding encounter data, including DHCFP's media and file format requirements, liquidated damages and submittal timeframes. The MCO must assist DHCFP in its validation of encounter data.

Compliance with reporting requirements is described in the Reporting Guide of the current DHCFP Managed Care Contract.

The MCO is required to submit encounter data for the NCU program in the same manner as the Medicaid program. NCU recipients must be separately identified from Medicaid recipients, but the information can be combined for submission.

All encounters must be submitted in a timely manner for proper and accurate reporting and must be submitted within the timeframes specified in the Reporting Guide of the current DHCFP Managed Care Contract.

b. Summary Utilization Reporting

The contracted MCO shall produce reports using the Health Plan Employer Data and Information Set (HEDIS), as specified in Section 2.6.1 of the DHCFP Managed Care Contract. The MCO must submit these reports to DHCFP in a timely manner pursuant to contract requirements in addition to the other reports required by this contract.

c. Dispute Resolution Reporting

Contracted MCOs must provide DHCFP with monthly reports documenting the number and types of provider disputes, recipient grievances, appeals and fair hearing requests received. Reports must be submitted within 45 business days after close of the quarter to which they apply.

These reports are to include, but not be limited to, the total number of recipient grievances, the total number of notices provided to recipients, the total number of recipient and appeals requests, and provider disputes filed, including reporting of all subcontractor's recipient grievances, notices, appeals and provider disputes. The reports must identify the recipient grievance or appeal issue or provider dispute received; and verify the resolution timeframe for recipient grievances and appeals and provider disputes.

The reports must identify the recipient grievance or appeal issue or provider dispute received and verify the resolution timeframe for recipient grievances and appeals and verify the resolution timeframe for recipient grievances and appeals and provider disputes.

Comprehensive recipient grievance and appeal information, fair hearing requests, and provider dispute information, including, but not limited to, specific outcomes, shall be retained for each occurrence for review by the DHCFP.

d. Quality Assurance Reporting

Studies will be performed by the contracted MCOs pursuant to guidelines established jointly by the MCOs, DHCFP, and the External Quality Review Organization (EQRO) as well as those identified in the current DHCFP Managed Care Contract. In addition, the MCO must provide outcome-based clinical reports and management reports as may be requested by DHCFP. Should the MCO fail to provide such reports in a timely, DHCFP will require the MCO to submit a Plan of Correction (POC) to address contractual requirements regarding timely reporting submissions.

e. Recipient Satisfaction Reporting

Each contracted MCO must collect and submit to DHCFP a statistically valid uniform data set measuring recipient satisfaction prior to the third quarter of each contract year, unless

the requirement is waived by DHCFP due to an EQRO performed survey. This may be done in conjunction with the MCO's own satisfaction survey. DHCFP may request a specific sample, and/or survey tool.

Survey results must be disclosed to the State, and, upon State's or enrollee's request, disclosed to enrollees.

f. Financial Reporting

The MCO must meet the financial reporting requirements set forth in the Reporting Guide of the current DHCFP Managed Care Contract including any revisions or additions to the document.

g. Fraud and Abuse Reporting

The MCO must have administrative and management arrangements or procedures, and a mandatory compliance plan, that are designed to guard against fraud and abuse. These arrangements or procedures must include the following:

1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards;

2. The designation of a compliance officer and a compliance committee that are accountable to senior management;

3. Effective training and education for the compliance officer and the organization's employees and subcontractors;

4. Effective lines of communication between the compliance officer and the organization's employees and the rights of employees to be protected as whistleblowers must be included in any employee handbook;

5. Enforcement of standards through well-publicized disciplinary guidelines;

6. Provision for internal monitoring and auditing;

7. Provision for prompt response to detected offenses and for the development of corrective action initiatives relating to the MCO's contract; and

8. Instructions and details of how to report Fraud and Abuse in the Member Handbook.

The MCO and its subcontractors must provide immediate notification to DHCFP regarding all suspected recipient and provider fraud and abuse.

Upon the MCO's awareness of any disciplinary action or sanction taken against a network provider or any suspected fraud or abuse, the MCO shall immediately inform DHCFP.

The MCO and/or its subcontractors are responsible for informing DHCFP of any suspected recipient fraud or abuse.

These reporting requirements shall be included in all MCO subcontracts.

h. Other Reporting

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

3603.26 INFORMATION SYSTEMS AND TECHNICAL REQUIREMENTS

A. The MCO will be required to provide compatible data in a DHCFP prescribed format for the following functions:

1. Enrollment;

2. Eligibility;

3. Provider Network Data;

4. PCP Assignment;

5. Claims Payment; and

6. Encounter Data.

The MCO must provide an interface with all applicable systems to provide DHCFP, providers and recipients access to appropriate data.

B. Current Environment – A description of the current functional requirements for the following systems can be found in the MMIS Contract and supporting documentation located at the DHCFP.

1. Enrollment;

2. Eligibility;

3. Provider Network Data;

4. PCP Assignment;

5. Claims Payment; and

6. Encounter Data.

C. The MCO must provide encounter data report files in prescribed data fields to DHCFP's encounter data processing agent on a monthly basis. DHCFP will provide the required data fields and data transfer instructions upon execution of the contract.

D. The MCO will be required to provide encounter data from all providers. It is the MCO's responsibility to require this data and enforce the requirement from their providers.

## 3603.27 SANCTIONS

Pursuant to 42 CFR 438.726, the State has developed a plan to monitor MCO acts and failures to act as specified in Subpart I, 42 CFR 438 and to implement provisions of this subpart. The State will monitor MCO activities to validate:

a. the extent to which the MCO provides the covered medically necessary services required under the contract with the State;

b. the imposition of any cost sharing;

c. the basis of disenrollment or refusal to enroll a recipient;

d. the accuracy of information furnished by the MCO to CMS or the State and its designees;

e. the accuracy of information furnished to an enrollee, potential enrollee, or health care provider;

f. compliance with physician incentive plans as required in the contract;

g. prior approval of marketing materials and the accuracy of information provided therein; and

h. compliance with sections 1903(m) and 1932 of the Act.

The State's monitoring activities include contract requirements which include, but are not limited to, recipient and provider satisfaction surveys, review and confirmation of all financial reports and encounter data, the collection of enrollment and disenrollment reporting data, State prior approval of all MCO policies/procedures as well as all marketing materials proposed by the MCO for distribution, and review and approval of all base provider contracts. If the State determines the MCO violates any prohibition listed in 42 CFR 438.700, the State will provide written notice to CMS of any imposition of sanctions or remedies taken against the MCO pursuant to 42 CFR 438.724(b).

The State will implement provisions of this Subpart through remedies under the MCO contract, which include:

i. civil penalties in the amounts specified in 42 CFR 438.704;

j. appointment of temporary management for the contractor as provided in 42 CFR 438.706;

k. granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll;

l. suspensions of all new enrollments, including default enrollment, after the effective date of the sanction;

m. suspension of payment for recipients enrolled after the effective date of the sanction until CMS or the State is satisfied that the reason for the sanction no longer exists and is not likely to recur; or

n. any additional sanctions allowed under State statute or State regulations that address areas of non-compliance specified in 42 CFR 438.700 as well as additional areas of non-compliance. Additional sanctions may include liquidated damages and imposition of plans of correction in addition to its remedies at law.

# 3604 GRIEVANCES, APPEALS AND HEARINGS

The MCO shall establish a system for enrollees that include a grievance process, an appeal process, and access to the State Fair Hearing system.

a. Enrollee Grievances and Appeals

The MCO's grievance and appeal system must be in writing and submitted to DHCFP for review and approval at the time the MCO policies and procedures are submitted. DHCFP will refer all enrollee grievances and appeals to the MCO for resolution. The MCO must provide information about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. The MCO is required to provide access to state fair hearings in the event an enrollee's MCO appeal is not resolved wholly in favor of the enrollee. An enrollee may file for an MCO appeal or grievance either orally or in writing. A provider, acting on behalf of the enrollee and with the enrollee's written consent, may also file an appeal.

1. Action

The MCO must provide standard authorization decisions as expeditiously as the enrollee's health requires and within the State's established timelines that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days if the enrollee or provider requests the extension; or, the MCO justifies (to the DHCFP upon request) a need for additional information and how the extension is in the enrollee's interests.

For cases in which a provider indicates or the MCO determines that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide a Notice of Decision as expeditiously as the enrollee's health condition warrants and no later than three working days after receipt of the request for service. The MCO may extend the three working days time period by up to 14 calendar days if the enrollee requests an extension or if the MCO justifies (to the State, upon request) a need for additional information and how the extension is in the enrollee's interest.

2. Notice of Decision (NOD)

The MCO must provide a NOD to the requesting provider and the enrollee when the MCO takes adverse action or makes an adverse determination. Pursuant to 42 CFR 438.404(b) and §438.210(c) the NOD must explain:

a. The action the MCO or its contractor has taken or intends to take;

b. The reasons for the action;

c. The enrollee's or the provider's right to file an appeal;

d. The enrollee's right to request a State Fair Hearing after the enrollee has exhausted the MCO's internal appeal procedures;

e. The procedures for exercising the enrollee's rights to appeal or grieve;

f. The circumstances under which expedited resolution is available and how to request it;

g. The enrollee's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services;

h. That the enrollee may represent himself or use legal counsel, a relative, a friend, or other spokesman;

i. The specific regulations that support, or the change in federal or State law that requires the action; and,

j. The enrollee's right to request an evidentiary hearing if one is available or a state agency hearing, or in cases of action based on change in law, the circumstances under which a hearing will be granted.

The MCO must give notice at least ten days before the date of action when the action is a termination, suspension, or reduction of previously authorized covered services, except when the day of action is shortened to five days if probable recipient fraud has been verified.

The MCO must give notice by the date of the action for the following circumstances:

k. The death of the enrollee;

l. A signed written enrollee statement requesting termination or giving information requiring termination or reduction of services (where the enrollee understands that this must be the result of supplying that information);

m. The enrollee admission to an institution where he is ineligible for further services;

n. The enrollee's address is unknown and mail directed to him has no forwarding address;

o. The enrollee has been accepted for Medicaid services by another local jurisdiction;

p. The enrollee's physician prescribes the change in level of medical care;

q. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989; or,

r. The safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or the resident has not resided in the nursing facility for 30 days (applies only to adverse action for nursing facility transfers).

Pursuant to 42 CFR 438.404(c)(2) the MCO must give a notice of action on the date of action when the action is a denial of payment.

Pursuant to 42 CFR 438.404(c)(5) the MCO must give notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions.

3. Handling of Grievances and MCO Appeals

An enrollee may file an appeal of an adverse action or a grievance with the MCO. The MCO is required to dispose of each grievance and resolve each appeal and provide notice as expeditiously as the enrollee's health condition requires within the State's established time frames specified as follows:

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

b. Standard resolution of appeals: The MCO is allowed no more than 30 days from the date of receipt of the appeal;

c. Expedited resolution of appeals: The MCO is allowed up to three working days from the date of receipt of the appeal. The MCO is required to establish and maintain an expedited review process for appeals when the MCO determines or the provider indicates that taking the time for a

standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. The enrollee or the provider may file for an expedited review either orally or in writing; no additional enrollee follow up is required. The MCO must ensure that punitive action is not taken against a provider who supports an expedited appeal. If the MCO denies a request for an expedited resolution of an appeal, it must transfer the appeal to the standard resolution of appeals and make reasonable efforts to give the enrollee oral notice of the denial and follow up within two calendar days with a written notice.

These time frames may be extended up to 14 days if the enrollee requests such an extension or the MCO demonstrates to the satisfaction of the DHCFP that there is a need for additional information and how the extension is in the enrollee's interests. If the State grants the MCO's request for an extension, the MCO must give the enrollee written notice of the reason for the delay.

In handling grievances and appeals, the MCO must meet the following requirements:

1. The MCO must provide enrollees any reasonable assistance in completing forms and taking other procedural steps, including assisting the enrollee and/or the enrollee's representative to arrange for non-emergency transportation services to attend and be available to present evidence at the appeal hearing. This includes but is not limited to providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability;

2. Acknowledge receipt of each grievance;

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

4. Ensure that the individuals who make decision on grievances, if deciding a grievance regarding the denial of an expedited resolution of an appeal or a grievance involving clinical issues, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

The process for appeals also requires:

5. That oral inquiries seeking to appeal an action are treated as appeals (in order to establish the earliest possible filing date for the appeal) and must be confirmed in writing unless the enrollee requests expedited resolution;

6. The enrollee be provided a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The MCO is required to inform the enrollee of the limited time available for this in the case of expedited resolution;

7. The enrollee and his/her representative is provided the opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other document and records considered during the appeals process; and,

8. Include, as parties to the appeal, the enrollee and his/her representative or the legal representative of a deceased enrollee's estate.

The MCO is required to fully exhaust, in good faith, its internal appeal process on behalf of the enrolled recipient before referring the recipient to the State's Fair Hearing process. This appeal process must be completed within 30 days; if the dispute is not resolved within 30 days, the MCO shall refer the enrollee to the State for a fair hearing.

The MCO shall notify the enrollee of the disposition of grievances and appeals in written format. The written notice must include the results of the resolution process and the date it was completed. For appeals that are not wholly resolved in favor of the enrollee, the notice must also include:

9. The right of the enrollee to request a State Fair Hearing and how to do so;

10. The right to request to receive benefits while the hearing is pending and how to make this request; and

11. That the enrollee may be held liable for the cost of those benefits if the State Fair Hearing Officer's decision upholds the MCO's action.

For expedited appeal resolution requests, the MCO is required to make a good faith effort to provide an oral notice of the disposition in addition to the required written notice.

The MCO is required to maintain records of grievances and appeals, which the State will review as part of the State's quality strategy.

4. State Fair Hearings Process

The State Fair Hearing process is described in Chapter 3100 of the MSM. An enrollee, enrollee's representative or the representative of a deceased enrollee's estate has the right to request a State Fair Hearing when they have exhausted the MCO's appeal system without receiving a wholly favorable resolution decision. The request for a State Fair Hearing must be submitted in writing within 90 calendar days from the date of the MCO's final notice of decision. The MCO will participate as the State Contractor in the State fair hearing process requested by their enrollees. The MCO is bound by the decision of the Fair Hearing Officer.

5. Continuation of Benefits While the MCO and the State Fair Hearing are Pending

The MCO must continue the enrollee's benefits if the enrollee or provider files the appeal in a timely manner. Timely means filing the appeal on or before the later of the following: within ten days of the MCO mailing the notice of decision or the intended effective date of the MCO's proposed action. In addition, the MCO must continue benefits if the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; if the services were ordered by an authorized provider; if the original periods covered by the original authorization have not expired; and, if the enrollee requests an extension of benefits.

If, at the enrollee's request, the MCO continues the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

a. The enrollee withdraws the appeal;

b. Ten days pass after the MCO mails the notice of decision, providing the resolution of the appeal against the enrollee, unless the enrollee, within the ten day timeframe has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached;

c. A State Fair Hearing Officer issues a hearing decision adverse to the enrollee; and

d. The time period of service limits of a previously authorized service has been met.

If the final resolution of the appeal is adverse to the enrollee, the MCO may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section and in accordance with policy set forth in 42 CFR431.230 (b).

If the MCO or Fair Hearing Officer reverses an action to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires. If the MCO or State Fair Hearing Officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO or the State must pay for those services in accordance with State policy and regulations.

## 3604.1 PROVIDER DISPUTE AND DISPOSITION

The MCO must have an alternative dispute resolution process to dispose of provider disputes including, but not limited to, quality of plan service, policy and procedure issues, denied claims, claim processing time, and other disputes. The written procedures must be submitted to DHCFP for review and approval at the time the MCO policies and procedures are submitted. The process must include, but not be limited to:

a. The MCO's final decision to be issued, in writing, no later than 30 days after the provider files the dispute;

b. A written record in the form of a file or log is kept of the dispute to include a description of the dispute, date filed, dates and nature of actions taken and final resolution; and,

c. The MCO shall refer provider disputes to the DHCFP for fair hearings on matters of Medicaid provider enrollment or termination. Matters other than Medicaid provider enrollment or terminations may not be referred for fair hearings until the MCO's dispute resolution process has been exhausted. DHCFP will not provide fair hearings for contract disputes between the provider and the MCO.

3605 REFERENCES AND CROSS REFERENCES

3605.1 APPLICABLE MEDICAID SERVICES MANUAL (MSM) CHAPTERS ARE AS FOLLOWS:

Chapter 100 Medicaid Program
Chapter 200 Hospital Services
Chapter 300 Radiology Services
Chapter 400 Mental Health and Alcohol/Substance Abuse Services
Chapter 500 Nursing Facilities
Chapter 600 Physicians Services
Chapter 800 Laboratory Services
Chapter 900 Private Duty Nursing
Chapter 1000 Dental
Chapter 1100 Ocular Services
Chapter 1200 Prescription Drugs
Chapter 1300 Durable Medical Equipment (DME)
Chapter 1400 Home Health Agency (HHS)
Chapter 1500 Healthy Kids Program (EPSDT)
Chapter 1600 Intermediate Care for the Mentally Retarded (IFC/MR)
Chapter 1700 Therapy Services
Chapter 1800 Adult Day Health Care
Chapter 1900 Transportation
Chapter 2100 Home and Community-Based Waiver – Mental Retardation (MR)
Chapter 2400 Comprehensive Outpatient Rehabilitation (COR) Services
Chapter 2500 Case Management (CM)
Chapter 2800 School Based Child Health Services
Chapter 3100 Hearings
Chapter 3200 Hospice
Chapter 3300 Program Integrity
Chapter 3500 Personal Care Services Program

NEVADA CHECK UP MANUAL:

Chapter 1000 Nevada Check Up Program

3605.2 EXTERNAL QUALITY ASSURANCE ORGANIZATION (EQRO)

The DHCFP's EQRO is:

Health Services Advisory Group, Inc.
301 E. Bethany Home Road
Suite B-157
Phoenix, AZ 85012-1265

Telephone Number: (602) 264-6382

3605.3 CONTRACTED ACTUARIAL SERVICES FIRM

The DHCFP's contracted actuarial services firm is:

Milliman USA
1301 Fifth Avenue, Suite 3800
Seattle, WA 89101-2605
Telephone Number: (206) 504-5618

3605.4 THE NEVADA HEALTH NETWORK REPORTING GUIDE

Copies are available upon request by contacting the DHCFP Contract Specialist or the Nevada Medicaid Business Lines Unit.

3605.5 THE DHCFP MANAGED CARE CONTRACT

Copies are available upon request by contacting the DHCFP Contract Specialist or the Nevada Medicaid Business Lines Unit.