A Plan to Monitor Healthcare Access for Nevada Medicaid Beneficiaries

Medicaid Fee for Service (FFS) Program:

Methods for Assuring Access to Covered Medicaid Services

-Updated January 2018-

Executive Summary

The Nevada Department of Health and Human Services (DHHS) promotes the health and well-being of its residents through the delivery or facilitation of a multitude of essential services to ensure families are strengthened, public health is protected, and individuals achieve their highest level of self-sufficiency. The DHHS is comprised of six Divisions: Aging and Disability Services Division (ADSD); Division of Child and Family Services (DCFS); Division of Health Care Financing and Policy (DHCFP); Division of Public and Behavioral Health (DPBH); Division of Welfare and Supportive Services (DWSS); and the Public Defender.

The DHCFP works in partnership with the Centers for Medicare and Medicaid Services (CMS) to assist in providing quality medical care for eligible individuals and families with low incomes and limited resources, via the Nevada Medicaid and Nevada Check Up programs.

The DHCFP's framework for developing an Access to Care Monitoring Review Plan (ACMRP) for the fee for service (FFS) Medicaid population is adapted from a synthesis of several sources, including the agencies within the U.S. Department of Health and Human Services. The DHCFP framework includes the following components:

A. Characteristics and challenges of the beneficiary population
B. Approach for review and analysis
C. Improving access

The Code of Federal Regulations at 42 CFR 447.203 refers to the requirements for the ACMRP for payment rates and comparisons to the general population. The provision indicates it is necessary for states to compare Medicaid payment rates to the rates of Medicare or private payers. Due to the requirements set forth in Nevada Revised Statute (NRS 686B.080), the information for the rates paid by private payers is considered proprietary and is not subject to disclosure, therefore, the DHCFP will monitor, review and assess Medicaid rates and compare those rates to the rates paid by Medicare only.

Within the DHCFP framework of the ACMRP, measures were selected to provide a comprehensive overview of health care access in Nevada, while taking into account the limitations of available data sources.

The DHCFP has designed a process for monitoring health care access which includes data collection and trend analysis for identification and interpretation of access to care needs. The DHCFP has requested two Management Analyst positions to evaluate rates and funding to work with a contractor to gather and analyze data trends. The DHCFP Quality Chief will oversee the tracking of measures, compare with previous studies and lead quality improvement activities. Upon the identification of healthcare access problems, the DHCFP will analyze each measure in conjunction with public input to identify processes that need improvement and implement a remediation action plan.

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I. Overview

The mission of the DHCFP is to purchase quality health care services to low-income Nevadans in the most efficient manner possible; promote equal access to health care at an affordable cost to the taxpayers of Nevada; restrain the growth of health care costs; and review Medicaid and other state health programs to maximize potential federal revenue.

The DHCFP is part of DHHS and administers two major health coverage programs which provide health care to Nevadans: (1) Nevada Medicaid provides health care to low-income families, as well as aged, blind, and disabled individuals. Nevada, as part of Patient Protection and Affordable Care Act (PPACA), expanded the Medicaid program to include low-income childless adults effective January 1, 2014; and (2) Nevada Check Up, Nevada's Children's Health Insurance Program (CHIP) provides health coverage to low-income, uninsured children who are not eligible for Medicaid. Services for both programs purchase health services through managed care networks and fee for service basis.

The evaluation of healthcare access for all Nevadans is important to the DHHS and the information provided by the other DHHS agencies assists the DHCFP in determining if Nevada Medicaid and Check Up programs are positively affecting beneficiaries' health outcomes. In 2016 the DPBH conducted the Primary Care Needs Assessment of Nevada. In this assessment, primary care physicians indicated they had some concerns regarding health insurance, the Medicaid program, the limited number of providers, the high volume of paperwork and lack of transportation.

On July 12, 2016, the DHCFP presented an executive summary of the ACMRP at the Tribal Consultation meeting. The DHCFP received one main statement of concern from a member of the Tribal Consultation regarding providers not accepting new Medicaid beneficiaries. On July 19, 2016, the DHCFP presented the Draft version of the ACMRP to the Medical Care Advisory Committee (MCAC). The DHCFP received one request which was to submit the revised plan back to the MCAC prior to submission to CMS. No further comments have been received.

The proposed DHCFP access plan identifies an array of measurement methods and processes. The access monitoring system presented in this document will take into account: (1) the characteristics of Nevada Medicaid enrollees; (2) the availability of Nevada Medicaid providers; and (3) utilize a quality improvement process to address access issues. This plan will provide a comprehensive portrayal of healthcare access for Nevada Medicaid and Check Up beneficiaries. Moving forward, the set of measures identified in this document will be used to track trends and identify access deficiencies in the Nevada Medicaid program.

II. Characteristics of the Beneficiary Population

Nevada's geographical structure as well as the rapid growth in the Medicaid program poses challenges to access to health care. Nevada is made up of 17 counties which include urban, rural, and frontier areas. Due to the rural and frontier nature throughout the state, beneficiaries in must seek medical care outside their residential area. These rural and frontier areas experience scarce providers and services, including transportation providers. Residents living near state lines or borders may be geographically closer to out-of-state providers than in-state providers; therefore, Nevada recognizes border catchment areas as in-state providers and continues to seek guidance through the MCAC and public workshops in the identification of areas with shortages that impact Medicaid beneficiaries' access to care.

In 2014, Nevada opted to expand the Medicaid population through the Patient Protection and Affordable Care Act (PPACA). This has resulted in the population growth from approximately 320,000 beneficiaries in the summer of 2013 to over 662,000 beneficiaries in August 2016. Nevada has two health care delivery models: FFS and managed care. The managed care delivery model in 2016 consisted of two health plans. As of July, 2017 Nevada added an additional managed care health plan. Approximately 71 % of the combined Medicaid and Childrens' Health Insurance Program (CHIP) population are enrolled in managed care. The 29 % receiving care through FFS are comprised of individuals with disabilities, the elderly, and all beneficiaries living in rural and frontier areas. See figures 1, 2, and 3 below.

Figure 1. Total Medicaid Beneficiaries

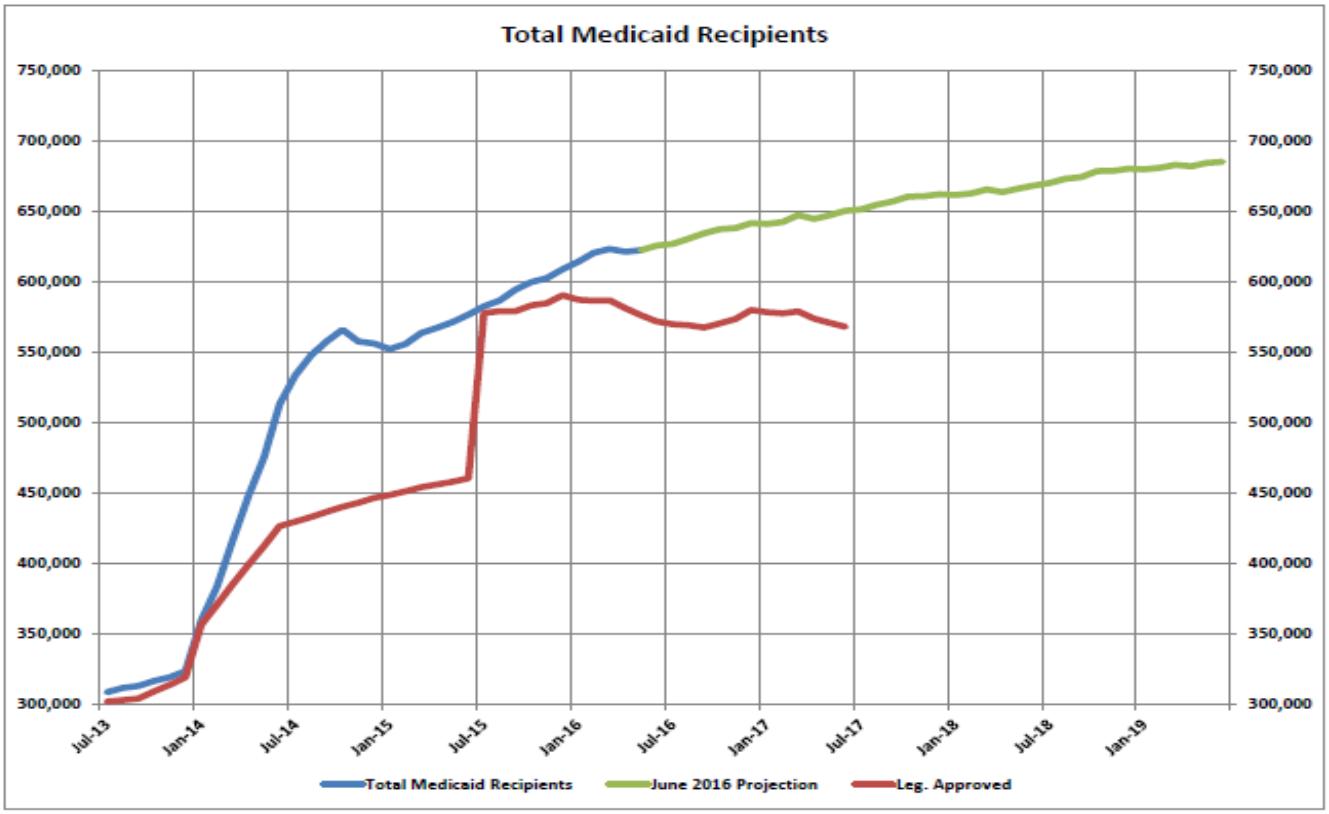


Figure 2. Nevada Check Up

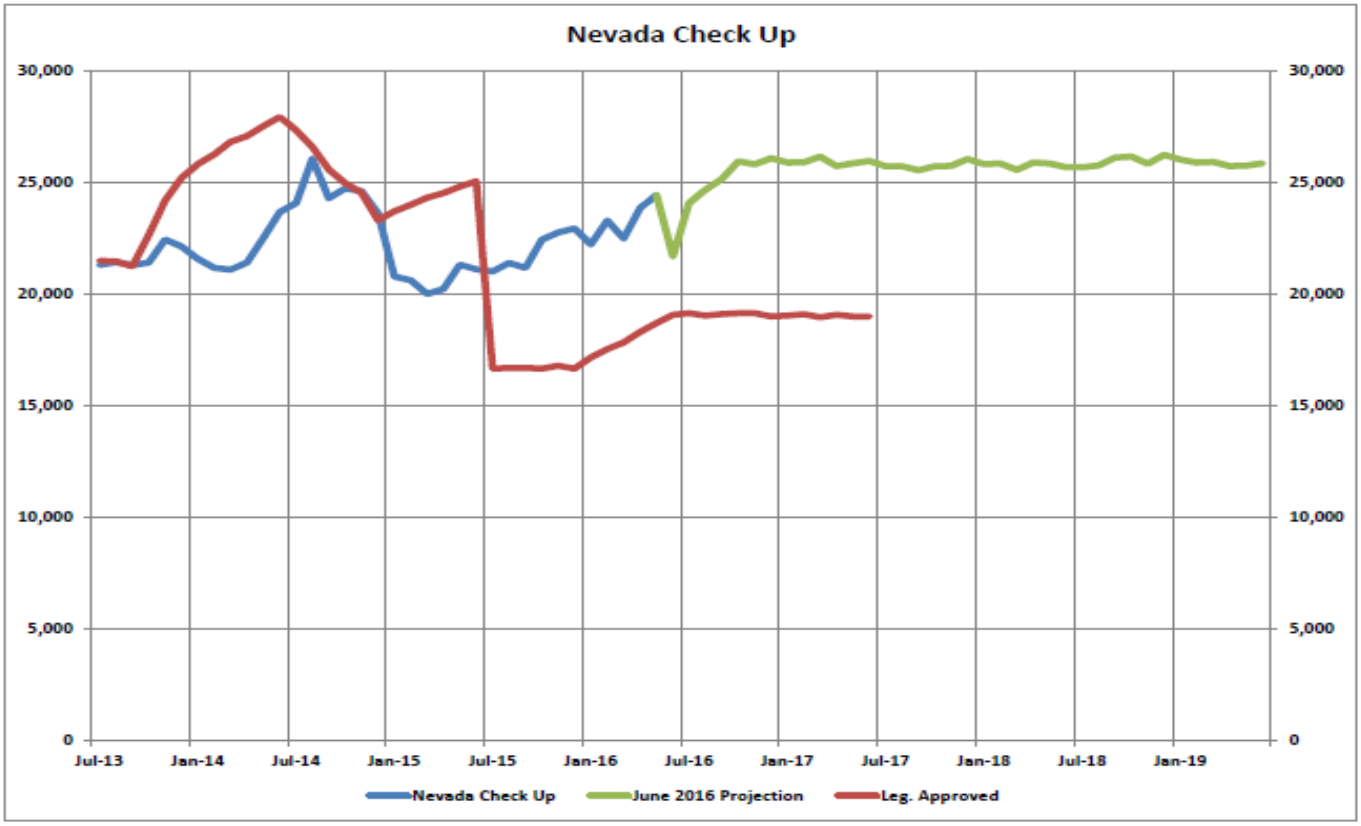
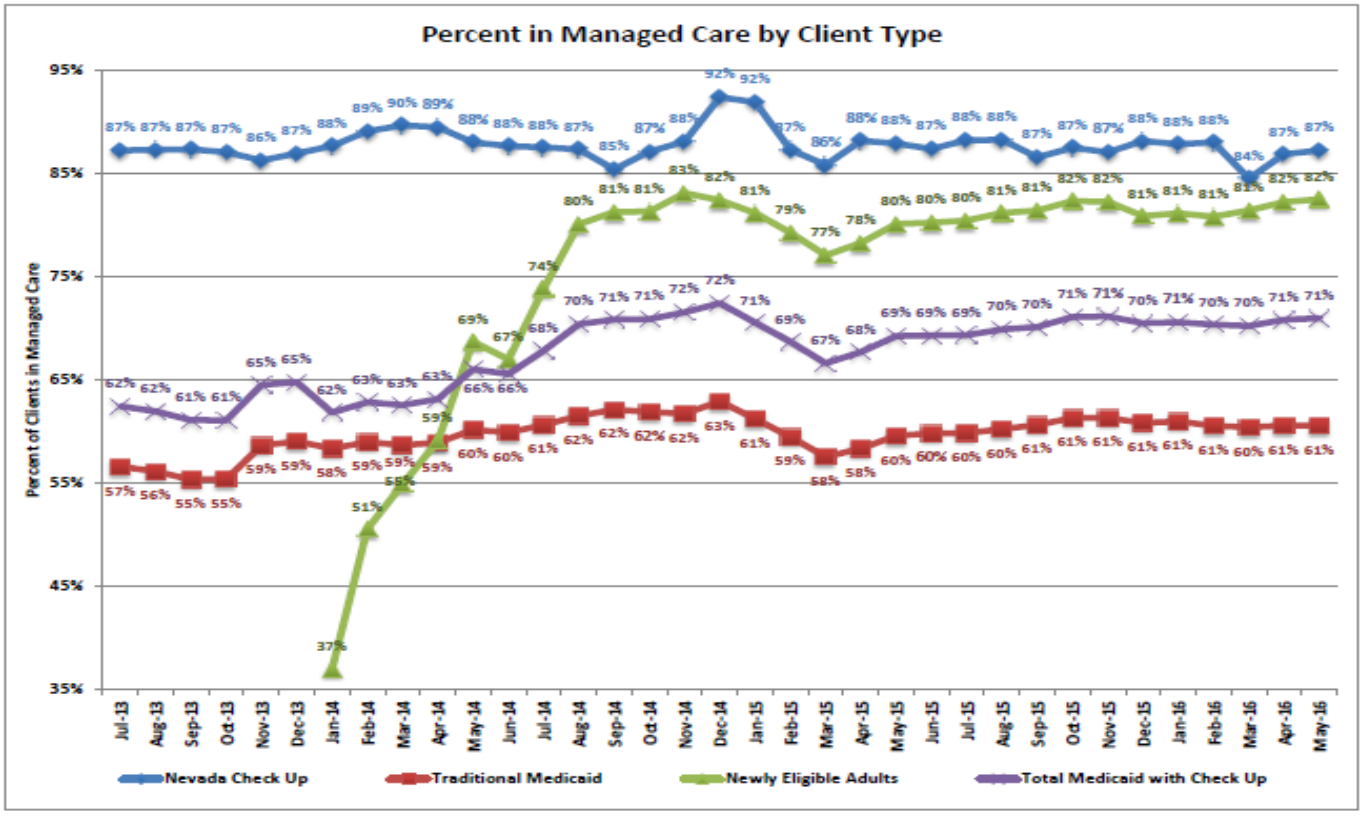


Figure 3. Percent in Managed Care by Client (Beneficiary) Type



III. Access Concerns Raised by Beneficiaries

The DHCFP currently gathers information from beneficiaries regarding access to care through customer service phone lines, public workshops and hearings, stakeholder meetings, and through the legislative process. The customer phone service line is a toll-free line operated through the four Medicaid district offices. Customer service representatives will assist callers to find health care providers. The DHCFP District Offices currently track beneficiary concerns through a statewide customer service phone line. Calls are documented by the reason for the call. The DHCFP has established a process for monitoring these calls to gather information on access to care, to address gaps in beneficiary need for information and to provide referrals to care coordination. The customer service phone line is similar to the DWSS customer service call center and the managed care customer service line. These customer service systems work together when necessary to provide referrals and information to recipients and staff collaborate on problem solving.

DHCFP program staff also attends stakeholder councils, consortiums, and boards where stakeholders share concerns and develop long term strategic plans. In addition, the DHCFP gathers input through legislative meetings and testimony.

The State continues to hold public workshops and hearings to solicit public input including provider qualifications and potential access issues when services are developed or changed.

IV. Comparison Analysis of Nevada Medicaid Payment Rates to Medicare

The data provided in Attachment A shows that for 2015, Nevada's payment rates are approximately 99 % of the Medicare non-facility rates and 103 % of the Medicare facility rates. By contrast, Utah, Nevada's neighboring state, averaged 84 % of the Medicare non-facility rates and 86 % of the Medicare facility rates. The DHCFP reimburses the same amount for adults and children.

Due to the requirements set forth in Nevada Revised Statute (NRS) 686B.080, an analysis was not performed comparing Nevada Medicaid rates to other payers, as the information for rates is considered proprietary and is not subject to disclosure.

Prior to submitting a State Plan Amendment (SPA), Nevada currently reviews any rate changes to identify the impact on access to care. When preparing a SPA that reduces rates or restructures provider payment, an access review may be conducted that is relevant to the affected service prior to submission in order to determine any potential impact to access to care. The results will be provided to CMS for their review when the SPA is submitted. An exception would be if an access review was completed that addresses the affected service within the 12 months prior to the SPA submission. In those instances, Nevada Medicaid will continue to provide the previous review to CMS. State Plan Amendments submitted in 2017 to CMS were in support of review

and analysis for Physician services. Attachment A. Facility & Non-Facility Rate Comparison has been updated to reflect current rate comparisons.

V. Review of Current Access to Care

In 2015, the DHCFP requested our contracted External Quality Review Organization (EQRO) conduct an evaluation of Nevada's Medicaid provider network. The purpose of the analysis was to estimate the provider network capacity, geographic distribution, and appointment availability for both the Managed Care Organizations (MCOs) and the FFS networks. The evaluation included a comparison by provider type, for each MCO and the FFS program relative to the access to care for the state of Nevada's general population. The analysis consisted of three dimensions of access and availability:

1. Capacity
   - Provider to Beneficiary ratio for Nevada provider network

2. Geographic Network Distribution
   - Time/Distance analysis for applicable provider specialties and average distance to the closest provider

3. Appointment Availability
   - Average length of time (number of days) to see a provider for MCOs and FFS (Secret Shopper Survey)

The 2015 study represents one of many ongoing attempts to capture, report, monitor, and explore the experience of Medicaid beneficiaries' access to health care services.

Overall, the result of this analysis, including the provider ratio analysis, the geographic network distribution analysis, and the secret shopper survey showed that while the MCOs and FFS have developed comprehensive provider networks, opportunities for improvement exist in the implementation of these networks. Across the four categories evaluated in the secret shopper analysis (primary care physicians (PCP), prenatal care providers, specialists, and dentists), nearly 50 % of all outreach calls to a specific provider failed to secure appointments (47.6 %), and of those calls that ended in an appointment, less than three-quarters (69.4 %) were scheduled within contract standards, as provided in Table 1. As such, while the network appears robust regarding the provider infrastructure, access to care is often affected by the ability to schedule appointments with a chosen provider.

Table 1. Appointment Availability Results

Specialty Category	Valid Cases	Unable to Schedule Appointment		Able to Schedule Appointment		Appointments within Compliance Standards	
		Number	Percent	Number	Percent	Number	Percent
PCP	208	85	40.9%	123	59.1%	73	59.3%
Prenatal Care							
First and Second Trimester	144	86	59.7%	58	40.3%	14	24.1%
Third Trimester	144	90	62.5%	54	37.5%	10	18.5%
Specialist	288	163	56.6%	125	43.4%	108	86.4%
Dentist	288	86	29.9%	202	70.1%	185	91.6%
Total	**1,072**	**510**	**47.6%**	**562**	**52.4%**	**390**	**69.4%**

As a result of the 2015 study, the DHCFP and the MCOs formed a focus workgroup, which is utilizing a quality improvement approach. The purpose behind the improvement approach is to hold each health plan accountable through action.

The MCOs have developed several approaches to remediate the concerns discussed from the 2015 study. They have implemented the use of outreach mobile units that provide comprehensive exams and they have increased telemedicine services for urgent and primary care. They have also put nurses into the community to provide health care services and to work with beneficiaries who are homeless. Each health plan is increasing their provider relations by on-site visits and providing one-on-one education to providers for billing. Other areas of focus include assisting with non-emergency transportation ride set up, daycare outreach solutions, reaching out to specialists in Nevada, and quicker response time for reimbursements.

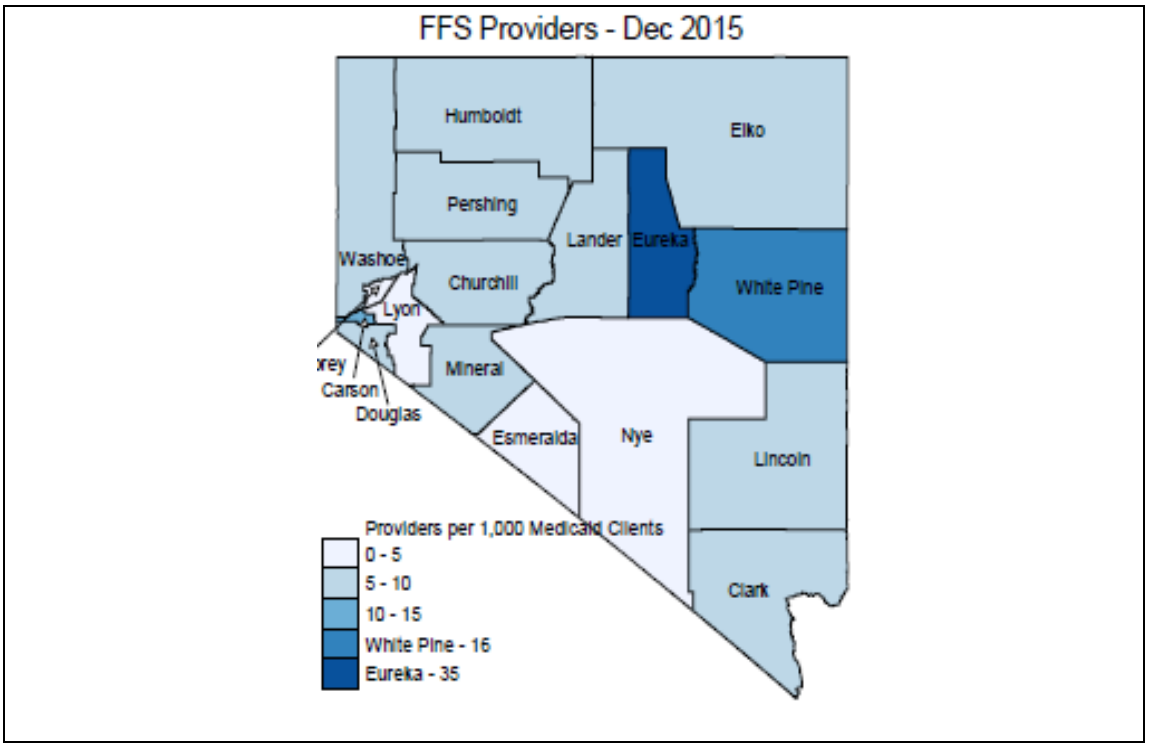
VI. Nevada Medicaid/Check Up Provider Composition

Figure 4 below is the geographic mapping of the Nevada FFS providers per 1,000 Medicaid beneficiaries:

Figure 4. Fee for Service (FFS) Providers

Maps ACA Outcomes by County, continued Source-uninsured-CPS Medicaid totals

DWSS ILD file; other DHCFP



The geographical structure of Nevada is made up of 17 counties with unique demographic and clinical characteristics. Through geographical analysis studies a complete understanding of the population we serve will ensure that all beneficiaries are able to successfully obtain the healthcare services they need and are entitled to under Federal and State law.

Table 2 below shows the provider enrollment for primary care, specialist, maternity, behavioral health and home health in calendar year 2016 for each county.

Table 2. Provider enrollment within each county 2016

Provider Enrollment (CY 2016)							
County	Primary Care	Specialist	Maternity	Behavioral Health	Home Health	*Medicaid Population	**Nevada Population
Carson City	255	14	34	133	1	13,154	55,168
Churchill	74	1	14	42	-	5,554	25,770
Clark	3,912	173	456	3,342	58	505,122	2,107,031
Douglas	110	4	11	51	1	4,966	48,220
Elko	137	6	21	13	1	7,659	54,677
Esmeralda	-	-	-	-	-	143	1,013
Eureka	3	-	-	-	-	162	1,919
Humboldt	40	1	-	5	-	3,192	17,942
Lander	14	-	-	1	-	986	6,766
Lincoln	9	-	-	-	-	794	5,076
Lyon	64	1	16	93	-	11,560	54,229
Mineral	15	1	4	5	-	1,202	4,463
Nye	109	3	10	192	-	12,464	45,798
Pershing	11	-	-	2	-	866	6,807
Storey	-	-	-	-	-	186	3,995
Washoe	1,173	13	115	712	4	84,098	451,248
White Pine	45	4	5	9	-	1,633	10,320
Total:	5,971	221	686	4,600	65	653,741	2,900,442

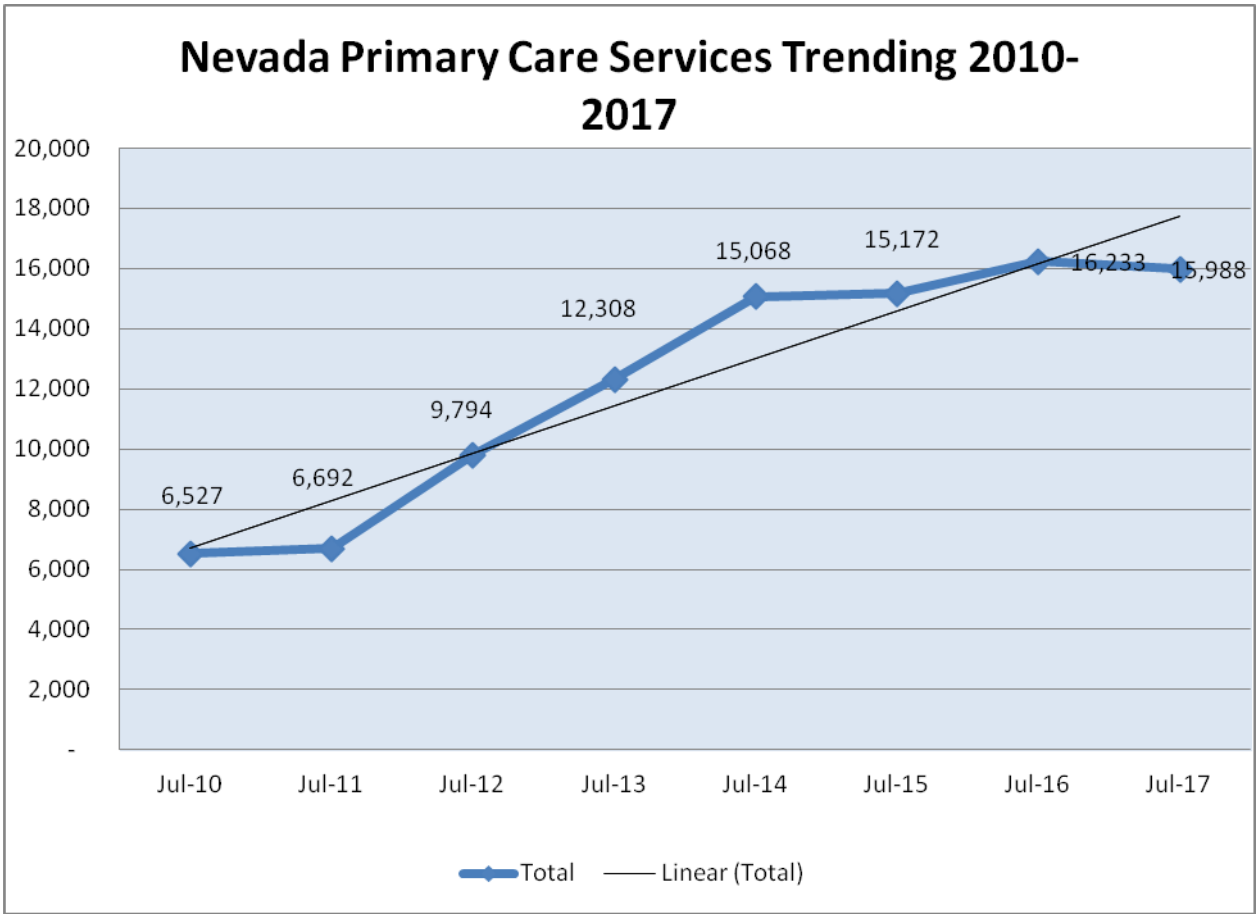
* Total members across CY 2016

** 2016 Nevada Projection – NV State Demographer

Figure 5 reflects the FFS provider enrollment in the core provider categories of Primary Care Practitioners/PCP-Extenders, Physician Specialty Services, Behavioral Health Providers, Pre and Post-Natal Providers, Home Health Agencies and Dental Providers. In 2010, there were 6,527 providers enrolled, compared to 15,988 in July 2017.

The one year provider revalidation cycle happened September 2017, and the 2016 provider enrollment numbers were recalculated. There was a slight decrease from 16,653 to 16,233, which was a decline of 0.98 %.

Figure. 5 Enrolled Core Provider Snapshot for year 2010-2017



See Attachment B for the outline of each of the primary core categories of service used as a basis for the projected measure guidelines within the ACMRP, Providers identified by Provider Type and Specialty Code.

VII. Outline of Review Analysis of Services – Access Review Plan

The DHCFP will put the monitoring procedures in place for primary care services, physician specialists, behavioral health services, pre- and post-natal obstetric services, home health services, and dental services. The plan will evaluate for access to care issues and implement process improvement. The overall plan will be to implement, continue, or improve current processes to identify the extent to which provider payment rates are consistent with efficiency, economy, and quality of care. Nevada's aim is to enlist enough providers so that the care and services available to the general population in the geographic area are also available to Medicaid recipients. The Division will also evaluate network composition and availability to address beneficiary concerns.

The DHCFP also plans to use the Consumer Assessment Healthcare Providers and System survey (CAHPS) and the District Office customer service phone line to gather communication data. Using this data our contracted EQRO will conduct Network Access Analysis studies in monitoring access to care and the DHCFP staff will conduct rate analysis studies.

CAHPS

At initial ACMRP submission the DHCFP presented the utilization of our EQRO, to conduct a Medicaid Fee for Service Beneficiary CAHPS. The CAHPS survey would focus on the topics, "Getting Care Quickly" and "Getting Needed Care." These measures were to allow the DHCFP to monitor, evaluate, and trend beneficiary perceived timely access to services.

The example below shows Nevada's CAHPS initial design for conducting an Access to Care survey to Medicaid beneficiaries.

Example:

Adult Medicaid CAHPS, Child Medicaid and Nevada Check Up Medicaid CAHPS

	FFS Baseline	FFS Year 1	FFS Year 2
Composite Measures			
Getting Needed Care			
Getting Care Quickly			

1. A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result, otherwise denoted as N/A.

During the 2017 Nevada Legislative session, the overall budget for DHHS was approved, which included the new regulation 42 CFR 438.358 mandatory External Quality Review activity; Network Adequacy study, including the FFS CAHPS.

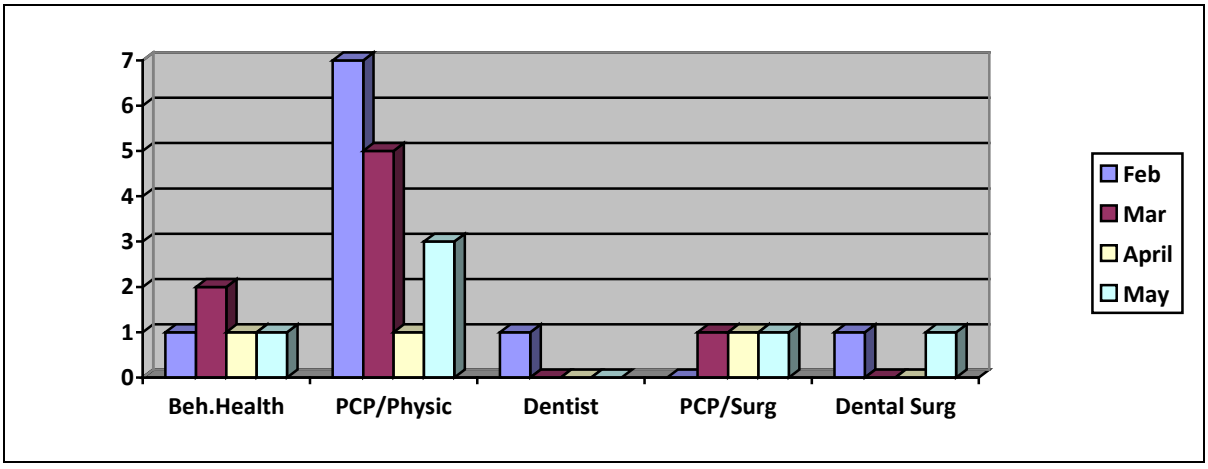
Nevada developed a FFS survey asking families to take a 20 minute survey about their child's health care. An independent research firm was asked to work collaboratively with the States EQRO and to conduct the survey.

District Office Customer Service Phone Line

The DHCFP will monitor beneficiary calls by entering data pertaining to the reason for the call into the call center tool in the form of tracking log. This data will identify geographic areas, core provider type and the specific access to care issue. The call center tool is designed to track multiple calls including incoming beneficiary concerns, issues and/or complaints: FFS-recipient complaints about providers, FFS-recipient inquiries to locate a provider, MCO-complaints from providers, MCO-recipient complaints about providers, and MCO-recipient inquiries to locate a provider. The call center tool also includes geographical location of calls such as Washoe, Clark, Carson City, and Rural. Starting September 1, 2016, statistical data had been gathered in order to produce reports for analysis. An analysis will continue to be completed on an ongoing basis and at the required three-year revision to further understand any gaps in access that exist for Nevada Medicaid beneficiaries.

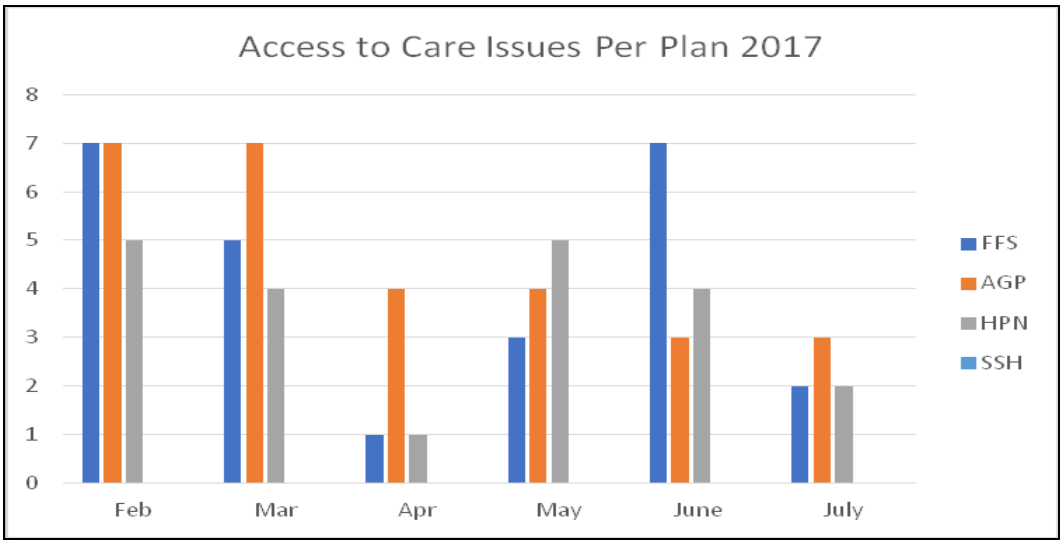
The Medicaid District Office (DO) developed a tracking log to capture the beneficiaries' issues and complaints, which may be monitored to determine any access to care issues. The tracking log includes information related to provider types, if the enrollee was in a Managed Care Health plan or FFS. The DO provided a report that included providers by enrollee need and was based on the five main categories outlined by CMS: Behavioral Health, Primary Care Physician, Dentist, Primary Care Physician Surgeon, and a Dental Surgeon. The information included providers who were enrolled in each benefit service health plan from February through May 2017. The report showed that Primary Care Provider/Physicians were more sought out in February and March than any other month. See Figure 6 below for more details.

Figure 6. Access To Care: Provider Type; February through May 2017



In order to reflect which benefit health plan and the provider type may be experiencing access to care issues, the current benefit health plans were compared to provider types defined as PCP/Physician, Behavioral Health, and Dental. In Figure4 below, DHCFP looked at the provider types and which benefit plan the beneficiary was enrolled in at the time of the call. In April 2017, two of the three benefit health plans demonstrated a significant decline in barriers of access to care. The other health plan showed a steady unresolved concern of access to care barrier(s). For this tracking purpose, the numbers reflective in the table below are actual counts and do not reach above the number of 10 per month.

Figure 7. Access To Care: Benefit Service and Provider Type; February through July 2017

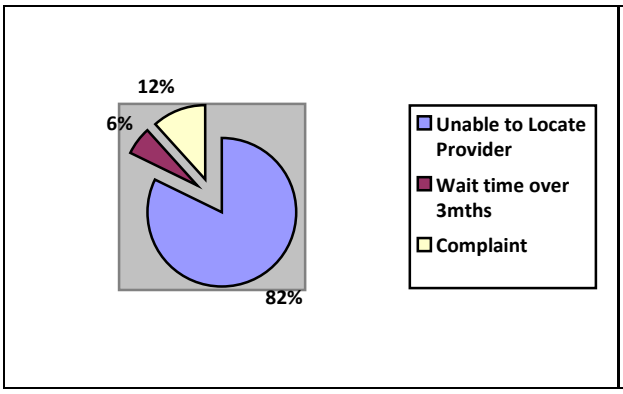


It was determined through the redefining process that categories presented by beneficiaries were defined as: Unable to locate provider, wait time over three months and complaint with no action by the Medicaid District Office (DO) required. Four main regions were used; Urban Washoe and Clark, Carson and Rural.

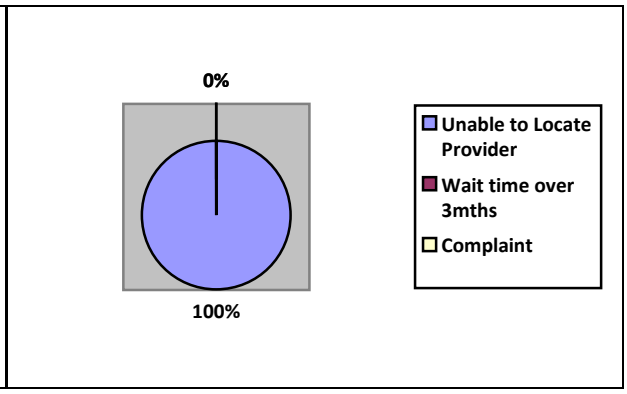
It became evident through the process of redefining reasons for beneficiary calls that “Unable to locate provider” was the number one barrier in all regions of Nevada; 82% of the calls for the Northern region of Nevada fell under “Unable to locate provider,” 37% in Clark County and 100% in both Carson City and the Rural areas of Nevada. The actual call count was no higher than 15 per month. See Figure 8 below for more details.

Figure 8. Access to Health Care: Reason for Call by Region; February through May 2017

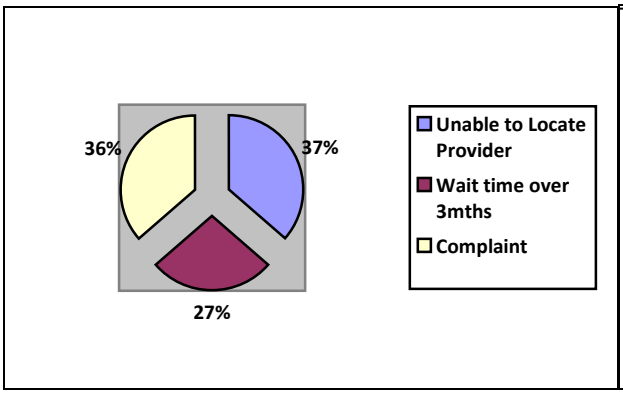
Washoe



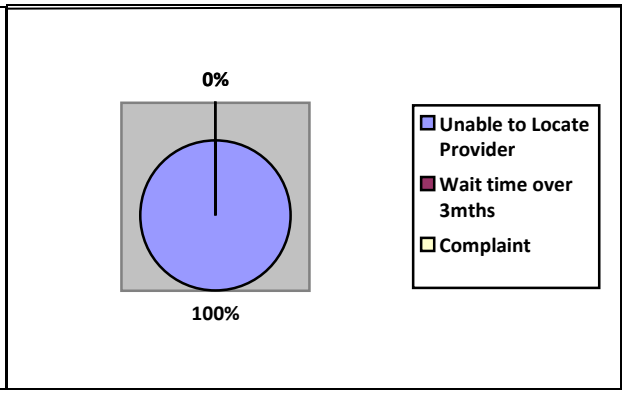
Carson



Clark



Rural



In November of 2013, Nevada DHCFP was approved to implement a FFS Care Management program through the 1115 Nevada Comprehensive Care Waiver. The Health Care Guidance Program (HCGP) submitted surveys to the FFS population enrolled in the program. The surveys included questions about certain chronic conditions (such as, COPD, HIV, Kidney Disease, etc…). The HCGP serves only the FFS population primarily located in the rural areas of Nevada.

The result of the surveys is as follows:

- In 2014, there were 3,031 initial completed surveys. Of those who responded, 'finding a provider' was identified as the biggest challenge.
- In 2015, there were 3,205 completed surveys. Of those responded, 'finding a provider' was identified as the biggest challenge.
- In 2016, there was an increase in the number of candidates; however only 2,153 completed the surveys. Of those responded, 'finding a provider' was identified as the biggest challenge, as outlined in Table 3.

Table 3. HCGP Survey

2014		2015		2016	
Survey Completions	3,031	Survey Completions	3,205	Survey Completions	2,153
Survey Candidates	33,866	Survey Candidates	34,857	Survey Candidates	38,554
Q7 Response: Provider Access	*15.7% of respondents or 243 members cited finding a provider as the biggest challenge*	*Q7 Response: Provider Access*	*20.1% of respondents or 243 members cited finding a provider as the biggest challenge*	*Q7 Response: Provider Access*	*11.3% of respondents or 243 members cited finding a provider as the biggest challenge*

Table 4 provides an overview of the monthly average of those members enrolled in the HCGP, and outlines the percentage of HCGP enrollees seeing the physician type indicated. Challenges with gaining access have been reported in the following physician types outlined below. Not all provider types outlined in Table 7 are focused categories of the ACMRP.

However, the majority of the provider types are parallel to what DHCFP has outlined in the plan and it should be recognized that the few physician categories reflected in the table below are areas the State of Nevada continues to work to enhance access to care. The first three provider types; Specialty Physician (Orthopedic/Ortho Surgeon), Primary Care, and Dentist, demonstrate why Nevada has been evaluating new initiatives in bringing in new providers.

Table 4. Monthly Physician Average -HCGP Enrollee Challenged Areas

Physician	Avg % Monthly	Avg # encounters/ mo
Orthopedic/Ortho Surgeon	35%	2275
Primary Care	34%	2203
Dentist	23%	1517
Podiatry	20%	1300
Physical Therapy (In-home)	14%	939
Physician - Pain Management	14%	903
Child Psychiatry	12%	794
Family Practice	12%	773
Rheumatology	7%	469
GI Pulmonologist	6%	397
Behavioral Health	6%	361
Allergist	6%	361
Colostomy Supplies/TPL	5%	339
Dermatology	4%	289
Out-Patient Infusion Center	4%	289
MRI	3%	217
Oral Surgeon	3%	217
Pediatric Surgery	2%	144
Maxillofacial Surgeon	0%	0

Provider Network Access Analysis

The DHCFP, through our EQRO, will conduct an evaluation of Nevada's Medicaid provider network. This analysis will estimate the provider network capacity, geographic distribution, and appointment availability for the FFS network. The evaluation will include a comparison by the core provider types, including dental, for the FFS program relative to the access to care for the State of Nevada's general population. It is estimated that the DHCFP will conduct this study after legislative approval in 2017. The analysis will consist of three dimensions of access and availability:

1. Capacity
   - Provider to Beneficiary ratio for Nevada provider network

2. Geographic Network Distribution
   - Time/Distance analysis for applicable provider specialties and average distance to the closest provider

3. Appointment Availability
   - Average length of time (number of days) to see a provider for MCOs and FFS (Secret Shopper Survey)

Comparison analysis of Nevada Medicaid payment rates to Medicare

The DHCFP will complete an ongoing review and analysis for the identified core provider types at a minimum of every three years. The DHCFP will also monitor access for any affected provider groups after implementation of a SPA that reduces or restructures provider payment that takes into consideration: enrollee needs; availability of care and providers; utilization of services; and service payment information. Reviews will be conducted periodically over a minimum three-year period following implementation of the SPA.

Additional Activities

In addition to the above discussed processes, the DHCFP's monitoring activities will consist of gathering and analyzing information from public workshops and hearings, stakeholder meetings, and through the legislative process. This will be done throughout the year for each of the six core focused provider categories of this plan to identify early indications of changes in health care access.

a. Review Analysis of Primary Care Services

For the purpose of the ACMRP, Nevada's primary care services include Physicians, Physician Assistants, Nurse Practitioners, Pediatricians, and those with a focus in the area of family health. Primary care services also include special clinics consisting of Federally

Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Table 5 below is a snapshot of the number of FQHCs/RHCs. Trended over time, the State of Nevada primary care service special clinics increased from 28 providers in 2010 to 49-FQHCs/ RHCs in 2017.

Table 5. FQHC/RHC

Provider Type/Specialty	July 2010	July 2011	July 2012	July 2013	July 2014	July 2015	July 2016	July 2017
017 Special Clinics	**28**	**31**	**33**	**35**	**38**	**39**	**44**	**49**
180 Rural Health Clinic	7	8	9	9	10	11	11	12
181 Federally Qualified Health Center	21	23	24	26	28	28	33	37

Figure 9 shows a snapshot of the six core focused primary care providers enrolled with Nevada Medicaid in the month of July for the period of 2010 to 2016. In 2010, Nevada had a total of 6,527 enrolled core providers, which included 2,068 Primary Care Practitioners (PCP)/PCP Extenders. Trended over time, the State of Nevada in 2017 increased PCP/PCP Extenders to 4,263 providers. This information will continue to be used as the benchmark in Nevada's review of access to care for Primary Care services.

Data sources for analysis of primary care services will include:

- Provider Enrollment
- Nevada Medicaid Management Information System (MMIS) claims payment
- Medicaid Member Eligibility System
- Medicaid District Office Call Center Tool
- Results of CAHPS Survey (access-related questions)
- Results of EQRO - Provider Network Access Analysis that also includes data from:
  - National Plan and Provider Enumeration System (NPPES)
  - U.S. Census Bureau

b. Review Analysis of Physician Specialist Services

For the purpose of the ACMRP, Physician Specialist Services were defined by Nevada Medicaid to include specialists such as, but not limited to, Optometrist, Optician, Urologist, Cardiologist, Endocrinologist and Neurologist (See Attachment B). Figure 9 shows a snapshot of the number of physician specialists enrolled with Nevada Medicaid in the month of July for the period of 2010 to 2016. In 2010, Nevada had a total of 6,527 enrolled in the six core focused providers, which included 2,020 physician specialists. In 2017, this provider group decreased to 4,343. This information will continue to be used as the benchmark in Nevada's review of access to care for Physician Specialist services. Rate reviews are conducted on an ongoing basis as needed for fiscal analyses for various staff requests. During Nevada's 2017 Legislative session, a bill was passed (AB108) mandating a review of the rate of reimbursement every four years for each service or item provided under the State

Plan for Medicaid. The bill stipulates the first review to be done on or before January 1, 2018.

State Plan Amendments (SPA)

During 2017, there were three SPAs approved by CMS resulting in rate reductions for several provider types. The SPAs were necessary to align the rates for the same services across provider types and to set more appropriate rates for outpatient surgery, ambulatory surgical centers (ASC), and durable medical equipment, prosthetics, orthotics and supplies (DMEPOS).

SPA 17-001: Affecting outpatient surgery and ASCs. The methodology was changed to move from the nine ASC levels to the CMS Ambulatory Payment Classifications system (APC) methodology, which allows Nevada Medicaid to align with CMS. The prior methodology only supported nine distinct rates for all procedures provided in these settings. It was determined that this was no longer an effective methodology as appropriate reimbursement (based on comparisons against current CMS ASC reimbursement). Many services provided today fall outside of the range available in the nine existing reimbursement levels. The new methodology accounts for those services and allows a significantly more varied reimbursement range than the prior obsolete methodology.

SPA 17-002: Affecting Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). As a result of recent changes to the CMS DMEPOS fee schedule, the DHCFP is updating the rate methodology to set more appropriate rates for Nevada Medicaid DMEPOS. The prior rates were set as of August 2011.

SPA 17-003: Affecting hospital outpatient, podiatrist, optometrist, psychologist, radiology and non-invasive diagnostic centers, therapy, chiropractor, optician, optical business, laboratory, pathology clinical, nurse anesthetist, nurse midwife and audiologist.

There was a SPA previously approved in 2015 which allowed changes in the reimbursement methodology for physicians, advanced practice registered nurses and physician's assistants. The SPA approved in 2017 was necessary to allow Nevada Medicaid to align the reimbursement methodology for the same services across provider types.

The change resulted in varied rate changes for each service within the impacted provider types. The average rate change for each of the affected provider types is as follows:

Provider Type 12 (Hospital, Outpatient)	*-1.9%*
Provider Type 21 (Podiatrist)	*30.8%*
Provider Type 25 (Optometrist)	*1.4%*

Provider Type 26 (Psychologist)	*-5.0%*
Provider Type 27 (Radiology)	*-4.7%*
Provider Type 34 (Therapy)	*.6%*
Provider Type 36 (Chiropractor)	*50.1%*
Provider Type 41 (Optical Business)	*-5.6%*
Provider Type 43 (Laboratory)	*-7.1%*
Provider Type 72 (Nurse Anesthetist)	*-14.9%*
Provider Type 74 (Nurse Midwife)	*1.7%*
Provider Type 76 (Audiologist)	*-3.5%*

For all three SPAs, there were multiple public workshops and public hearings to solicit comment, provide an opportunity for dialog with stakeholders, and allow clarification where there were concerns. There was a Web Announcement (#1335) published on the Nevada Medicaid website which provided information about the status of the three SPAs: https://www.medicaid.nv.gov/.

Baseline reports were produced for all the services affected by the changes and, on an annual basis, new reports will be run to determine any increase or decrease in utilization. If there is an indication of a dramatic decrease, this will be researched to determine the cause and any concerns will be evaluated and discussed.

Data sources for analysis of physician specialist include:

- Provider Enrollment
- MMIS claims payment
- Medicaid Member Eligibility System
- Medicaid District Office Call Center Tool
- Results of CAHPS Survey (access-related questions)
- Results of EQRO - Provider Network Access Analysis that also includes data from:
  - National Plan and Provider Enumeration System (NPPES)
  - U.S. Census Bureau

c. Review Analysis of Behavioral Health Services

For the purpose of the ACMRP, Behavioral Health services were defined by Nevada Medicaid to include Inpatient Psychiatric Hospitals, Behavioral Health Outpatient Treatment Providers, Psychiatrists, Psychologists, Psychiatric Residential Treatment Facilities (PRTF), and Behavioral Health Rehabilitative Treatment Providers (see attachment B). Figure 9

shows in 2010, Nevada had a total of 6,527 enrolled in the six core focused providers, which included 1,425 Behavioral Health providers. In 2017, this provider group decreased to 6,435. This information will continue to be used as the benchmark in Nevada's review of access to care for Behavioral Health services.

Data sources for analysis of behavioral health will include:

- Provider Enrollment
- MMIS claims payment
- Medicaid Member Eligibility System
- District Office Call Center Tool
- Results of CAHPS Survey (access-related questions)
- Results of EQRO - Provider Network Access Analysis that also includes data from:
  - National Plan and Provider Enumeration System (NPPES)
  - U.S. Census Bureau

d. Review Analysis of Pre- and Post-Natal Obstetric Services including Labor and Delivery

For the purpose of the ACMRP, Pre-and Post-Natal Obstetric services including Labor and Delivery were defined by Nevada Medicaid to include Obstetricians (OB), Gynecologists (GYN) and Midwives. Figure 9 shows in 2010, Nevada had a total of 6,527 enrolled in the six core focused providers, which included 269 OB/GYN and Midwives. In 2017, this provider group increased to 405. This information will continue to be used as the benchmark in Nevada's review of access to care of Pre- and Post-Natal Obstetric services including Labor and Delivery.

Data sources for analysis of Pre-and Post-Natal Obstetric services including Labor and Delivery will include:

- Provider Enrollment
- MMIS claims payment
- Medicaid Member Eligibility System
- District Office Call Center Tool
- Results of CAHPS Survey (access-related questions)
- Results of EQRO - Provider Network Access Analysis that also includes data from:
  - National Plan and Provider Enumeration system (NPPES)
  - U.S. Census Bureau

e. Review Analysis of Home Health Services

For the purpose of the ACMRP, Home Health services were defined by Nevada Medicaid to include services provided by Home Health Agencies. Figure 9 shows in 2010, Nevada had a total of 6,527 enrolled in the six core focused providers, which included 55 Home Health Agencies. The provider group decreased to 57 Home Health providers from 63 providers in

2016. This information will continue to be used and monitored as the benchmark in Nevada's review of access to care for Home Health services.

Data sources for analysis of home health will include:

- Provider Enrollment
- MMIS claims payment
- Medicaid Member Eligibility System
- District Office Call Center Tool
- Results of CAHPS Survey (access-related questions)
- Results of EQRO - Provider Network Access Analysis that also includes data from:
  - National Plan and Provider Enumeration system (NPPES)
  - U.S. Census Bureau

f. Review Analysis of Dental Services

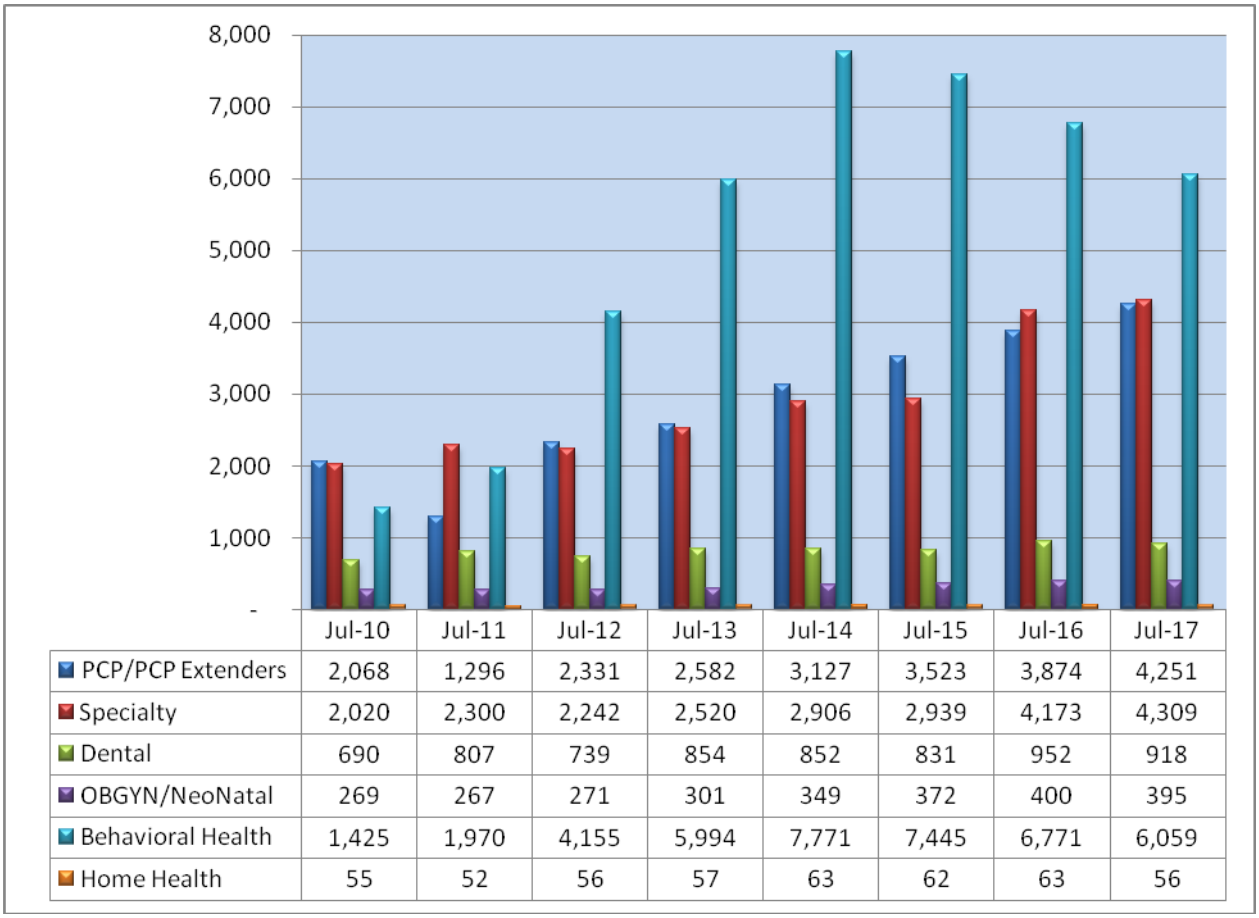
For the purpose of the ACMRP, Dental services were defined by Nevada Medicaid to include General Dentist, Oral Surgery, Pediatric Dentist, and Dental Hygienist. Figure 9 shows in 2010, Nevada had a total of 690 dentists enrolled as providers. In 2017, this provider group decreased to 918 from 952 in year 2016 dental providers. This information will continue to be used as the benchmark in Nevada's review of access to care for dental services.

Data sources for analysis of dental will include:

- Provider Enrollment
- MMIS claims payment
- Medicaid Member Eligibility System
- District Office Call Center Tool
- Results of CAHPS Survey (access-related questions)
- Results of EQRO - Provider Network Access Analysis that also includes data from:
  - National Plan and Provider Enumeration system (NPPES)
  - U.S. Census Bureau

Figure 9 reflects Nevada's six core focused providers and shows a decrease in provider enrollment for 2017 to 15,988.

Figure 9. July snapshot of selected provider types year 2010-2017



	Jul-10	Jul-11	Jul-12	Jul-13	Jul-14	Jul-15	Jul-16	Jul-17
PCP/PCP Extenders	2,068	1,296	2,331	2,582	3,127	3,523	3,874	4,251
Specialty	2,020	2,300	2,242	2,520	2,906	2,939	4,173	4,309
Dental	690	807	739	854	852	831	952	918
OBGYN/NeoNatal	269	267	271	301	349	372	400	395
Behavioral Health	1,425	1,970	4,155	5,994	7,771	7,445	6,771	6,059
Home Health	55	52	56	57	63	62	63	56

VIII. Remediation Action Plan

Nevada Medicaid will use the Plan Do Study Act (PDSA) model in quality improvement initiatives. The model incorporates the idea of continuous quality improvement through a process and problem-solving approach. The continuous quality improvement process will monitor access to care, timeliness of care, beneficiary satisfaction with their access to care, and complete a rates analysis. This process will help identify opportunities for improvement that exist throughout the Nevada Medicaid program. Once opportunities have been identified, the DHCFP will implement intervention strategies to improve outcomes and performance, evaluate the interventions, and reassess performance through re-measurement to identify new opportunities for improvement.

As needed, the DHCFP will develop a remediation action plan to address identified access to healthcare issues in the core service areas. Remedial actions may include policy revision, process simplifications, rate adjustment, and/or enhanced provider outreach. The DHCFP will monitor access after implementation of a SPA that reduces or restructures provider payment that takes

into consideration: enrollee needs; availability of care and providers; utilization of services; and service payment information. Reviews will be conducted periodically over a minimum three-year period following implementation of the SPA.

In order to coordinate efforts to determine what constitutes adequate access to care, the DHCFP has also developed relations with the Nevada Division of Insurance (DOI). Information has been developed through public meetings, participation in rate discussions, and discussions on the shortage of providers. Discussions on Network Access to Care will continue.

The State of Nevada has historically conducted improvement plans for access to healthcare issues. Once Nevada becomes aware of a need to correct any access to care issues, an in-depth analysis is conducted. This analysis includes policy research, public input including input from beneficiaries, and collaboration with the MCAC resulting in the implementation of a corrective action plan. In January 2018, a revised version of the AMCRP was presented to the MCAC for review and comments. The MCAC was appreciative to see Nevada focus on Dental and services available to both Medicaid and CHIP enrollees.

In conclusion, as the healthcare access monitoring review program evolves in Nevada, it is envisioned that identified remediation actions will occur in response to the initial set of review analysis data for the following services:

- Primary Care Services
- Physician Specialty Services
- Behavioral Health Services
- Pre- and Post-Natal Services
- Home Health Services
- Dental Services

The State of Nevada's ongoing plan will include the EQRO Network Access Analysis, the access portion of the CAHPS, the District Office customer service call center data, and the rates review. An analysis will be completed to determine benchmarks within the first year of the plan, or when a SPA that reduces or restructures provider payment is submitted to CMS. Information gained from these analyses, as well as stakeholder processes and any remediation activities, will be utilized to update Nevada's ACMRP.

a. 2016 NV Medicaid Online Provider Enrollment Survey

In the fall of 2015, DHCFP Provider Enrollment staff worked collaboratively with the state fiscal agent to develop a Nevada Medicaid Provider Enrollment Survey. The purpose of this survey was to obtain feedback from providers regarding how they would rate different areas of service provided as part of the Medicaid program. The timeframe of the survey was 31 days and consisted of 19 questions. As of April 2016, there were 26,632 providers enrolled in Nevada Medicaid. There were 366 responses received, which was only a 1.37% response rate.

1. **Provider profile questions** consisted of:

A. Primary type/s (PT-11, PT-14 PT-17, PT-19, PT-20, PT-22, and PT-25) and Secondary Provider type/s (PT-11, PT-12, PT-14, PT-22, and PT-82)

B. NPI/API Provided (Out of 366 responses, 181 did not provide responses to this question)

C. NV Medicaid Provider Service Duration (84% of respondents have been with Medicaid for 3 + years.)

D. Accepted NV Medicaid Plans: For those who answered Fee for Service and provided their NPI/API:
   - Las Vegas 68%
   - Reno 15%
   - Henderson 5%
   - Sparks 3%
   - Carson City 2%

E. Accepting New NV Medicaid Patients: The main reasons provided as to why respondents are NOT accepting new Medicaid patients are as follows:
   - Practice is Full
   - Extremely poor reimbursement, as Medicaid rates are not competitive
   - Difficulty/Inability to get claims paid

   There were seven providers who answered "No" and included their NPI/API to perform further outreach and follow up for clarification and education.

F. Method of Receiving Provider Notification: The survey was sent out via email and an announcement was posted on the Nevada Medicaid Provider Web portal. Based on the delivery system of this survey, the two highest categories in the area of "currently receive notification through which delivery system" were Web Portal and Email.

G. Method of Submitting Claims to NV Medicaid: With the no-paper initiative, Nevada requested the survey to address this very issue. Of the responses, 16.1% indicated that the providers send in paper claims. Any member who provided their NPI/API number, outreach activities were conducted to move toward electronic claim submissions. This also provided the State the opportunity to inform providers that the Allscripts Payerpath was going away.

2. **Provider Web Portal**

The use of the Web Portal questions addressed two main areas: verification of recipient eligibility prior to rendering services, and view claims status. Out of the 366 who responded, 279 answered the question pertaining to verification of recipient eligibility prior to rendering

services. The top comments provided as to why the provider did not utilize the Web Portal before rendering services were:

- Not a current job function
- Little manpower with small office
- Unaware of existence
- Not user friendly
- Information is not up to date on the portal *(Note: The portal contains the information found in the MMIS, however, data is received every 24 hours to refresh.)*
- Not registered

The top comments provided as to why the provider does not utilize the web portal to view claims status were:

- Web Portal is to "Clunky" to use *(Note: Updates to the web portal in version 5 is to eliminate some of the performance issues. This is currently an ongoing modernization enhanced project.)*
- Did not know we could view the claims status on the web portal
- Too many checks and not enough time

In order to capture provider feedback, the survey asked for suggestions for improvement to the Web Portal. The top four enhancement options were made up of 55.6% who stated they would want, "Ability to submit prior authorization peer to peer and reconsideration request," 50.4% stated, "Ability to submit claim appeal request," 36.7% requested "Increased prior authorization queue sorting capabilities" and 30.4% provided additional enhancement options: ability to check patient history. Other additional enhanced options include; warnings about prior authorization expirations; ability to see next month's MCO status as well as eligibility; ability to do online claim corrections; secondary, and claim reversal; access claims online; a place to report third party liabilities; and the ability to input your provider number and generate a list of active authorizations, unit, time period, and eligibility that you can sort by client name, authorization number, and authorization start and stop dates.

3. **Provider Representative questions** consisted of two main areas: Who are they and how they can assist, and Knowledge & Able.

Out of the 366 responses for the question addressing who their provider representative was and how they can help, there were 279 who answered provider representative question and 87 of those skipped the question. The top two highest comments provided were: 1) Do not know who their assigned representative is, and 2) Having issues with the responsiveness of inquires by the assigned representative.

A provider representative not being knowledgeable and able was discovered to be an alarming educational and training component. Out of the 366 responses for this question, there were 279 who answered provider representative question and 87 of those skipped the question. Of the responses, 31% felt either strongly agree or agree that the provider representative was knowledgeable and able, and 11% of the responses either strongly disagree or disagree that their

provider representative was well-informed and able. An immediate increase in communication to providers and DHCFP's fiscal agent team regarding changes/issues that impact them was put into place.

4. **Overall provider experience** rating consisted of:

- Prior Authorization
- Claims Adjudication
- Claims Appeals
- Provider Call Center
- Overall

Out of the 366 respondents, there were 279 respondents who answered prior authorization, claims adjudication, claim appeals and provider call center questions and 87 of them skipped this area of questions. There were 48% who were satisfied with the current prior authorization submission process, and 35.1% felt responses to request are timely. The question regarding whether the decision letters are clear and understandable received a 30.5% ranking, and authorization request processed accurately received a 28.7% ranking.

Top responses of concern in the area of prior authorization (PA) were: inconsistency of information, faxed PA submissions tool, FFS and MCO all use different PA forms, providers are getting kicked out of the portal, having notice of decision (NOD) letter available in portal, providers complaining the NODs are confusing, and providers requested more timely feedback.

Nevada considers the majority of these issues will be no longer a concern once Nevada updates their current Medicaid Management Information System targeted completion 2018.

In regard to the questions regarding Claims Adjudication, 56.6% responded they were satisfied with the claim submission process, 55.6% stated clean claims were paid in a timely manner, 45.2% answered clean claims are processed accurately, and 41.6% felt remittance advices are clear and understandable.

The top responses were that remittance advices are hard to read, confusing and do not provide enough information, third party liability (TPL) claim difficulties surrounding billing, and Call Center challenges were reported as being difficult to reach and not enough experience.

Of the respondents, 29% were satisfied with the claim appeal submission process, 22.2% agreed that appeals are processed in a timely manner, 20.8% stated clean appeals are processed accurately, and 17.9% indicated appeal decision letters are clear and understandable.

Provider Call Center was ranked on level of knowledge (Excellent, Average, Fair or Poor). The top three areas for improvement were: questions could not be answered, required multiple transfers to get to someone who knows the answer, and calls made to representatives regarding Medicaid manual specific to the Medicaid Services Manual (MSM), Chapter 400, were never answered appropriately. The next area of the provider Call Center was focusing on the timeliness

of responses to escalated inquires. Two main responses that scored at the level of being poor response were the wait time and that representatives rushed through their answer and were unwilling to answer more than one inquiry per call. These two areas of concern were found to be in-line with the ratings received for professionalism and efficiency. Issues expressed through the response of professionalism were: differences that were wildly dependent on which MCO you are trying to reach, some representatives don't seem to follow through with what they say they are going to do, maintains a non-committal attitude, and afraid to even answer a simple question about using the correct form. It was noted that representatives are polite; however, they were transferred multiple times and unable to get Prior Authorization Request denial help, which creates delay in patient care.

The Nevada Medicaid overall provider experience question was answered by 270 providers and 96 of them skipped this question. The results were: 30.7% in excellent, 41.5% for average rating, 21.1% in the fair category, and 6.7% in the poor category. The top response as to why Nevada was ranked accordingly was FFS providers lose patients to MCO providers and issues with quality of the system (portal kick out).

Providers were given the opportunity to provide suggestions for improvement. Below is a list of areas for improvement outlined by providers, which are not provider type specific:

- Claim Representative-Better Training
- Claims Processing-Quicker resolution
- Provider Representative
- Outreach-Annual Conference, provider type breakout sessions
- Portal-PA being Web based.
- Providers-Create standard process and requirements between FFS and all MCO's

Nevada Medicaid online provider enrollment survey also asked what was going well. The responses included: Nevada received multiple congratulations for incorporating the "Treatment History into the Web Portal," "Overall customer service is great," "Much improved service versus 8 years ago-Bravo," "Nevada's fiscal agent-DXC has done an excellent job of updating the Medicaid system and helping providers keep up with the changes: and "It's getting easier."

Takeaways from the 2016 Medicaid provider survey consisted of, but not limited to: listing all action items for appropriate manager distribution for improvement focus, assigning action owners for provider follow-up and issues addressed individually where providers feel like they have been heard, and prioritize each task with a set target date and feedback to the state.

b. 2017 Dental Revisions

During the 2017 Legislative Session, a bill was passed (AB 108) mandating Nevada Medicaid to review all rates on a rotating four-year cycle, including Dental. There are no Medicare rates to compare to as Dental is not a Medicare covered benefit. In 2017, dental services were carved out of the managed care health plans. The DHCFP submitted to CMS the 1915i Waiver requesting

approval to implement a Dental Business Administrator (DBA) plan. A Public Workshop was held to discuss available options and to allow stakeholder input. Options were developed, along with comparisons to other States and aligning the appropriate baseline data for tracking and monitoring. As outlined in the plan, the DHCFP will monitor utilization over a three-year period to determine if there may be any access issues as a result of the changes. If there appears to be a negative impact to access, the information will be evaluated, as the change in utilization may not be directly related to reimbursement. It could be a result of policy changes or the new DBA. If it is determined the decline in access was directly related to the rate, then it would be presented to Administration for consideration to reevaluate the rates.

The change to implement a DBA plan was necessary to increase the focus of the dental program to separate it from the Medical portion of the MCO in order that there could be a better focus on Dental for prevention and disease reduction. After the change occurs, the data will include DBA and FFS Dental data.

c. **2017 Nevada Child FFS CAHPS Survey**

Nevada developed a FFS survey asking families to take a 20 minute survey about their child's health care. An independent research firm was asked to work collaboratively with the States EQRO and to conduct the survey. The main focus areas reach beyond Nevada's initial CAHPS survey example:

- Child's Health Care in the Last six Months,
- Your Child's Personal Doctor,
- Getting Health Care from Specialists,
- Your Child's Medicaid Program, and
- About your Child and You.

There are three separate communication attempts to reach out to families for completing the survey. The anticipated survey delivery date to Medicaid FFS families is set for early December to Mid-January 2018. Result of this survey is not expected to be completed until the end of March 2018. In January 2018, the DHCFP received an updated report for the 2017 Nevada Child FFS CAHPS Survey administration. The response rate is 21.04 %.

Additionally, the survey officially closed on January 19th. Currently, the States EQRO is working on reconciling the survey data into a final data file, and will submit a final disposition report to the DHCFP by mid-February 2018. Figure 10 below provides a preliminary response rate.

Figure 10. NV FFS CAHPS Preliminary Response Rate 2017-2018

CAHPS 5.0H Child Medicaid Health Plan Survey
Nevada Department of Health and Human Services
January 19, 2018

			Completes			Returns			Ineligible			
	Sample Size	Preliminary Response Rate	Total	Phone	Mail	Mail 1	Mail 2	Undel.	Total	Not Enrolled	Deceased	Language Barrier
Nevada Fee-for-Service Total	**2,145**	**21.04%**	**451**	**165**	**286**	**190**	**96**	**266**	**1**	**0**	**1**	**0**
Child Fee-for-Service	2,145	21.04%	451	165	286	190	96	266	1	0	1	0

Note: Preliminary response rates do not reflect the final reconciliation process. All reported response rates are preliminary until the final reconciliation is completed after the close of the survey field.

IX. Resources & Link to Nevada Reports

1. Nevada Department of Health and Human Services (DHHS) Fact Book, February 2016

   URL:http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Reports/DHHS_FactBook.pdf

2. Nevada Division of Health Care Financing and Policy, External Quality Review-Technical Report SFY 2015-2016, Health Services Advisory Group, October 2016

   URL:http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Members/BLU/NV2015-16_EQR_TechRpt_F1.pdf

3. Nevada Division of Health Care Financing and Policy, Provider Network Access Analysis SFY 2014-2015, Health Services Advisory Group 2015

   URL:http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Members/BLU/2014-2015%20Network%20Adequacy%20Report.pdf

4. Nevada Fiscal Agent; DXC (Previously Hewlett Packard Enterprise Services (HPES), 2016 Nevada Medicaid Provider Survey, Provider Web Portal

   https://www.medicaid.nv.gov/Downloads/provider/Survey_Results_20160708.pdf

Attachment A. Facility & Non-Facility Rate Comparison

Procedure Code & Description		Nevada Medicaid Rates	2016 Medicare (MC) Non-Facility (NF) Rates for NV	Percent of MC NF Rates for NV	2016 MC Facility Rates for NV	Percent of MC Facility Rates for NV	Utah Medicaid Rates	2016 MC NF Rates for Utah	Percent of MC NF for Utah	2016 Medicare Facility Utah
59400	PB care antepartum vag dllvr & postpartum	$2,144.73	$2,192.03	98%	$2,192.03	98%	$2,028.50	$2,144.92	95%	$2,144.92
59409	Vaginal delivery only	$840.57	$854.03	98%	$854.03	98%	$802.83	$847.98	95%	$847.98
59510	OB antepartum care cesarean dlvr & postpartum	$2,371.93	$2,432.07	98%	$2,432.07	98%	$2,028.50	$2,385.12	85%	$2,385.12
59514	Cesarean delivery only	$945.68	$962.24	98%	$962.24	98%	$802.83	$956.64	84%	$956.64
71010	Chest x-ray 1 vew frontal	$27.15	$23.36	116%	$23.36	116%	$18.39	$21.48	86%	$21.48
72148	MRI spinal canal lumbar w/o contrast material	$256.98	$233.26	110%	$233.26	110%	$357.48	$212.00	169%	$212.00
73580	Contrast x-ray of knee joint	$127.06	$120.91	105%	$120.91	105%	$84.64	$108.91	78%	$108.91
73615	Contrast x-ray of ankle	$107.15	$109.64	98%	$109.64	98%	$71.98	$98.92	73%	$98.92
73718	MRI lower extremity w/o dye	$482.91	$383.24	126%	$383.24	126%	$584.59	$343.02	170%	$343.02
76380	Cat scan follow-up study	$181.72	$153.25	119%	$153.25	119%	$122.57	$139.36	88%	$139.36
76811	OB us detailed single fetus	$249.06	$190.97	130%	$190.97	130%	$212.39	$177.57	120%	$177.57
77054	X-ray of mammary ducts	$130.69	$80.44	162%	$80.44	162%	$57.74	$72.92	79%	$72.92
77077	Joint survey single view	$53.68	$38.93	138%	$38.93	138%	$26.77	$35.79	75%	$35.79
78102	Bone marrow imaging ltd	$106.07	$184.84	57%	$184.84	57%	$70.64	$165.14	43%	$165.14
78300	Bone imaging limited area	$126.34	$197.12	64%	$197.12	64%	$84.44	$176.32	48%	$176.32
78452	Myocardial spect multiple studies	$389.83	$515.18	76%	$515.18	76%	$336.23	$460.24	73%	$460.24
90472	IM Admin PRQ ID subq/IM NJXS Each vaccine	$7.80	$12.90	60%	$12.90	60%	$13.81	$12.06	115%	$12.06
90791	Psychiatric diagnostic evaluation	$139.46	$134.02	104%	$129.50	108%	$33.16	$131.49	25%	$127.53
90792	Psychiatric diagnostic eval w/medical services	$124.29	$148.21	84%	$143.69	86%	$33.16	$145.33	23%	$141.37
90834	Psychotherapy patient &/family 45 minutes	$73.92	$86.09	86%	$85.72	86%	$97.06	$84.77	114%	$84.44

Procedure Code & Description		Nevada Medicaid Rates	2016 Medicare (MC) Non-Facility (NF) Rates for NV	Percent of MC NF Rates for NV	2016 MC Facility Rates for NV	Percent of MC Facility Rates for NV	Utah Medicaid Rates	2016 MC NF Rates for Utah	Percent of MC NF for Utah	2016 Medicare Facility Utah
90837	Psychotherapy patient &/Family 60 minutes	$108.15	$129.50	84%	$128.37	84%	$120.79	$127.53	95%	$126.54
90847	Family psychotherapy w/patient present	$97.85	$108.17	90%	$107.42	91%	$27.19	$106.48	26%	$105.82
93306	Echo TTHRC R-T 2D w/WOM-mode compl spec & colr D	$203.53	$239.65	85%	$239.65	85%	$173.58	$216.51	80%	$216.51
99204	Office outpatient visit, new 45 min	$162.51	$170.06	96%	$133.56	122%	$120.63	$161.91	75%	$129.88
99214	Office outpatient visit, est 25 min	$105.48	$110.93	95%	$80.45	131%	$85.38	$104.77	81%	$78.03
99215	Office outpatient visit est 40 min	$141.04	$149.31	94%	$113.94	124%	$114.84	$141.58	81%	$110.55
G0299*	Direct skilled nursing svcs RN	$25.60					$22.72			
G0300*	Direct skilled nursing svcs LPN	$17.00					$17.72			
G0151*	Svcs performed by Phys Therapist	$16.36					$19.83			
G0153*	Svcs performed by Speech-Lang Path	$16.36					$17.97			
	Total Average Comparison			99%		103%			84%	

The current Medicare Physician Fee Schedule does not price the following Healthcare Common Procedure Coding System (HCPCS) codes for Home Health services. The information below provides a sample comparison of Nevada Medicaid rates to Utah Medicaid rates:

Procedure Code & Description		Nevada Medicaid Rates	Utah Medicaid Rates
G0299	Direct skilled nursing services of a RN	$11.87	$22.72
G0300	Direct skilled nursing services of a LPN	$8.84	$17.72
G0151	Services performed by a qualified physical therapist	$14.03	$19.83
G0153	Services performed by a qualified speech-language pathologist	$14.03	$17.97

Medicare does not cover most dental. The table below provides a comparison of Nevada Medicaid rates to Utah Medicaid Rates for 2016:

Procedure Code & Description		Nevada Medicaid Rates	UTAH Medicaid Rates
D0140	Limited oral evaluation-problem-focused	$33.24	$23.11
D0220	Intraoral first dadiograph-periapical	$18.86	$11.55
D0230	Intraoral radiograph-perapical-each addl imag	$5.89	$8.97
D0274	Bitewings-four radiographic images	$23.57	$29.51
D1120	Dental prophylxis-child	$57.28	$32.07
D5110	Complete dentury-maxillary	$615.00	$604.53
D5214	Mand part denture-cast metal frane w/resin bases	$615.00	$646.70
D7210	Surg removal erupted tooth req removal bone	$87.12	$78.27

Attachment B. Provider Table

Nevada Six Core Providers Focus Areas 2010 - 2017										
Identifiers	**Provider Type**	**Provider Specialty**	**Jul-10**	**Jul-11**	**Jul-12**	**Jul-13**	**Jul-14**	**Jul-15**	**Jul-16**	**Jul-17**
PCP/PCP Extenders	17-Special Clinics	180, 181	28	31	33	35	38	39	44	49
	20-Physician	053, 056, 060, 139,148	1,380	548	1,512	1,647	1,950	2,080	2,195	2,288
	24-APRN	N/A	303	352	399	449	609	805	964	1,182
	77-PA/PA-C	N/A	357	365	387	451	530	599	671	732
Specialty	20-Physician	57, 58, 59, 61, 64, 65, 66, 68, 72, 73, 74, 92, 100, 101, 103, 104, 106, 107, 108, 110, 112, 114, 116, 118, 119, 120, 121, 122, 123, 125, 126, 127, 128, 130, 131, 132, 133, 134, 135, 136, 137, 138, 140, 141, 142, 143, 144, 149, 150, 151, 152, 153, 154, 156, 157, 158, 159, 170, 218	1,770	2,021	1,952	2,209	2,551	2,566	2,726	2,820
	25-Optometrist	N/A	241	261	278	296	339	360	376	373
	34-Therapy	027, 028, 029,176, 219	-	-	-	-	-	-	986	1,027
	41-Optician, Optical Business		9	18	12	15	16	13	14	16
	76-Audiologist		-	-	-	-	-	-	71	73
Dental	22-Dentist	N/A	690	807	739	854	852	831	952	918
OBGYN/NeoNatal	20-Physician	062, 067,117, 124, 129, 145	261	263	267	294	341	358	377	376
	74- Nurse Midwife	N/A	8	4	4	7	8	14	23	19
Behavioral Health	13-Psychiatric Hospital, Inpatient	N/A	10	10	11	11	12	12	12	11
	14- Behavioral Health Outpatient Treatment	N/A	616	1,142	3,258	4,697	6,141	5,893	5,545	5,218
	20-Physician	113, 146, 147,	86	100	100	120	154	162	167	187
	26-Psychologist	N/A	138	150	160	154	175	193	200	192
	63-Residential Treatment Center	N/A	3	3	3	3	3	4	4	6
	82-Behavioral Health Rehabilitative Treatment	N/A	572	565	623	1,009	1,286	1,181	843	445
Home Health	29-Home Health Agency	N/A	55	52	56	57	63	62	63	56

Year	Jul-10	Jul-11	Jul-12	Jul-13	Jul-14	Jul-15	Jul-16	Jul-17
Total	6,527	6,692	9,794	12,308	15,068	15,172	16,233	15,988

Attachment B. Provider Table Specialty Code Defined

2016 Nevada Medicaid Provider Types and Specialties: Primary Care Services, Physician Specialist, Behavioral Health, Pre and Post-Natal Obstetrics, Home Health and Dental.

Provider Type Number	Description
13-Psychiatric Hospital, Inpatient	**Psychiatric-Behavioral Health**
14-Behavioral Health Outpatient Treatment	**Behavioral Health**
17- Special Clinics	**Special Clinic** *One or more specialty codes are required on the Application.* 166: Family Planning 167: Genetic 171: Methadone 174: Public Health 179: School Based Health Centers (SBHC) 180: Rural Health Clinic 181: Federally Qualified Health Center 182: Indian Health Programs, Non-Tribal 183: Comprehensive Outpatient Rehabilitation Facilities (CORF) 195: Community Health Clinics – State Health Division 196: Special Children's Clinics 197: TB Clinics 198: HIV 215: Substance Abuse Agency Model (SAAM)
20-Physician	**Physician, M.D., Osteopath, D.O.** *One or more specialty codes are required on the Application.* 053:Family Practice 056:General Practice 057:Anesthesiology 058:Colon/Rectal Surgery 059:Dermatology 060:Internal Medicine 061:Neurosurgery 062:Obstetrics/Gynecology 064:Orthopedic Surgery 065:Otolaryngology 066:Pathology 067:Neonatology 068:Physical Medicine 072:Radiology 073:General Surgery 092:Rehabilitation 100:Mammography 101:Resontructive Surgery 103:Allergy 104:Bronchoesophagology 106:Cardiovascular 107:Cardiovascular Surgery 108:Chemotherapy 110:Diabetes 112:Endocrinology

Provider Type Number	Description
	113:Behavioral Health-Forensic Psychiatry 114:Gastroenterology 116:Geriatrics 117:Gynecology 118:Hand Surgery 119:Hand/Neck Surgery 120:Hematology 121:Immunology 122:Infectious Disease 123:Laryngology 124:Maternal Fetal Medicine 125:Nephrology 126:Neurology 127:Neuropathology 128:Nuclear Medicine 129:Obstetrics 130:Occupational Medicine 131:Oncology 132:Otology 133:Otorhinolaryngology 134:Pain Management 135:Pediatric Neurology 136:Pediatric Intensive Care 137:Pediatric Ophthalmology 138:Pediatric Surgery 139:Pediatrics 140:Pediatrics-Allergy 141:Pediatrics-Cardiology 142:Pediatrics-Hematology 143:Pediatrics-Oncology 144:Pediatrics-Pulmonary 145:Perinatal Medicine 146:Behavioral Health-Psychiatry 147:Behavioral Health-Psychiatry-Child 148:Public Health 149:Pulmonary Diseases 150:Radiation Therapy 151:Respiratory Diseases 152:Rheumatology 153:Sports Medicine 154:Traumatic Surgery 156:Urologic Surgery 157:Vascular Surgery 158:Vitreoretinal Surgery 159:Rhinology 170:Maxillofacial Surgery 218:Diagnostic Radiology
22-Dentist	**Dentist** *One or more specialty codes are recommended on the Application.* 078:General Dentistry 079:Orthodontia 080:Oral Surgery 081:Periodontics 164:Emergency Dentistry

Provider Type Number	Description
	165:Family Dentistry 170:Maxillofacial Surgery 172:Maxillofacial Prosthetics 173:Pediatric Dentistry 175:Prosthodontics 187:Dental Hygienist – – :Endodontist: On the Application, please write "*endodontist*" in the "Specialty Code" section.
24-APRN	**Advanced Practice Registered Nurse (APRN)**
25-Optometrist	**Optometrist**
26-Psychologist	**Psychologist**
29-Home Health	**Home Health Agency**
41- Optician, Optical Business	**Optician, Optical Business**
63-Residential Treatment Center	**Psychiatric Residential Treatment Facilities (PRTF)**
74-Nurse Midwife	**Nurse Midwife**
77-PA/PA-C	**Physician's Assistant (PA/PA-C)**
82-Behavioral Health Rehabilitative Treatment	**Behavioral Health Rehabilitative Treatment**