Nevada Medicaid Managed Care MCO Expansion Recommendations

Nevada Division of Health Care Financing and Policy (DHCFP) has finalized the bid process for its Medicaid Managed Care program for effective date of July 1, 2017.

As the State of Nevada enters into the contract negotiation phase for the selected Medicaid Managed Care Services, the Nevada Hospital Association (NHA) would like the State to once again consider including the following items in the design of the contract:

Network Requirements

1. **Adequate Provider Networks**
    a. Require payers to report only Medicaid providers they contracted as part of their network for adequate network determination
        i. Include any limitations on access – (i.e., number of beds available for Medicaid patients, limits on taking new Medicaid patients, etc., including but not limited to, mental health services and post-acute providers such as SNF, Home Health and LTACH.)
        ii. Reporting should be updated at least monthly.
    b. Require payers to ensure Medicaid MCO enrollees establish a relationship with a primary care provider to reduce unnecessary visits to hospital emergency rooms by incorporating the following in the contracts:
        i. Medicaid MCO members are assigned a primary care provider (PCP)
        ii. All Medicaid MCO enrollees must have a visit with their primary care provider within a specific period of time (i.e. six months or a year) to establish a relationship with their PCP if they don't yet have an established
        iii. All of the Medicaid MCO's must provide access to primary/urgent care 7 days a week including after-hours care (i.e., 8 am – 9 pm daily)
    c. Develop network adequacy standards and assess penalties when standards are not met on a consistent basis (i.e., more than two months in a row).
    d. Require payers to pay for the level of care their members are consuming. When patients are waiting for placement/discharge services to be arranged, hospitals should be paid at the hospital acute rate which is the level of care provided. Acute care hospitals do not provide skilled nursing facility services and should not be subject to the same reimbursement levels as free-standing SNFs. Consider either:
        i. Eliminating the administrative rate for general acute care hospitals and do not allow MCOs to deny payment for days the patient is holding for placement, or
        ii. Significantly increasing the administrative rate in the Medicaid Fee Schedule to at least 50% of the acute rate to provide incentive for payers to get patients discharged and to the appropriate level of care.
    e. Provide more points to MCOs that have expanded "covered services" to include more levels of care so that care can be provided more timely and cost effectively (i.e., for those needing some level of care, allow for ICF, Group Home, Assisted Living, Home Care, if appropriate).

2. **Out of Network Protections**
    a. Clear guidelines for out-of-network (OON) payments.

i. Should not unfairly advantage MCOs over providers.
ii. Providers should not be penalized for not being able to reach agreement with MCOs.

3. **Medicaid MCO geographic expansion**
   a. Exclude rural communities from the Medicaid MCO expansion until such time that the state can ensure these rural facilities are kept whole and reimbursement rates remain in compliance with Medicaid cost based reimbursement. Most of these rural sole community providers are already struggling financially and do not have the resources to work through the issues experienced by urban facilities to get paid from the managed care payers.

MCO Payer Accountability

Authorization and Utilization Review: Among others not listed here, providers need to be assured that they will be covered by the following protections under the Nevada Managed Medicaid program:

1. Clear guidelines that detail how MCOs will provide authorizations to providers for patient care services to be rendered.
   a. Electronic connectivity for requesting and issuing authorizations that must be documented between the parties.
   b. Universal authorization (if one Medicaid payer provided an authorization for a service, the service is covered regardless of the final Medicaid payer paying the claim)
   c. Authorizations must be provided quickly (real-time basis) and cannot be delayed for any reason. An authorization needs to be defined as a promise to pay and cannot be revoked once granted. Authorizations must be granted at the time of request within a reasonable period of time for MCO review, such as 24 hours or the next business day.
   d. Require payer authorizations to be final.
   e. No authorization should be required for emergency or post-stabilization care and services, including admissions from the Emergency Room.

2. Clear guidelines on Utilization Management practices by the MCO.
   a. MCOs should be required to pay for medically necessary care consistent with InterQual clinical guidelines. The proper definition of Medical Necessity is critical.
   b. MCOs should not be allowed to unilaterally change the level of care authorized to or ordered by licensed physicians and actually rendered by providers pursuant to such orders.
   c. Licensed physicians' orders should prevail (over MCO edicts) when a patient has not been discharged.
   d. Require payers to follow all State Medicaid policies
      i. If not using Interqual for level of care determination, a cross walk must be developed and used to effectively get to Interqual.
      ii. Ensure payers must follow Interqual clinical levels as they are mapped to revenue codes in Medicaid policy.

3. Clear guidelines on approving and paying emergency services and care.
   a. Non-emergent denials are not allowed for patients seeking ER services. Not paying the provider for the service provided does not impact the Medicaid recipient who chose to access care in the ER.

    a. An MCO payer must ensure all members have been assigned to a primary care provider and provide education to members regarding access (member sign off as having received information).
  b. MCO must pay for all services medically necessary to adequately screen, stabilize and treat a patient.
  c. MCO must pay for emergency services and care, including all screening, stabilization and treatment services, even if an emergency medical condition is later determined not to have existed.
  d. Coding, level-of-care and corresponding payments must be consistent with ACEP, CMS and NUBC criteria.

Payment and Appeal Protections

4. Clearly defined claims processing and payment guidelines.
  a. Standardize timeframes for authorizations/billing/appeals for all Medicaid payers
  b. Reasonable timely filing requirements (at least six months, and subject to automatic exceptions and exemptions based on items including the patient presenting the wrong ID card or with no ID card as a self-pay patient, COB cases in respect to which the provider filed its claim with a different payer reasonably thought to be primary or other cause that is not the fault of the provider).
  c. Properly completed UB should be considered a clean claim.
  d. Require Medicaid MCO payers to follow policies similar to Nevada's current prompt pay statute
    a. Prompt pay rules that have teeth (e.g., meaningful late payment penalties, inability of plans to delay payment by suspending claims for medical record reviews – i.e., plan should be required to "pay first, ask questions later").
  e. Commitment to offer electronic billing, claims review, remit and payment (ERA, EFT, etc.).
  f. Reasonable appeal submission (12 months), denial overturn requirements placed on the MCO based on medical necessity, processing deadlines and required plan response times.

Other Accountability/Reporting Requirements

5. Develop a monthly (trended) and YTD payer report card – goals should be set for each category
    a. Average days from receipt to payment
    b. Average days from service date to received date
    c. Using a 30 day metric: turnaround time (receipt to payment) % achieved
    d. First time claim EDI: % achieved
    e. First time claim auto adjudicated: % achieved
    f. By provider: claims billed/claims paid/claims denied and/or underpaid by reason/claims appealed/claims overturned

6. Ensure that the State has the ability to assess penalties for key agreed upon objectives not routinely achieved (i.e., out of compliance more than two months in a row).

7. Above reports need to be posted on the Nevada DHCFP website to promote transparency.

MCO standard monthly and YTD reporting – by provider

8. Utilization reporting including:

a. For inpatients: admissions/days/case mix index/trauma cases/trauma days/administrative days paid
b. For outpatients: ER visits/other visits

9. Posted publicly on the Nevada DHCFP website to promote transparency

General Conditions to Participate

10. Payers must participate in the HIE.

Standard Template Contract Language

Below is recommended contract language that we ask the Nevada Division of Health Care Financing and Policy to adopt as required language in standard template contracts between the Medicaid payers and hospitals.

Authorizations and Utilization Review

Emergency Services

Regardless of either party's clinical determination as to whether or not the Member was treated for an Emergency or Emergency Medical Condition, Plan will reimburse Facility for services rendered in the emergency department (ED) as outlined herein. Plan will reimburse all Facility claims based upon the attached Payment Rate schedule and will not deny, down code or otherwise underpay any claims billed relative to ED services. Plan will not have the right to change the CPT Code properly billed by Facility and/or change the payment for the CPT Code properly billed. This does not modify the current contractual rights associated with the determination of Member Eligibility in accordance with the Section of the Agreement but Members will be presumed to be covered for ED services and payments under the rate attachment if they were enrolled Members with Plan at the time of service.

Important Definitions

Emergency Medical Condition: *A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:*

a. *Serious jeopardy to the health of a patient, including a pregnant woman or a fetus and acute mental health conditions.*
b. *Serious impairment to bodily organ or part.*
c. *Serious dysfunction of any bodily organ or part.*

With respect to pregnant women, an emergency medical condition exists when there is:

a. *Inadequate time to effect safe transfer to another facility prior to delivery.*
b. *Transfer may pose a threat to the health and safety of the patient or fetus.*
c. *Evidence of onset of uterine contractions or rupture of the membranes.*

Emergency Services and Care: *Medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician to determine if an Emergency Medical Condition exists and if it does, the care, treatment, or surgery for a Member by a physician necessary to relieve or eliminate the Emergency Medical Condition provided in accordance with the federal Emergency Medical Treatment and Active Labor Act (EMTALA).*

Medically Necessary*: The use of services and/or supplies provided by or to be provided to a Member under the provisions of this Agreement which are:*

a. *Appropriate for the symptoms, diagnosis or treatment of the Member's medical condition, disease, illness or injury as ordered by the treating physician;*
b. *In accordance with standards of accepted medical practice within the medical community in which the services are being rendered;*
c. *Not primarily for the convenience of the Member or his or her physician; and*
d. *Provided for the diagnosis/treatment or direct care of illness, disease or injury of the Member's medical condition as directed by the treating physician.*

Plan agrees, by law, that what constitutes medically necessary services (i) may be no more restrictive than that used in the Managed Medicaid Program as indicated in state statutes and regulations and other State policy and procedures and (ii) must address the extent to which the managed care organization is responsible for covering services related to the following: (a) the prevention, diagnosis, and treatment of health impairments; (b) the ability to achieve age-appropriate growth and development; and (c) the ability to attain, maintain, or regain functional capacity.

Facility will notify Plan of the presentation of a Member to Facility for inpatient services, including emergency admissions, for individuals who identify themselves as Members, within the longer of twenty-four (24) hours of the presentation or the end of the next business day.

Authorizations

Plan will issue an authorization number immediately upon notification that reflects Covered Services from the date of Member's presentation through the date of discharge consistent with physician orders as they relate to patient type (i.e., admission vs. observation) with confirmation by electronic transmission.

Requests for treatment authorization after notification cannot be pended with no authorization provided.

Regardless of any provision in this Agreement or Plan policy or procedure to the contrary, in the case of an emergency, Facility is not required to provide notice, obtain coverage verification or prior authorization from Plan prior to providing Emergency Services and Care and Post-Stabilization Care Services (specifically including, but not limited to, Observation Services rendered subsequent to and as a part of the emergency care episode) to a Member in accordance with 42 CFR §422.113.

Where services were previously authorized by the Plan, payment for those services cannot be retrospectively denied for any reason.

Subject to Facility's policies and bylaws, Facility shall exert commercially reasonable efforts to cooperate with Plan's policies including but not limited to quality assurance, quality improvement, member grievance and appeal, medical records retention and credentialing criteria policies (the "Plan Policies"), provided that such Plan Policies have been provided to the Facility in writing sixty (60) days in advance of their effective date and Plan has made any reasonable modifications to such Plan Policies that are requested by Facility. Plan Policies shall be consistent with the terms of this Agreement, with Facility's policies and procedures, and with applicable Regulatory Requirements; commercially reasonable; in writing; and changes thereto will be noticed in writing. To the extent Plan Policies conflict with this Agreement, the terms of this Agreement will prevail.

Payment and Appeal Protections

Important Definitions

Claim: *A paper or electronic billing instrument that consists of a complete UB-04 or CMS 1450, as applicable, data set, or their respective successor forms, with entries stated as mandatory by the National Uniform Billing Committee, and with respect to electronic claim forms, completed in the format and with the data content and data conditions specified in HIPAA.*

Covered Services: *Health care services and supplies that a Member is entitled to receive which are reimbursable by Plan pursuant to the rate attachment which sets out the Facility's reimbursement under the Managed Medicaid Program.*

Plan is liable and must pay Facility for any Covered Services provided to Members which are authorized by the Plan or its agent unless Facility knowingly provided false and misleading information upon which the authorization was granted.

Plan shall not deny a Claim for Emergency Services and Care because the condition was subsequently determined not to be an emergent condition.

Plan agrees that it will not deny payment solely because Facility fails to verify eligibility or obtain pre-authorization for services rendered to Members. This will not relieve Facility of its obligations in the normal course of business to make responsible attempts to obtain authorization for non-emergency services if so required by Plan's Policies.

If Facility's Claim is partially or totally denied in a remittance advice or other appropriate written notice, then Facility may submit an appeal to Plan within twelve (12) months of the receipt of the partial or total denial of the Claim. The appeal should include any documentation or information reasonably necessary to support the appeal for reconsideration. Plan must respond to the appeal within sixty (60) days after receipt of the request.

Notwithstanding any provision in the Agreement to the contrary, Facility may appeal and Plan shall review Claims that were totally or partially denied for Facility's failure to i) file a Claim within the time limit set forth in the Agreement; ii) provide a notice required by the Agreement; iii) follow Plan Policies; iv) determine eligibility; or v) obtain an authorization, to determine if the services rendered were Covered Services, were Medically Necessary and would have been authorized had prior authorization been sought. If in its evaluation of Facility's reconsideration request, Plan reasonably determines, following review by a physician licensed in the State of Nevada in the medical specialty most clinically applicable to the case in question, that the services provided by Facility were Covered Services, were Medically Necessary and appropriate for the Covered Person's condition, and would have been authorized by Plan, then Plan shall reverse its denial and reimburse Facility in accordance with terms outlined in the Agreement within ten (10) days of such determination.

Service Availability: *Plan acknowledges not all Covered Services are available on a 24 hour per day, 7 days per week basis (e.g. cardiac catheterization laboratory, outpatient surgery, certain diagnostic testing, etc.). Accordingly, Plan will not deny Claims or otherwise penalize Facility for services that are not made available and provided to Members on a 24 hour per day, 7 days per week basis consistent with standards of the Facility in question as are applied to all other of Facility's patients.*

Prompt Denial Process: *If Plan contests Facility's Claim or any portion of a Claim, Plan shall notify Facility in writing within thirty (30) days after Receipt of the Claim by Plan that the Claim is contested. The notice that the Claim is contested must specifically identify the contested portion of the Claim and the specific reason for contesting the Claim, and must include a request identifying the specific additional medical information required. If Plan requests additional medical information, Facility must, within thirty (30) days after receipt of such request, mail or electronically transfer the information to Plan. Plan shall pay the Claim or portion of the Claim within twenty (20) days after receipt of the requested information.*

Timeframes for Under/Overpayment and no Offsetting: *With the exception of those extenuating circumstances (e.g., COB, Facility unable to timely identify a patient as a Plan member through no fault of Facility, etc.), and regardless of any provision to the contrary, no request shall be allowed for any alleged overpayment or underpayment made more than three hundred and sixty-five (365) days from inpatient discharge dates and outpatient service dates, as applicable. Neither party has a right of offset, any right of retroactive reductions in payment, or any right to demand a refund of alleged overpayment or underpayment unless performed in accordance with this Agreement or mutually agreed upon in writing by the parties.*