

**MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER**

January 28, 2022

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES *Casey Angres*
Casey Angres (Mar 7, 2022 08:21 PST)
 MANAGER OF DIVISION COMPLIANCE

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

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3600 – Managed Care Organizations are being proposed to align with the new contracts held with the Managed Care Organizations (MCOs). The proposed changes include revisions and clarification to existing policy related to MCO responsibility and coverage of Certified Community Behavioral Health Centers (CCBHCs); Residential Treatment Centers (RTC); and Population Health program.

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

Entities Financially Affected: This proposed change affects all Nevada Medicaid MCOs.

Financial Impact on Local Government: Unknown at this time.

These changes are effective January 29, 2022.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 03/22 MSM Chapter 3600 – Managed Care Organizations	MTL 16/20 MSM Chapter 3600 – Managed Care Organizations

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3600	INTRODUCTION	Revised “three” to “four” Health Maintenance Organizations (HMO).
3603.1(A)(10)	ELIGIBLE GROUPS	Revised number 10 “TANF and CHAP adults diagnosed as Seriously Mentally Ill (SMI).”

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3603.4(B)	EXCLUDED SERVICES AND/OR COVERAGE LIMITATIONS	Added “medical” to non-emergency transportation (NEMT).
3603.4(D)		Revised “45”days to “180” days. Revised “40 th ” to “175 th ” day. Revised “46 th ” to “181 st ” day.
3603.4(H)		Deleted the item (Residential Treatment Center (RTC) Limitations).
3603.4(I)		Added language “such as crisis residential services.”
3603.4(M)		Revised “45” days to “180” days. Revised “#c” to “#D.”
3603.4(O)		Deleted any reference to Seriously Mentally Ill (SMI) I this section. Deleted “Newly Eligibles” and replaced with “and Nevada Check Up recipients.”
3603.4(Q)		Deleted language related to Certified Community Behavioral Health Centers (CCBHC) in this section.
3603.5(D)	SPECIAL REQUIREMENTS FOR SELECTED COVERED SERVICES	Added language “FQHCs not contracted with a Contractor must follow the Contractor’s Prior Authorization Policy.”
3603.5(F)(4)		Added language “Maternity Kick payment will be processed per delivery episode regardless of how many babies are delivered.”
3603.5(F)(6)		Revised language to Coordination of Care to align with Code of Federal Regulation (CFR) requirements.
3603.5(G)		Added language to clarify Essential Community Providers (ECP) requirements.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3603.10	CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTERS (CCBHC)	Added language related to CCBHCs.
3603.11	RESIDENTIAL TREATMENT CENTER (RTC)	Added language related to RTC.
3603.12	CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) AND MENTAL HEALTH SERVICES FOR ADULTS	Added language to clarify services included.
3603.12(a)		Added “or Case Manager.”
3603.12(b)		Added “as part of the Utilization Management process.”
3603.13	TRANSPLANTATION OF ORGANS AND TISSUE, AND RELATED IMMUNO- SUPPRESSANT DRUGS	Revised “\$100,000” to “\$500,000.”
3603.15	POPULATION HEALTH PROGRAM	Added section related to Population Health Program.
3603.18(A)(1)	ENROLLMENT AND DISENROLLMENT REQUIREMENTS AND LIMITATIONS	Revised “45” to “180” days.
3603.18(C)		Revised language to clarify reporting on newborn enrollments.
3603.18(C)(1)		Revised language to clarify MCO responsibilities for Medicaid Eligible Newborns.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3603.18(C)(2)		Revised language to clarify MCO responsibilities for Nevada Check Up (NCU) Newborns.
3603.18(D)(2)		Added language “and outlines in the Medicaid State Plan.”
3603.18(F)		Added new section F “Performance Based Auto Assignment.”
3603.20(B)	TRANSITIONING/ TRANSFERRING OF ENROLLEES	Added language to clarify enrollees changing MCOs or reverting to Fee-for-Service (FFS).
		Deleted number 12.
		Added number 17.
3603.20(C)		Added item C section related to Transitions of Child Welfare Involved Children from FFS to an MCO.
3603.21(A)(1)	INFORMATION REQUIREMENTS	Added language to the Member Handbook requirements.
3603.21(A)(2)		Added language to the role of Primary Care Physician (PCP).
3603.21(A)(3)		Deleted number 3.
3603.21(A)(4)		Added language “as well as their right to select a Primary Care Site (PCP) that meets their cultural and/or racial preferences.”
3603.21(A)(10)		Deleted language related to explanation of procedures for urgent medical situations.
3603.21(A)(11)		Added language related to explanation of procedures for urgent medical situations.
3603.21(A)(12)		Added “and information that a referral is not required in choosing a family planning provider.”
3603.21(A)(13)		Added language to clarify that MCOs must notify enrollees when the MCO changes a policy based on moral or religious objectives.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3603.21(A)(24)		Added language to clarify how to report fraud and abuse.
3603.21(A)(25)		<p>Added number 25 “The transition of care policy and instructions on how to access continued services upon transition to FFS or another MCO.”</p> <p>Revised language throughout the section for more clarification on the Member Handbook.</p>
3603.21(B)		Revised item B “Identification of Cards” to “Member Newsletter.”
3603.21(E)		<p>Added “calendar” days.</p> <p>Revised “working” to “business” days.</p>
3603.22(A)	MEDICAL PROVIDER REQUIREMENTS	Revised language related to PCP or PCS requirements in this section.
3603.22(B)		Added language related to PCP or PCS assignment.
3603.22(B)(2)		Added language to clarify access to PCPs per CFR requirements and removed Nevada Administrative Code (NAC) reference.
3603.22(B)(5)		Added number 5 “Assigning an enrollee to a PCP upon receipt of a claim for services rendered by a PCP to the enrollee.”
3603.22(C)(1)		Deleted “The materials used to notify enrollees shall be approved by DHCFP prior to publication and/or distribution.”
3603.22(C)(2)		Changed “business” to “calendar” days.
3603.22(C)(3)(B)		Changed “25” to “10” miles.
3603.23	PROVIDER DIRECTORY	Revised language to clarify Provider Directory requirements.
3603.24(A)(3)	NETWORK MAINTENANCE	Added number 3 “Monitoring of adherence to the network adequacy and timely access standards under the contract and remediation of any deficiencies.”

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3603.25(B)	RETRO-CAPITATION AND CAPITATION RECONCILIATION	Throughout the chapter “Forms and Reporting Guide” is replaced with “MOVE it reporting repository.”
3604(A)(1)	GRIEVANCES, APPEALS AND HEARINGS	Added language related to enrollee grievances and appeals actions.
3604(A)(3)		Added language related to State Fair Hearings Process.

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3600 INTRODUCTION

In 1992, the Nevada State Department of Human Resources (now called the Department of Health and Human Services (DHHS)) initiated the development of a fully capitated, risk based Managed Care Program. The capitated, risk-based Managed Care Program was implemented under a Section 1915(b) Waiver which established a mandatory Managed Care Program, serving recipients in urban 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/Aid to Dependent Children (AFDC/ADC)” and related programs as well as the Child Health Assurance Program (CHAP) 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) oversees the administration of all Medicaid Managed Care Organizations (MCOs) in the state. Nevada Medicaid operates a Fee-for-Service (FFS) 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, enrollee 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 inpatient care exceed a threshold during a specified time period; Very Low Birth Weight Newborns (VLBW); and the Primary Care Physician (PCP) enhancements, according to the Patient Protection and Affordable Care Act (ACA) and as approved by CMS.

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 Nevada Administrative Code (NAC) 695C.160.

All MCOs must be in compliance with all applicable Nevada Revised Statutes (NRS), NAC, the Code of Federal Regulations (CFR), the United States Code (USC), and the Social Security Act (the Act) 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 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 DHCFP determines to

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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 each month a capitated payment is made. DHCFP will continue to provide, on a FFS basis, certain services that are not contained in the MCO contracts or the capitated benefits package.

Currently, DHCFP contracts with **four** Health Maintenance Organizations (HMO) as MCOs and one Prepaid Ambulatory Health Plan (PAHP) as the Dental Benefits Administrator (DBA) for the State of Nevada. Enrollment in an MCO is mandatory for the Family Medical Category (FMC) categories of Temporary Assistance for Needy Families (TANF) (Section 1931) and 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 two MCO options in the recipient’s geographic service area. The eligibility and aid code determination functions for Medicaid and NCU applicants and eligible populations are the responsibility of the Division of Welfare and Supportive Services (DWSS). The enrollment function is the responsibility of the Medicaid Management Information System (MMIS).

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

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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 MCOs and their network 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, CMS Publication 45-2;
- B. Section 1932, provisions relating to managed care, (including Section (a)(1)(A)) of the Act, 42 United States Code (U.S.C.) 1396(a) governing state plans for medical assistance and 42 CFR 438.10 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 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 (ADs), as set forth in 42 CFR §438, 42 CFR §431.20 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;

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- I. The requirement that certain entities be excluded from participation, as set forth in Section 1128 and Section 1902(p) of the 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 Section 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 the Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- 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. The requirements for health information technology under the Health Information Technology for Economic and Clinical Health Act (HITECH);
- Q. The 21st Century Cures Act, §12006; and
- R. 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.

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3602 RESERVED

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3603 POLICY

3603.1 ELIGIBLE GROUPS

A. Mandatory Managed Care Program Enrollees:

The State of Nevada Managed Care Program requires the mandatory enrollment of recipients found eligible for Medicaid program coverage under specific categories under the FMC when there are two or more MCOs in the geographic service area. These specific categories include the following:

1. TANF;
2. Two parent TANF;
3. TANF – Related Medical Only;
4. TANF – Post Medical (pursuant to Section 1925 of the Act);
5. TANF – Transitional Medical (under Section 1925 of the Act);
6. TANF Related (Sneede vs. Kizer);
7. CHAP;
8. Aged-out Foster Care (Young adults who have “aged out” of foster care); and
9. New Medicaid Newly Eligibles, defined as childless adults ages 19 – 64, and the expanded parent and caretakers ages 19 – 64, who are made eligible as part of the Patient Protection and Affordable Care Act (PPACA) expansion population and who are receiving the Alternative Benefit Plan.
10. **TANF and CHAP adults diagnosed as Seriously Mentally Ill (SMI);**

In addition, the mandatory enrollment of recipients found eligible for Medicaid program coverage include the following categories when there are two or more MCOs in the geographic service:

11. Children’s Health Insurance Program, NCU.

B. Ineligible Managed Care Program Enrollees:

The State of Nevada Managed Care Program makes ineligible the following Medicaid recipients from enrollment in managed care:

1. Recipients who are eligible for Medicare;

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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; and
6. 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 Enrollees:

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

1. American Indians and Alaskan Natives (AI/AN) 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 Seriously Mentally Ill (SMI); and
4. TANF and CHAP children diagnosed as Severely Emotionally Disturbed (SED).

3603.2 GEOGRAPHIC AREA

The State assures individuals will have a choice of at least two MCOs for the Medicaid Managed Care enrollees in each geographic area. When fewer than two MCOs are available for choice in the geographic areas listed, enrollment in Managed Care will be voluntary.

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3603.3 COVERED SERVICES

No enrollee shall receive fewer services in Managed Care than they would receive in the current Nevada Medicaid/NCU 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

AI/AN may access and receive covered medically necessary services at IHS facilities and Tribal Clinics. If an AI/AN voluntarily enrolls with an MCO and seeks covered services from the IHS, the MCO should request and receive medical records regarding those covered services/treatments provided by the IHS. If treatment is recommended by the 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 DHCFP or other reviewers. The MCO is required to coordinate all services with IHS. If an AI/AN recipient elects to disenroll from the MCO, the disenrollment will commence no later than the first day of the next administrative month and the services will then be reimbursed by FFS.

B. Non-Emergency Medical Transportation (NEMT)

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

C. Ground Emergency Medical Transportation (GEMT)

GEMT Services are available to eligible managed care enrollees; however, the services are reimbursed under FFS pursuant to the MSM Chapter 1900. The MCO is not responsible for payment of any GEMT service received by an enrollee. The GEMT provider will submit their claims directly to DHCFP's Fiscal Agent and will be paid by DHCFP through the Medicaid FFS fee schedule. The MCO is responsible for ensuring referral and coordination of care for GEMT services.

D. All Nursing Facility stays over 180 days

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The MCO is required to cover the first 180 days of a Nursing Facility 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 175th day of any nursing facility stay expected to exceed 180 days. The enrollee will be disenrolled from the MCO and the stay will be covered by FFS commencing on the 181st day of the facility stay.

E. 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.

F. School Health Services (SHS)

DHCFP has provider contracts with several school districts to provide Early Periodic Screening, Diagnostic, and Treatment (EPSDT) medically necessary covered services to eligible Title XIX Medicaid and Title XXI NCU recipients. School Based Health Clinics are separate and distinct from SHS.

The school districts can provide, through school district employees or contract personnel, medically necessary covered services. Medicaid reimburses the school districts for these services in accordance with the school districts' provider 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.

G. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID)

Residents of ICF/ID facilities are not eligible for enrollment with the MCO. If a recipient is admitted to an ICF/ID 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.

H. Hospice Services

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Recipients who are receiving Hospice Services are not eligible for enrollment with the MCO. Hospice Services are an optional program under Title XVIII Section 1905(o)(1)(A) of the Act and are governed by 42 CFR §418 and §489.102(I). Once admitted into hospice care, Medicaid recipients will be disenrolled immediately. NCU recipients will not be disenrolled. However, payment for NCU Hospice Services will be billed as FFS. It is the responsibility of the MCOs to provide reimbursement for all ancillary services until properly disenrolled from managed care.

I. Inpatient Hospital Services

MCOs may provide Inpatient Hospital Services, to mandatory enrollees within an alternative inpatient setting, which is licensed by the State of Nevada, in lieu of services such as crisis residential services in an inpatient hospital. The alternative inpatient setting must be a lower cost than the traditional inpatient setting.

J. Adult Day Health Care (ADHC)

ADHC services for eligible managed care recipients are covered under FFS pursuant to the MSM Chapter 1800. The MCO is responsible for ensuring referral and coordination of care for ADHC services. The MCO must ensure that recipients who are receiving ADHC services are receiving all medically necessary services covered in the managed care benefit package.

K. Habilitation Services

Habilitation services for eligible managed care enrollees who have a traumatic brain injury (TBI) or acquired brain injury (ABI) are covered under FFS pursuant to the MSM Chapter 1800.

L. 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.

M. All Pre-Admission Screening and Resident Review (PASRR) and Level of Care (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 180 days of admission (see #D above).

N. Pharmacy Drug Limitations

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Zolgensma® is a high-cost gene therapy drug used to treat children less than two years old with spinal muscular atrophy (SMA). Recipients receiving this drug will not be disenrolled from managed care; however, payment for the drug will be carved out and FFS should be billed.

O. 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 by an in-network provider 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 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. Enrollees who receive either an SED or SMI determination must be redetermined at least annually.

The MCO is required to adhere to the MSM Chapter(s) 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. 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, the disenrollment will commence the first day of the next administrative month and the services will then be reimbursed by FFS.

Nevada Medicaid and Nevada Check Up recipients cannot opt out of managed care, where available, based on a determination of SMI.

3603.5 SPECIAL REQUIREMENTS FOR SELECTED COVERED SERVICES

A. Out-of-Network Providers

When it is necessary for enrollees 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,

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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 according to the Emergency Medical Treatment and Labor Act (EMTALA) of an emergency, rendered at a rate limited to the amount that would have been paid if the service had been provided under FFS, 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 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 FFS. 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. Final determination of coverage and payment must be made taking into account the presenting symptoms rather than the final diagnosis.

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 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:

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1. Post-stabilization services obtained within or outside the network that are pre-approved by a network provider or the 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 an FQHC or an 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 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 DHCFP FFS reimbursement schedule, regardless of whether the FQHC or RHC is in or out of network. 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. **FQHCs not contracted with a Contractor must follow the Contractor's Prior Authorization Policy.**

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 OOS provider to accept the MCO's reimbursement as payment

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in full. The only exception is for Third-Party Liability (TPL). The OOS provider must not bill, accept or retain payments from Medicaid or NCU recipients. OOS providers of emergency services must accept as payment in full no more than it would receive if the services were provided under FFS, pursuant to §1932(b)(2)(D) of the 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 DWSS. The DWSS staff is available to provide information regarding available community support programs to enrollees identified as experiencing any of the specified high-risk social issues. DHC FP District Office staff is available to assist in limited care coordination.

2. Obstetrical Global Payment

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 Current Procedural Terminology (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 FFS reimbursement schedule.

a. Network Providers

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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.

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 (PA)

The MCO's PA 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 DHCFP FFS reimbursement schedule for services rendered to the enrollee.

4. Maternity Kick Payment (aka Supplemental Omnibus Reconciliation Act (SOBRA) payment)

The MCO will receive a maternity kick payment from 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 and there is an accompanying provider claim for the delivery. The third trimester commences

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at 27 weeks of gestation. Maternity kick payments will be generated upon submission of encounter data confirming the delivery. **Maternity Kick payment will be processed per delivery episode regardless of how many babies are delivered.**

The maternity kick payment is intended to offset most of the costs to the health plans for costs associated specifically with the covered delivery of a child, including prenatal and postpartum care. Ante partum care is included in the capitation rate paid for the mother. Costs of care for the newborn are included in the capitation rate.

DHCFP will not pay a SOBRA payment in a situation where there is no accompanying provider claim for the delivery.

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 the MSM Chapter 600, tubal ligations and vasectomies are a covered benefit for recipients 21 years of age or older. In accordance with federal regulations, the recipient must fill out a consent form at least 30 days prior to the procedure. The physician is required to send the consent form to the Fiscal Agent with the initial claim. 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 vendor or entity, including dental, pharmacy, or through FFS. Upon request or notification of need, the MCO is required to communicate with other vendors or entities** serving the enrollee the results of its identification and assessment of that enrollee's needs to ensure services are not duplicated. The MCO must implement procedures to ensure that in

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the process of coordinating care, each enrollee’s privacy is protected consistent with the confidentiality requirements in 45 CFR §160 and §164 (HIPAA). 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. The MCO case managers will also be responsible for coordinating the transition of services for those enrollees transferring to or from FFS, another MCO, and/or the State-designated Health Insurance Exchange (HIX).

7. Freestanding Obstetric/Birth Centers

Section 2301 of the ACA requires coverage of services furnished at freestanding birth centers. The MCO is required to provide services at freestanding obstetric/birth centers.

A freestanding birth center is described as a health facility that is not a hospital or physician’s office, where childbirth is planned to occur away from the pregnant woman’s residence. The birth center must be in compliance with applicable state licensure and nationally recognized accreditation organization requirements for the provision of prenatal care, labor, delivery and postpartum care. “Obstetric Center”, Nevada’s legal term for birth center, complies with Section 2301 of the ACA birth center requirements related to the health and safety of recipients provided services by licensed birth centers.

DHCFP birth center coverage and reimbursement is limited to medically necessary childbirth services which use natural childbirth procedures for labor, delivery, postpartum care and immediate newborn care. Birth center coverage and reimbursement are limited to women admitted to a birth center in accordance with adequate prenatal care, prospect for a normal uncomplicated birth defined by criteria established by the American College of Obstetricians and Gynecologists and by reasonable generally accepted clinical standards for maternal and fetal health. Prior authorization is not required.

Refer to the Maternity Care section of the MSM Chapter 600 – Physician Services, for comprehensive maternity care coverage provided by physicians and/or nurse midwives. Refer to Attachment A, Policy #02-01, of the MSM Chapter 200 for comprehensive birth center covered services and provider requirements.

G. Essential Community Providers (ECP)

As defined by the ACA and Section 340(B)(a)(4) of the Public Health Service Act, ECPs are providers that have historically provided services to underserved populations and demonstrate 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,

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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 patient's financial limitations. The MCOs must make a good faith effort to negotiate a contract with the ECPs who are located in the plan's geographic service area, **including but not limited to those identified in the managed care contract. The State has identified ECPs that may not meet the aforementioned requirements but are critical to ensuring access to Covered Services in the Contractor's Provider Network.** The Health Resources and Services Administration (HRSA) provides a non-exclusive list of ECPs; however, DHCFP reserves the right to modify this list at any time.

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 benefit package for those mandatorily enrolled in a Managed Care geographic area. A contracted PAHP will be responsible for all covered medically necessary dental services pursuant to the MSM Chapter 1000, the NCU State Plan and the State Plan, Section 3.1-A.

3603.8 PRIVATE DUTY NURSING

Private duty nursing services (42 CFR §440.80) are included in the MCO package for recipients who require more individual and continuous care. These services are provided:

- A. By a Registered Nurse (RN) or a Licensed Practical nurse (LPN);
- B. Under the directions of the recipient's physician; and
- C. In the recipient's home, or any setting where normal life activities occur.

For additional information, reference the 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 Medicaid/NCU State Plan.

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

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The MCO must have a policy for transitioning a recipient's prescriptions from FFS, another MCO or the HIX, to the MCO, vendor or HIX. 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.

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.

The MCO will report all claims billed for drugs that were acquired through the 340B drug pricing program using standard identifiers as defined by DHCFP so they can be properly excluded from federal drug rebates. Entities that are identified on the HRSA website as 340B providers must be excluded from rebate invoicing.

The MCO must operate a drug utilization review program for covered outpatient drugs that includes prospective drug review, retrospective drug use review, application of standards and an education program in compliance with the requirements described in Section 1927(g) of the Act and 42 CFR part 456, subpart K.

Pursuant to Sec. 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT ACT) the MCOs are required to have a constructed or designed claims review, process, or program as outlined in the Managed Care contract.

3603.10 CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTERS (CCBHC)

Services furnished in a CCBHC are available to eligible Managed Care enrollees. The MCO must pay CCBHCs no less than the approved rates in the Medicaid State Plan. The required Prospective Payment System (PPS) reimbursement for CCBHCs will be accounted for in the Capitation Payments. The quality incentive payment will be calculated by the State and distributed through the MCOs after the value of the incentive payment for each contract year is known.

3603.11. RESIDENTIAL TREATMENT CENTER (RTC)

The MCO is responsible for reimbursement of all RTC charges including admission, bed day rate and ancillary services.

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3603.12 CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) AND MENTAL HEALTH SERVICES FOR ADULTS

The MCO benefit package **must** include certain services for **members with special health care needs, including CSHCN, Early Intervention**, 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 PCP **or Case Manager** with enrollee participation, and in consultation with any specialists caring for the enrollee;
- B. Approved by the MCO, **as part of the Utilization Management process**, 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 the MSM Chapters 400 and 2500 for all SED and SMI referrals and determinations and must reimburse providers of these services pursuant to the referenced MSM Chapters. Medicaid eligible recipients have the option of disenrolling from the MCO, if determined to be SED or SMI, with the exception of the Nevada Medicaid Newly Eligible childless adults ages 19 – 64 and the expanded parent and caretakers ages 19 - 64. Title XXI NCU recipients must remain enrolled with the MCO who is responsible for ongoing patient care.

3603.13 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 Medicaid State Plan. DHCFP via its Medicaid 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

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will be covered. The MCO may claim transplant case reimbursement from DHCFP for in-patient medical expenses above the threshold of \$500,000 in a one-year period (State Fiscal Year). 75% of the expenses above \$500,000 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 FFS payments with no added markup.

3603.14 TARGETED CASE MANAGEMENT (TCM)

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

3603.15 POPULATION HEALTH PROGRAM

The MCO must establish a Population Health program that establishes population health goals and targeted annual improvements that are aligned with the State’s Quality Strategy. The MCO’s Population Health program must align the efforts and resources of the MCO’s Care Management programs (i.e., disease management, Care Coordination, Case Management, and programs that address social determinants of health and racial and ethnic disparities in health care), Quality Management, and the Contractor’s value based contracting strategies to achieve population health improvements.

3603.16 IMMUNIZATIONS

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

The MCOs shall require VFC enrolled network providers to participate in the DPBH’s Immunization Registry to ensure 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 with the DPBH to interface directly with the Immunization Registry.

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3603.17 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

The MCO is required to cover EPSDT screenings of its enrollees under the age of 21 years. The screening must meet the EPSDT requirements found in the MSM as well as Sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act, and 42 CFR §441.50 through §441.62. The MCO must cover all interperiodic screening on behalf of eligible enrollees, 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 Medicaid/NCU State Plans. The MCO is responsible for coverage of 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 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 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 Medicaid/NCU State Plan.

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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 enrollees for EPSDT services. These efforts may be reviewed and audited by DHCFP or its designee.

3603.18 ENROLLMENT AND DISENROLLMENT REQUIREMENTS AND LIMITATIONS

A. Eligibility and Disenrollment

The eligibility and enrollment functions are the responsibility of DHCFP and the DWSS. The MCO shall accept each recipient who is enrolled in or assigned to the MCO by DHCFP and/or its enrollment sections and/or for whom a capitation payment has been made or will be made by DHCFP to the MCO. 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 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 State reserves the right to recover pro-rated capitation whenever the MCO's responsibility to pay medical claims ends in mid-month. A situation where a mid-month capitation recovery may occur includes, but is not limited to:

1. Enrollee is in a nursing facility over 180 days;
2. Enrollee is in an acute hospital swing bed over 45 days;
3. Enrollee is placed in an out of home placement;
4. Medicaid enrollee is placed in a hospice;
5. Enrollees enters an ICF/ID;
6. Enrollee enters a Home and Community Based Services (HCBS) Waiver Program.

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The MCO is not financially responsible for any services rendered during a period of retroactive eligibility except in the specific situation(s) described in this Chapter. The MCO is responsible for services rendered during a period of retroactive enrollment in situations where errors committed by DHCFP or the DWSS, though corrected upon discovery, have caused an individual to not be properly and timely enrolled with the MCO. In such cases, the MCO shall only be obligated to pay for such services that would have been authorized by the MCO had the individual been enrolled at the time of such services. For in-state providers in these circumstances, the MCO shall pay the providers for such services only in the amounts that would have been paid to a contracted provider in the applicable specialty. OOS providers in these circumstances will be paid according to a negotiated rate between the MCO and the OOS provider. The timeframe to make such corrections will be limited to 180 days from the incorrect enrollment date. DHCFP is responsible for payment of applicable capitation for the retroactive coverage. As described in Section 3603.15(C)(1), the MCO is responsible for Medicaid newborns effective the first day of the month in which the infant was born.

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.

B. Enrollment of Pregnant Women

The eligibility of Medicaid applicants is determined by the DWSS. The 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.

C. Enrollment of Newborns

The MCO must have written policies and procedures for newborns of enrollees. The MCO is required to **report births electronically on a weekly basis to the State's fiscal agent**. The MCO will be responsible for all covered medically necessary services included in the MCO benefit package to the qualified newborn.

Enrollment requirements for newborns are as follows:

1. Medicaid Eligible Newborns

The MCO is responsible for Medicaid newborns as of the date of birth, provided the mother was actively enrolled or retroactively enrolled at the date of birth.

In situations where it is determined that eligibility decisions were made that caused incorrect enrollment decisions, the MMIS may be corrected to show correct enrollment and all payments due the MCO reconciled accordingly. In such cases,

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the MCO shall only be obligated to pay for such services that would have been authorized by the MCO had the individual been enrolled at the time of such services. For in-state providers in these circumstances, the MCO shall pay the providers for such services only in the amounts that would have been paid to a contracted provider in the applicable specialty. OOS providers in these circumstances will be paid according to a negotiated rate between the MCO and the OOS provider. The timeframe to make such corrections will be limited to 180 days from the incorrect enrollment date.

2. NCU Newborns

The head of household or mother must notify the MCO and NCU of the pregnancy prior to and within 14 **calendar** days following the delivery in order to qualify to receive coverage from the date of birth. **If the family of the newborn is an NCU family currently receiving coverage from the MCO for a sibling of the newborn, the newborn is qualified to receive coverage from the date of birth, and is eligible for NCU, the MCO will receive a Capitation Payment and provide coverage for the month of birth. The MCO will also receive a Capitation Payment and provide coverage 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 mother has other health insurance coverage that provides for 30 **calendar** days of coverage of the newborn and she has other children enrolled in NCU, the newborn will be enrolled in the MCO as of the first day of the next administrative month.

D. Auto Assignment Process

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

1. The maintenance of existing provider individual relationships or relationships with traditional Medicaid providers; and
2. Distributing the recipients among the contracted MCOs based upon an algorithm developed by DHCFP **and outlined in the Medicaid State Plan** when maintaining such relationships is not possible.

E. Automatic Re-enrollment

Enrollees disenrolled solely due to the loss of Medicaid or NCU eligibility will be auto assigned to their last known MCO upon re-entry within 60 days of disenrollment and if that MCO remains under contract. Should the MCO no longer be under contract, enrollee(s)

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will make a selection during redetermination at DWSS or be assigned to an alternate MCO. After assignment, enrollee(s) have an additional 90 days in which to exercise the option of selecting an alternative MCO.

F. Performance Based Auto Assignment

Member auto assignment after December 31, 2023, will be based on MCO performance on selected quality measures with preference given to high performing MCOs. Measure domains intended for auto assignment during contract year 2024 are 1) MCO performance in maternal and child health outcomes, and 2) reduction in inappropriate hospitalizations during contract year 2022. DHCFP has the sole authority for determining the methodology and criteria used for the auto assignment of members and can change the algorithm at any time with appropriate notice to the MCOs.

G. Disenrollment Requirements and Limitations

1. Disenrollment at the Request of the Enrollee

Enrollees eligible in the 90-day “right to change” period may request disenrollment from the MCO without cause at any time during this period. The enrollee is required to notify DHCFP Fiscal Agent by mail of his/her decision to disenroll and, if he/she is a mandatory recipient, as defined by the mandatory managed care geographical areas of urban Clark or Washoe County, will be assigned to an alternate 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 until the next 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 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. The enrollee is required to contact the NCU office if they request disenrollment from the MCO and they are a mandatory enrollee, must select an alternate 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 as defined by 42 CFR §438.56(d)(2).

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2. Disenrollment at the Request of the MCO

The MCO may request disenrollment of an enrollee if the enrollee 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 an 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 apply as in the separate PCP or MCO instances. Prior approval from DHCFP is required for these disenrollments.

DHCFP reserves the right to review and act upon the MCO’s request for disenrollment without the enrollee 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.

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

- a. An adverse change in the enrollee’s health status;
- b. Pre-existing medical condition;
- c. The enrollee’s utilization of medical services;
- d. Diminished mental capacity;
- e. 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);

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- f. An enrollee’s attempt to exercise his/her grievance or appeal rights; or,
- g. Based on the enrollee’s national origin, creed, color, sex, religion, age, pursuant to 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 DHCFP with written assurances that it is not requesting disenrollment for any reason(s) other than those permitted under DHCFP Managed Care contract.

- 3. Disenrollment Pursuant to a finding of SED or SMI Status:
See Section 3603.4(p).

H. 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.

I. Provider Enrollment Roster Notification

The MCO must establish and implement a mechanism to inform each PCP about any new MCO enrollees 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 network provider within five business days of the MCO receiving the Benefit Enrollment and Maintenance (834) file from DHCFP.

3603.19 CHANGE IN AN ENROLLEE’S STATUS

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

3603.20 TRANSITIONING/TRANSFERRING OF ENROLLEES

A. Transitioning Recipients into MCOs

The MCO will be responsible for enrollees 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 enrollees 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 an enrollee’s smooth transition from FFS to the MCO:

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1. Enrollees 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. Enrollees 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 Medicaid/NCU State Plans but covered by Medicaid under EPSDT for children.
3. Enrollees 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 Enrollees Between MCOs

It may be necessary to transfer an enrollee 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 an enrollee, the MCO (via their subcontractors when requested by the MCO) **within 5 calendar days or as medical needs dictate** must send the receiving MCO or provider information regarding the enrollee's condition. This information shall include **the name of the assigned PCP, as well as the following information**, without limitation, **as to** whether the enrollee is:

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1. Hospitalized;
2. Pregnant;
3. Receiving dialysis;
4. Chronically ill (e.g., diabetic, hemophilic);
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), which 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. Referred to a Specialist(s);
13. Receiving substance abuse treatment;
14. Receiving prescription medications;
15. Receiving DME or currently using rental equipment;
16. Currently experiencing health problems;
17. Receiving case management (including the case manager's name and phone number); or
18. Receiving Long Term Services and Supports, such as but not limited to, Personal Care Services and/or Home Health.

When an enrollee changes MCOs or reverts to FFS while hospitalized, the transferring MCO shall notify the receiving MCO, the receiving provider(s) providing direct care (if

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the Member changes Contractors or transitions to FFS), or DHCFP Quality Improvement Organization (QIO-like vendor). The notification process must occur as soon as the transition is known to the MCO.

An enrollee may need to be transitioned between Medicaid and the HIX, due to changes in eligibility. When notified that an enrollee is eligible for HIX coverage or other non-exchange coverage to include individual and employer-based coverage or Medicare, the MCO must have written policies and procedures in place to notify any insurance carrier or plan of relevant patient information. This must be done in compliance with HIPAA and other privacy laws.

C. Transitions of Child Welfare Involved Children from FFS to an MCO

For children that received Medicaid benefits through the FFS system while in the custody of the Child Welfare system (e.g., foster care, juvenile justice) that become eligible for and enroll in the managed care program, the following requirements for continuity of care apply:

1. For a period of no less than 12 months from the date of enrollment with an MCO, the member must maintain full access to the Providers and level of services that were received while in FFS.
2. Any service Providers affiliated with or employed by the State or County Child Welfare system that treated the member prior to the transition to managed care must be under a single case agreement or part of the MCO's Network. Regardless of such Provider's status with the MCO, such Providers must be reimbursed no less than FFS reimbursement under the Medicaid State Plan.

3603.21 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. "Prevalent" is determined as the primary language spoken by 1,000 or 5% (whichever is less) of the MCO's members. 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

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enrollees and accommodating physically disabled recipients in accordance with the revised regulations of the Americans with Disabilities Act of 1990 (ADA), ADA Amendments Act of 2008, and Section 504 of the Rehabilitation Act of 1973. 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.

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. Member Handbook

The MCO must provide all enrollees with a Member 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 Member Handbook to DHCFP before it is published and/or distributed. DHCFP will review the handbook and has the sole authority 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 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 Member Handbook on the MCO’s internet website upon contract implementation and will update the website, as needed, to keep the Member Handbook current. The MCO shall issue updates to the Member Handbook, 30 days before the intended effective date, as described in 42 CFR §438.10(f)(4), when there are material changes that will affect access to services and information about the Managed Care Program.

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

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1. **An explanation** of benefits and how to obtain benefits, including out-of-plan benefits, and how to access them; the address and **toll-free** telephone number of the MCO's **member services, medical management or any other office or facility providing services directly to enrollees**; and the days that the office or facility is open, and services are available;
2. The role of the PCP **and a description of how the Member will receive confirmation of their selection of a PCP, if a PCP was designated at the time of enrollment**;
3. Any restrictions on the enrollee's freedom of choice among network providers;
4. Procedures for changing a PCP **as well as their right to select a PCP that meets their cultural and/or racial preferences**;
5. Enrollee rights and protections as specified in 42 CFR §438.100;
6. 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;
7. Procedures for obtaining benefits, including authorization requirements;
8. The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers;
9. Procedures for disenrollment;
10. 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;
11. **Explanation of procedures for urgent medical situations and how to utilize services, including the member services telephone number; clear definitions of urgent care; and how to use non-emergency medical transportation**;
12. Policy on referrals for specialty care and for other benefits not furnished by the enrollee's PCP, including explanation of authorization procedures **and information that a referral is not required in choosing a family planning provider**;

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13. How and where to access any benefits that are available under the Medicaid/NCU 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 **enrollees when it adopts a policy to discontinue coverage of a counseling or referral service based on moral or religious objectives at least 30 calendar days prior to the effective date of the policy for any particular service. The MCO must also notify** the State regarding services that meet this criterion and, in those instances, the State must provide the information on where and how to obtain the service;
14. Procedures for accessing emergency and non-emergency services when the recipient is in and out of the MCO service area;
15. Information on grievance, appeals, and fair hearing procedures and information as specified in 42 CFR §438.10(g);
16. Information on procedures for recommending changes in policies and services;
17. The MCO must provide adult enrollees with written information on Advance Directives (AD) 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/Resources/PI/AdvanceDirectives/>);
18. To the extent available, quality and performance indicators, including enrollee satisfaction;
19. 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);
20. The Member 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;
21. Information regarding prescription coverage;
22. 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;

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- 23. Notification of the enrollee’s responsibility to report any third-party payment service to the MCO and the importance of doing so; and
- 24. The transition of care policy and instructions on how to access continued services upon transition to FFS or another MCO.

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 must issue updates to the Member Handbook 30 calendar days before the intended effective date, as described in 42 CFR 438.10(f)(4), when there are material changes that will affect access to services and information about the managed care program. The MCO will provide notification when a change directly affects the ongoing care of Members.**

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 network 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. Member Newsletter

The MCO must publish a newsletter for enrollees at least twice per year. The newsletter will focus on topics of interest to enrollees and must adhere to the requirements for written enrollee materials in Section 3603.18. The MCO must provide a copy of all newsletters to the State. Additionally, these newsletters must be published on the MCO’s website.

C. 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 network providers regarding the card issued to enrollees. 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.

D. Information for Potential Enrollees

The MCO must provide information regarding contracted MCOs to potential enrollees pursuant to CFR §438.10. The information is to be furnished at the time the potential enrollee first becomes eligible to voluntarily enroll, or is first required to enroll, in managed care and, at that time, must be provided within a timeframe which enables the potential

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enrollee to use the information in choosing among available MCOs. The required 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 Medicaid/NCU State Plans 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.

E. Medical Records

Complete medical records shall be maintained by the MCO’s network providers, for each enrollee in accordance with 42 CFR §438.416. The records shall be available for review by duly authorized representatives of the State and CMS upon request of the State, CMS and other federal agencies.

The MCO shall have written policies and procedures to maintain the confidentiality of all medical records; provide accessibility and availability of medical records; ensure adequate record keeping and record review processes. Not more than ten calendar days after

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submitting a request, the State shall have access to an enrollee’s medical record, whether electronic or paper, and has the right to obtain copies at the MCO’s expense.

The recipient’s medical record is the property of the provider who generates the record. The MCO shall assist the enrollee or the parent/legal guardian of the enrollee in obtaining a copy of the enrollee’s medical records, upon written request, from the provider. Records shall be furnished in a timely manner upon receipt of such a request but not more than 30 **calendar** days from the date of request. Each enrollee or parent/legal guardian of the enrollee is entitled to one free copy of the requested medical records. The fee for additional copies shall not exceed the actual cost of time and materials used to compile copy and furnish such records.

When an enrollee changes primary care providers and/or health plans, the MCO’s network provider must forward all medical records in their possession to the new provider within **10 business** days from receipt of the request.

3603.22 MEDICAL PROVIDER REQUIREMENTS

A. PCP or Primary Care Site (PCS)

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

Each enrollee must be assigned to a PCP or PCS, within five business days of the effective date of enrollment. **Enrollees with disabilities must be given 30 calendar days to select a PCP.**

Enrollees with disabilities, chronic conditions, or complex conditions must be allowed to select a Specialist as their PCP and any Specialist can be a PCP based on Medically Necessary conditions. Enrollees must also be allowed to select a State-operated clinic as their PCP. If a Specialist is chosen as a PCP, the Provider should be reported as a Specialist. The Specialist does not count as both a PCP and Specialist for reporting purposes.

If the enrollee desires, the MCO shall allow him or her to remain with his or her existing PCP if the PCP is part of the MCO’s network.

B. Assignment of a PCP or PCS

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

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

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1. Assigning enrollees to a network 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 enrollee per **42CFR §438.68 and the Time and Distance requirements for PCPs outlined in the managed care contract;**
3. Assigning all children within a single family to the same PCP;
4. Assigning a CSHCN to a practitioner experienced in treating that condition, if the MCO knows of the condition; **and/or**
5. **Assigning an enrollee to a PCP upon receipt of a claim for services rendered by a PCP to the enrollee.**

C. Changing a PCP or PCS

1. An enrollee may change a PCP or PCS for any reason. The MCO shall notify enrollee of procedures for changing PCPs.
2. In cases where a PCP has been terminated, the MCO must notify enrollees in writing and allow enrollees to select another primary care provider or make a re-assignment within **15 calendar** days of the termination effective date and must provide for urgent care for enrollees until re-assignment.
3. The MCO may initiate a PCP or PCS change for an enrollee under the following circumstances:
 - a. Specialized care is required for an acute or chronic condition;
 - b. The enrollee's residence has changed such that distance to the PCP is greater than **10** 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 enrollee 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.

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3603.23 PROVIDER DIRECTORY

The MCO will publish its provider directory for all geographic service areas in machine readable, online and paper formats upon contract implementation. The MCO will update the paper directory quarterly (if a mobile-enabled provider directory is available) or otherwise monthly, and update the electronic directory on the website no later than 30 calendar days after the Contractor receives updated provider information. 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.

3603.24 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. Monitoring of adherence to the network adequacy and timely access standards under the contract and remediation of any deficiencies;
 4. Provider education; and,
 5. Discipline/termination
- 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 Office of the Inspector General (OIG), DHCFP or another state, federal or local agency has taken an action or imposed a sanction against a network provider, the MCO shall review the provider's performance related to DHCFP Managed Care Contract and take any action or impose any sanction, including disenrollment from the MCO's Provider Network.

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3603.25 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 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 DWSS 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 (**MOVEit reporting repository**).

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

3603.26 THIRD-PARTY LIABILITY (TPL) AND SUBROGATION

For DHCFP's contracts with the MCOs, 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 Section 6035 of the Deficit Reduction Act of 2005 that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State (Medicaid) Plan. TPL also

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includes the Coordination of Benefits (COB) cost avoidance and COB recovery. Under Section 1902(a)(25) of the 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 and NCU recipient.

For DHCFP’s contracts with MCOs, subrogation is the principle under which an insurer that has paid a loss under an insurance policy is entitled to all the rights and remedies belonging to the insured against a third party with respect to any loss covered by the policy.

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 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 DHCFP quarterly, as these amounts are considered part of their capitation.

MCOs are required to secure signed acknowledgements from enrollees or their authorized representative for any prior resources (Medicare, worker’s compensation, private insurance, and similar resources). The MCO must pursue TPL in accordance with 42 CFR §433.139. The MCO must also determine if casualty claims are filed and recover costs through subrogation on behalf of both Medicaid and NCU enrollees. The MCO is responsible for not only pursuing third party resources that it identifies but also for pursuing third-party resources identified and communicated to the MCO by DHCFP. All information on the third party, including collections and collection attempts, are to be reported to DHCFP (including circumstances under which the third-party refuses to pay) as instructed in the **State’s MOVEit reporting repository**.

DHCFP will monitor and evaluate the MCO’s TPL and subrogation collection reports to validate collection activities and results. The MCO will then be expected to meet or exceed baseline target collections as determined by DHCFP and its actuaries. If the MCO does not meet or exceed baseline TPL and subrogation collections, DHCFP will conduct a review to determine if there is a legitimate reason. If there is no legitimate reason as determined by DHCFP, the difference between baseline and actual 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.

The MCO is required to obtain TPL information independently of DHCFP for the purpose of avoiding claim payments or recovering payments made from liable third parties. TPL recovery may be incorporated into the capitated rate development by DHCFP and its actuary. The MCO has 365 days from claim paid date to recover the TPL payment; after 365 days, the MCO forfeits the right to recovery to the State unless the MCO can provide evidence that the recovery effort is active and/or in dispute.

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3603.27 PROHIBITION ON PAYMENTS TO INSTITUTIONS OR ENTITIES LOCATED OUTSIDE OF THE UNITED STATES

Pursuant to Section 6505 of the ACA, which amends Section 1902(a) of the Act, the MCO shall not provide any payments for items or services provided under the Medicaid/NCU State Plans or under a waiver to any financial institution or entity located outside of the United States (U.S.).

Payments for items or services provided under the Medicaid/NCU State Plans to financial institutions or entities such as provider bank accounts or business agents located outside of the U.S. are prohibited by this provision. Further, this Section prohibits payments to telemedicine providers located outside of the U.S. Additionally; payments to pharmacies located outside of the U.S. are not permitted.

Any payments for items or services provided under the Medicaid/NCU State Plan or under a waiver to any financial institution or entity located outside of the U.S. may be recovered by the State from the MCO.

For purposes of implementing this provision, Section 1101(a) (2) of the Act defines the term “United States” when used in a geographical sense, to mean the “States.” Section 1101(a)(1) of the Act defines the term “State” to include the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, when used under Title XIX.

The phrase, “items or services provided under the Medicaid/NCU State Plans or under a waiver” refers to medical assistance for which the State claims Federal funding under Section 1903(a) of the Act. Tasks that support the administration of the Medicaid/NCU State Plan that may require payments to financial institutions or entities located outside of the U.S. are not prohibited under this statute. For example, payments for outsourcing information processing related to Plan administration or outsourcing call centers related to enrollment or claims adjudication are not prohibited under this statute.

3603.28 MANAGEMENT INFORMATION SYSTEM (MIS)

- A. The MCO shall operate the MIS capable of maintaining, providing, documenting, and retaining information sufficient to substantiate and report MCO’s compliance with the contract requirements. The MCOs must maintain current International Classification of Diseases (ICD) and Electronic Data Interchange (EDI) compliance as defined by CMS regulation and policy and no funding will be provided for the MCO’s requirement.
- B. The MCO shall have an MIS capable of documenting administrative and clinical procedures while maintaining the privacy and confidentiality requirements pursuant to 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.

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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 enrollee 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 enrollee's eligibility through the current electronic verification system (EVS).
3. The MCO shall update its eligibility database whenever enrollees change names, phone numbers, and/or addresses, and shall notify DHCFP of such changes.
4. The MCO shall notify DHCFP of any enrollees for whom accurate addresses or current locations cannot be determined and shall document the action that has been taken to locate the enrollees. The MCO shall immediately notify DHCFP of the births and known deaths of all enrollees.

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 by the American National Standards Institute (ANSI), Accredited Standards Committee (ASC), Electronic Data Interchange (EDI) standards in current use and in the **State's MOVEit reporting repository** 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.

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3603.29 REPORTING

Adequate data reporting capabilities are critical to the ability of CMS and DHCFP to effectively evaluate 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 for all recipients and all claims paid and denied in accordance with current ANSI, ASC, EDI standards and 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.

B. Summary Utilization Reporting

The contracted MCO shall produce reports using the Healthcare Effectiveness Data and Information Set (HEDIS), as specified in the current 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, enrollee grievances, appeals and fair hearing requests

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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 enrollee grievances, the total number of notices provided to enrollees, the total number of enrollee and appeals requests, and provider disputes filed, including reporting of all subcontractor’s enrollee grievances, notices, appeals and provider disputes. The reports must identify the enrollee grievance or appeal issue, or provider dispute received; and verify the resolution timeframe for enrollee grievances and appeals and provider disputes.

Comprehensive enrollee 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 DHCFP.

D. Quality Assurance Reporting

Studies will be performed by the 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 manner, DHCFP may require the MCO to submit a Plan of Correction (POC) to address contractual requirements regarding timely reporting submissions.

E. Enrollee Satisfaction Reporting

Each MCO must collect and submit to DHCFP a statistically valid uniform data set measuring enrollee 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, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey.

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 **State’s MOVEit reporting repository** of the current DHCFP Managed Care Contract including any revisions or additions to the document.

G. Fraud and Abuse Reporting

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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.

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 the current DHCFP Managed Care Contract. Such reporting would provide DHCFP with the information necessary to better assess the MCO’s performance.

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3603.30 INFORMATION SYSTEMS AND TECHNICAL REQUIREMENTS

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

1. Enrollment;
2. Eligibility;
3. Provider Network Data;
4. PCP Assignment;
5. Electronic Visit Verification (EVV);
6. Claims Payment; and
7. 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 current MMIS Contract and supporting documentation located at 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 is 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.

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3603.31 SANCTIONS

Pursuant to 42 CFR §438.726, the State has developed a plan to monitor MCO actions 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 DHCFP Managed Care 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 including, but are not limited to, enrollee 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 DHCFP Managed Care Contract, which include:

- I. civil penalties in the amounts specified in 42 CFR §438.704;
- J. appointment of temporary management for the MCO 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;

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- L. suspensions of all new enrollments, including default enrollment, after the effective date of the sanction;
- M. suspension of payment for enrollees 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.

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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 DHCFP upon request) 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 within two calendar days and inform the enrollee of the right to file a Grievance if the Member disagrees with the decision. Prompt, oral notice must be provided in addition to the written notice for expedited Appeals. In the event of an extension, the MCO must resolve the Appeal as expeditiously as possible, but no later than the date the extension expires.**

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 (NOD) 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.

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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; 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.

3. State Fair Hearings Process

The State Fair Hearing process is described in the MSM Chapter 3100. An enrollee, enrollee’s authorized representative or the authorized 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 NOD. 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 or the court system if the hearing officer’s decision is appealed. **The Contractor must allow the Member, or Provider acting on behalf of the Member, to file a Grievance at any time.**

4. 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 NOD or not more than ten days after the date of action or intended effective date of the MCO’s proposed action according to 42 CFR §431.231. In addition, pursuant to 42 CFR §438.420, the MCO must continue benefits if the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and if the services were ordered by an authorized provider; and if the original period covered by the original authorization has not expired; and, if the enrollee requests an extension of benefits.

If, at the enrollee’s request, the MCO continues the enrollee’s benefits, the benefits must be continued until one of the following occurs:

- a. The enrollee withdraws the appeal;

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- b. Ten calendar days after the MCO mails the NOD, 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; or
- 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 recoup the cost of the services furnished to the enrollee, from the enrollee or beneficiary, 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 CFR §431.230 (b).

If the MCO or the State 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 the 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 to be maintained by the MCO for each provider 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 appeals to 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.