Medicaid Services Manual
Transmittal Letter

December 30, 2025

To: Custodians of Medicaid Services Manual

From: Casey Angres *Casey Angres*
Agency Manager

Subject: Medicaid Services Manual Changes Chapter 3600 – Managed Care Organization

Background And Explanation

Revisions to Medicaid Services Manual (MSM) Chapter 3600 – Managed Care Organization are being proposed to align with the Statewide Managed Care, the new Managed Care Contract and the State Plan Amendment (SPA) effective January 1, 2026. References to the Division of Health Care Financing and Policy (DHCFP) have been updated to Nevada Health Authority (NVHA) or Division of Nevada Medicaid (DNM).

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: Unknown at this time.

Financial Impact on Local Government: Unknown at this time.

These changes are effective January 1, 2026.

Material Transmitted	Material Superseded
MTL 36/25 3600 – Managed Care Organization	MTL 06/14, 16/20, 03/22 3600 – Managed Care Organization

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications, and Updates
3600	**Introduction**	Updated naming, and effectiveness of Statewide Managed Care.
3601	**Authority**	Made corrections to Authority numbers.
3603.1	**Eligible Groups**	Updated categories for covered, excluded, and volunteer eligible recipients.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications, and Updates
3603.2	**Geographic Area**	This section has been removed due to statewide managed care implementation.
3603.3	**Care Management and Care Coordination Requirements**	Removed Care Management requirement out of individual sections and created a section to explain care management and coordination requirements.
3603.4	**Excluded Services and/or Coverage Limitations**	Updated Non-emergency Medical Transportation (NEMT) to separate geographic locations, added Non-Emergency Secure Behavioral Health Transport (NESBHT), added additional information for nursing facility stays, removed Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IDD) from this section, Added Targeted Case Management (TCM) definition, removed Inpatient Hospital Services from this section, removed Severely Emotionally Disturbed/ Severely Mentally Ill (SED/SMI) from this section, Added Abortions, updated School Health Services (SHS), and made clarifications and clean up to other subsections.
3603.5	**Special Requirements for Selected Covered Services**	Added clarification and clean up to Out-of-Network Providers, emergency services, out-of-state (OOS) Providers, OBGYN services and post-stabilization services. Combined FQHC, RHC, and CCBHC into one section (removed them from Sections 3603.10 and 3603.11), added SED/SMI to this section. Removed Certified Nurse Midwife independent section and added it into the section as a whole. Added New Enrollees within the last trimester of pregnancy to this section, Summarized Family Planning services, Free standing obstetric/Birth centers and Essential Community Providers. Added a Prior Authorization section as a whole and removed from subsections throughout the chapter as applicable. Added clarification to Maternity Kick Payment and moved Coordination of Care section to Section 3603.3.
3603.6	**Value Added Services**	Made sentencing structure changes to provide a better flow and easier comprehension.
3603.7	**Dental Services**	Made sentencing structure changes to provide a better flow and easier comprehension.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications, and Updates
3603.8	**Private Duty Nursing Services (PDN)**	Made sentencing structure changes to provide a better flow and easier comprehension.
3603.9	**Pharmacy Services**	Expanded on Pharmacy Services based on the new contract.
3603.10	**Services for Members with Special Health Care Needs / Children and Youth with Special Health Care Needs and Mental Health Services for Adults**	Made changes to the name and summarized the section.
3603.11	**Organ Transplants**	Summarized section and made chapter referral for additional information.
3603.12	**Population Health Program**	Expanded on the minimum criteria.
3603.13	**Immunizations**	Made changes for clarification.
3603.14	**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and Well Baby/Child Services**	Made changes for clarification.
3603.15	**In Lieu of Services or Settings (ILOS)**	Added section.
3603.15(B)(4(c)		For housing-related deposits: the Managed Care Organization (MCO) may coordinate services through a case manager and pay the necessary entity directly, or the MCO may contract with any of the qualified providers, outlined in the contract, to pay for the cost of one-time housing-related deposits for a member.
3603.16	**Enrollment and Disenrollment**	Made changes for clarity and summarized some of the sub sections.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications, and Updates
	Requirements and Limitations	
3603.17	**Change in a Member's Status**	Made changes for clarity.
3603.18	**Transitioning/ Transferring of Members**	Made changes for clarity, naming corrections, and summary of subsections.
3603.19	**Member Information Requirements**	Summarized and made changes for clarity. Removed Identification Cards and information to potential enrollees as the information was found in different sections of the MSM and combined with others. Added an Advance Directives (AD) section and removed the definition from other sections. Clarifications made to Member Handbook and medical records.
3603.20	**Medical Provider Requirements**	Made changes for clarity.
3603.21	**Provider Directory**	Expanded on the explanation for requirements listed in the contract.
3603.22	**Network Maintenance and Availability of Services**	Expanded on requirements listed in the contract. Separated previously combined sections for clarity. Removed Retro Capitation and Capitation Reconciliation section from the MSM. This information will be updated in a future change based on finalization of contract amendments.
3603.23	**Third-party liability (TPL) and Subrogation**	Added definition, made changes for clarity, summarized some sections, and added additional requirements based on the contract.
3603.25	**Management Information System (MIS)**	Made changes for clarity and expanded on requirements listed in the contract. Removed old Section 3603.30 (information systems and technical requirements) to combine into this section.
3603.26	**Reporting Requirements**	Removed unnecessary language, added additional information regarding requirements listed in the contract, expanded on Encounter Data Report Files. Updated name to summary utilization to Health Employer Data and Information Set (HEDIS),

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications, and Updates
		removed dispute resolution and replaced with Sales and Transaction reporting, and changed Enrollee Satisfaction to Member Experience to stay consistent with the Managed Care Contract. Created a Program Integrity Unit subsection to expand on the Fraud and Abuse reporting. Added additional reporting requirements for Autism Spectrum Disorder (ASD) and applied behavioral analysis reporting.
3603.27	**Sanctions, Monetary Penalties and other remedies**	Added section to explain in detail information such as Plans of Corrections, Sanctions, Appointment of temporary management, Monetary penalties and other sanctions, suspension of enrollment, and contract termination.
3604	**Grievances, appeals and hearings**	Expanded on requirements for grievance, appeals, and hearings for both members and providers to ensure more information is readily available in the MSM.
3604.1	**Provider Dispute and Disposition**	Added details for provider Dispute and Disposition details to include electronic records for each provider grievance or appeals and must provide their written processes for handling provider disputes to NVHA.
3604.(D)		The MCO will participate in the State Fair hearing process. The MCO is responsible for any related expenses to participate in a hearing for each circumstance the MCO made an Adverse Benefit Determination that resulted in a State Fair hearing request.

NEVADA MEDICAID

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

MANAGED CARE ORGANIZATION

3600 INTRODUCTION

In 1992, the State of Nevada 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 formerly known as 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 (SPA).

The State of Nevada, Nevada Health Authority (NVHA), Division of Nevada Medicaid (DNM), 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 was previously only available to Medicaid and Nevada Check Up (NCU) recipients in urban Clark and Washoe counties. Effective January 1, 2026, Statewide Managed Care is available to rural and urban counties throughout Nevada.

All MCOs must be in compliance with all applicable Nevada Revised Statutes (NRS), Nevada Administrative Code (NAC), the Code of Federal Regulations (CFR), the United States Code (USC), and the Social Security Act (SSA) which assure program and operational compliance as well as assuring services that are provided to Medicaid and NCU recipients enrolled in an MCO are done so with the same timeliness, amount, duration, and scope as those provided to 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 Nevada Medicaid determines to be in the best interests of the State and eligible recipients. The MCO is responsible

for reimbursing claims of eligible members for services covered under the contract or for each month a capitated payment is made. Nevada Medicaid will continue to provide, on an FFS basis, certain services that are not contained in the MCO contracts or the capitated benefits package.

Currently, Nevada Medicaid contracts with five 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 Child Health Insurance Program (CHIP)/NCU recipients when there is more than one MCO option from which to choose in a 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 Social Services (DSS). The enrollment function is the responsibility of the Medicaid Management Information System (MMIS).

All Medicaid policies and requirements are the same for NCU, with the exception of the certain areas where Medicaid and NCU policies differ as documented in the NCU Manual.

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 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 SSA for MCOs and MCO 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 SSA, 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 SSA, 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 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 (AD), as set forth in 42 CFR §438, 42 CFR §431.20 and Section 1902(w);

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

I. The requirement that certain entities be excluded from participation, as set forth in Section 1902(p) of the SSA and Part 2 of the State Medicaid Manual, CMS Publication 45-2;

J. 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;

K. Confidentiality and privacy requirements as set forth in the Health Insurance Portability and Accountability Act (HIPAA) of 1996;

L. 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;

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

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

O. The requirements for health information technology under the Health Information Technology for Economic and Clinical Health Act (HITECH);

P. The 21st Century Cures Act, §12006; and

Q. 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 NVHA, acting through DNM 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's rules are in conflict with these rules, the rules set forth herein shall control.

3602 RESERVED

3603 POLICY

3603.1 ELIGIBLE GROUPS

A. Mandatory Managed Care Program Populations

The State of Nevada Managed Care Program requires the mandatory enrollment of eligible recipients for Medicaid or NCU program coverage under Family Medical Coverage (FMC), NCU, and Aged Out (AO) Foster Care Medical Only, unless identified as part of the voluntary populations or excluded populations.

B. Managed Care Excluded Populations

The following recipients are excluded from enrollment in the Managed Care Program:

1. Recipients who are receiving services through child welfare and/or foster care;
2. Recipients receiving services in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID);
3. Recipients receiving services in a Nursing Facility (NF) for more than 180 calendar days;
4. Recipients admitted to a swing bed stay in an acute care hospital over 45 calendar days;
5. Recipients receiving hospice services; and
6. Recipients enrolled in a 1915(c) Home and Community Based Services (HCBS) waiver program; and
7. Recipients in Medical Assistance to the Aged, Blind, and Disabled (MAABD).

C. Managed Care Voluntary Populations

The following Medicaid recipients are exempt from mandatory enrollment; however, they are allowed to voluntarily enroll in an MCO if they choose:

1. Eligible American Indians and Alaskan Natives (AI/AN) who are members of federally recognized tribes; and
2. Medicaid/NCU recipients determined to be Children and Youth with Special Health Care Needs (CYSHCN) or Severely Emotionally Disturbed (SED).

3603.2 COVERED SERVICES

No member 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.

3603.3 CARE MANGEMENT AND CARE COORDINATION REQUIREMENTS

The MCO must establish a care management program that promotes continuity of care and takes a comprehensive and collaborative approach to coordinating care for the populations and conditions as specified by the State through effective clinical programs that must include, at a minimum, Level 1 care coordination and Level 2 case management pursuant to 42 CFR 438.62(b)(1)-(2) and 42 CFR 457.1216 and outlined in the contract. This approach must include partnerships with PCPs, specialists, other providers, and members; Member/family outreach and education; and the ability to holistically address member health care needs. Care coordination and case management must be able to address not only the specific diagnosis, but also the complexities of multiple co-morbid conditions, including behavioral health or related issues, such as lack of social or family support.

Pursuant to 42 CFR §438.208(b) the MCO must ensure smooth transition of care by coordinating services across different care settings and services provided by other entities such as Fee-for-Service (FFS) or community and social support providers. This includes but is not limited to discharge planning after hospital or institutional stays to prevent readmissions or adverse outcomes. Upon request or notification of need, the MCO must formally designate a person or entity to handle coordinating services. The person or entity must be able to communicate with other vendors or entities serving the member to ensure services are not duplicated. The MCO must provide information to the member on how to contact this designated person or entity and implement procedures to ensure that each member's privacy is protected consistently 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.

The MCO must promote care management and early intervention services by conducting welcome calls and/or visits to new members. This method ensures that an orientation with emphasis on access to care, choice of PCP, and completion of an initial Health Needs Assessment occurs proactively with each member early upon enrollment with the MCO. If a screening risk level determines a need for further care management, the MCO must complete a referral.

The Health Needs Assessment must be conducted for all members to identify any existing and/or potential health care needs and need for care management services within 60 calendar days of enrollment pursuant to 42 CFR 438.208 and 42 CFR 457.1230 or 30 calendar days of enrollment

for pregnant individuals, children and youth with special health care needs, and adults with special health care needs.

The Health Needs Assessment must be repeated annually for members that are not actively engaged in care management during the year. If the member was actively engaging in care management during the prior year, an annual Health Needs Assessment is not required.

A minimum of three documented attempts to conduct the initial and annual Health Needs Assessment using a variety of methods beyond telephonic are required. If the attempts are unsuccessful, the MCO must document the barrier(s) to completion. For the initial assessment, the MCO will also have to document how they will overcome the barrier so that the assessment can be completed within the first 120 calendar days.

The MCO may have separate forms for the initial and annual health needs assessment; However, the State reserves the right to standardize the form across the MCOs. At minimum the form must address screenings for behavioral health, medical conditions, Health Related Social Needs (HRSN) and Pregnancy.

Identifying members for Case Management services should be evaluated through a variety of different methods including but not limited to the Health Needs Assessment, risk stratification, physical or behavioral health screenings, provider referrals, state agency referrals, member self-referrals; and/or health triggering events.

Some examples of a health triggering event could include inpatient hospitalization, hospital readmission within 30 calendar days, high-risk population, at risk for experiencing racial and/or ethnic health disparities, complex health and/or social factors that adversely influence health outcomes, positive for HRSN or behavioral health needs, frequent use of emergency room (ER) services, children diagnosed with a psychotic disorder, and individuals on long-acting psychotic injectable drugs .

Members with health conditions such as congestive heart failure, coronary arterial disease, hypertension, hemophilia, diabetes, chronic obstructive pulmonary disease, asthma, substance use disorder (SUD), opioid use disorder (OUD), co-morbid conditions, SED, SMI, special health care needs, Long Term Services and Supports (LTSS), high-risk pregnancy, severe cognitive and/or developmental limitation, Human Immunodeficiency Virus (HIV), justice-involved, supportive housing, homeless status, and other complex health conditions, at minimum, should be identified for case management services. The MCO must actively conduct outreach to engage these members with a reasonable number of attempts.

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 Indian Health Services (IHS) Facilities and Tribal Clinics

All Eligible 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 be able to receive medical records regarding those covered services/treatments provided by the IHS. If covered services are recommended by the IHS and the member 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 the State or other reviewers. The MCO is required to coordinate all services with IHS. If an AI/AN member elects to disenroll from the MCO, the disenrollment will commence no later than the first day of the second administrative month after which all covered medically necessary services will then be reimbursed by FFS.

B. Non-Emergency Medical Transportation (NEMT)

1. For the Urban Clark and Urban Washoe Service areas the State contracts with a NEMT broker that authorizes and arranges for all covered medically necessary NEMT that must provide services in accordance with the policies and procedures outlined in the Nevada Medicaid Services Manual (MSM) Chapter 1900 – Transportation Services. The MCO and its subcontractors must coordinate with the NEMT broker to ensure NEMT services are secured on behalf of members. The State reserves the right to terminate the NEMT contract and require the MCOs to be responsible for providing medically necessary NEMT for members in urban areas.

2. For the rural service area, the MCO is responsible for directly authorizing and arranging all covered medically necessary NEMT in accordance with the policies and procedures outlined in the Nevada MSM Chapter 1900. The MCO may subcontract with another entity to fulfill this obligation.

C. Non-Emergency Secure Behavioral Health Transport (NESBHT)

NESBHT is available to members; however, the services are reimbursed under FFS pursuant to MSM Chapter 1900 and are outside the scope of transportation services provided by the State's NEMT broker or the MCO. Providers of NESBHT are accredited and licensed by the Division of Public and Behavioral Health (DPBH). The MCO is responsible for ensuring referral and coordination of care for these services. The MCO is responsible for educating providers and members, as appropriate, about the availability of this service.

D. Ground Emergency Medical Transportation (GEMT)

GEMT Services are available to eligible managed care members; 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 a member. The GEMT provider will submit their claims directly to the State's Fiscal Agent and will be paid through the Medicaid FFS fee schedule. The MCO is responsible for ensuring referral and coordination of care for GEMT services.

E. All NF stays over 180 calendar days

The MCO must cover the first 180 calendar days of an NF admission. The MCO shall notify the State by the 175th calendar day of a member's NF stay expected to exceed 180 calendar days. The member will be disenrolled from the MCO and the stay will be covered by FFS commencing on the 181st calendar day of the facility stay. NF services are defined in MSM Chapter 500 – Nursing Facilities.

F. Swing bed stays in acute hospitals over 45 calendar days

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

G. School Health Services (SHS)

The State 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 members. The MCO must coordinate with Local Education Agencies (LEA), schools, and school districts that provide SHS. 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/NCU reimburses the school districts for these services in accordance with the school districts' provider contract. Nevada Medicaid will maintain the current school districts contracts. 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 the State or its designees. Medicaid and 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 must maintain regular check-ins between the SHS coordinator and LEA to stay up to date on efforts to promote State standards for SHS and ensure their delivery systems support the integration of SHS with Medicaid and NCU managed care services.

H. Targeted Case Management (TCM)

TCM, as defined by MSM Chapter 2500 – Case Management, is covered under FFS. Care Management, which differs from TCM, must be provided by the MCO when medically necessary.

I. Hospice Services

Once admitted into hospice care, Medicaid recipients will be disenrolled immediately. NCU members 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.

J. Adult Day Health Care (ADHC)

ADHC services for eligible managed care recipients are covered under FFS pursuant to the MSM Chapter 1800 - 1915(i) State Plan Option - Adult Day Health Care and Habilitation. 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. Day Habilitation and Residential Habilitation Services as described in MSM Chapter 1800, 1915(c) Home and Community Based Services (HCBS) Waiver

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

M. Drug Coverage Limitations

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.

N. Abortions

The MCO may only cover abortions if the pregnancy is the result of an act of rape or incest, or if the pregnant individual suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that places the pregnant individual in danger of death unless an abortion is performed per 42 CFR 441.202. No other abortions, regardless of funding, can be provided as a covered service.

3603.5 SPECIAL REQUIREMENTS FOR SELECTED COVERED SERVICES

A. Out-of-Network Providers

When it is medically necessary for members to obtain services from out-of-network providers the MCO must:

1. Exhaust all providers found within a certain radius, 25 miles of urban areas and 50 miles for rural areas, of the member's address before contracting with a provider outside of that radius.

2. Coordinate care with out-of-network providers;

3. Offer the opportunity to the out-of-network provider to become part of the network;

4. Validate that the out-of-network provider is licensed in its home state of practice to complete a single case agreement;

5. Negotiate a single case agreement to determine the payment prior to services being rendered; and

6. Coordinate the members' care as applicable.

B. Emergency Services

The MCO must provide emergency coverage 24 hours per day, seven days per week. The MCO must have written policies and procedures describing how members and providers can obtain urgent coverage and emergency services after business hours and on weekends. Urgent coverage means those problems, which, though not life threatening, could result in serious injury or disability unless medical attention is received. The MCO must pay the out-of-network provider, regardless of if the provider is in or out of state, for emergency services applying the "prudent layperson" definition of an emergency. Payment must be accepted as payment in full, no more than it would receive if the services were provided under FFS.

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 and 42 CFR 457.1228, the MCO may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms, nor refuse to cover emergency services based on the ER provider, hospital, or fiscal agent not notifying the member's PCP, MCO, or the State of the member's screening and treatment within 10 calendar days of the presentation for emergency services.

A member 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 member. The MCO is responsible for coverage and payment of services until the attending physician, or the provider actually treating the member, determines that the member 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 post-stabilization services obtained within or outside of the network that are:

1. Pre-approved by a network provider or the MCO representative;

2. Not pre-approved by a network provider or other MCO representative, but are administered to maintain, improve, or resolve the member's stabilized condition if the MCO does not respond to a request for pre-approval within one hour, the MCO cannot be contacted, or the MCO and the treating physician cannot reach an agreement concerning the member's care and a network provider or other MCO 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 member until a network physician is reached or one of the criteria in 42 CFR 438.114, 42 CFR §422.113, and 42 CFR 457.1228 is met.

Pursuant to 42 CFR §422.113 and 42 CFR 438.114, the MCO's financial responsibility for post-stabilization care has not pre-approved ends when a network physician with privileges at the treating hospital assumes responsibility for the member's care, a network physician assumes responsibility for the member's care through transfer, the MCO and the treating physician reach an agreement concerning the member's care or the member is discharged. The MCO must pay out-of-network providers of post-stabilization services equal to the State's FFS rates for services and must accept as payment in full no more than it would receive if the services were provided under the State's Medicaid and NCU FFS program.

The MCO may not charge members for post-stabilization care services an amount more than what the MCO would charge the member if the services were obtained in-network.

D. Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), and Certified Community Behavioral Health Centers (CCBHCs)

The MCO must cover services provided by an FQHC, an RHC, and a CCBHC regardless of network status. The MCO must pay out-of-network FQHCs, RHCs, and CCBHCs at a rate equivalent to the FFS rate. MCOs must pay FQHCs, RHCs, and CCBHCs, regardless of Network status, rates that are no less than the FFS Prospective Payment System (PPS) rates. This does not apply to out-of- network providers of emergency services.

E. Seriously Emotionally Disturbed (SED)/Severely Mentally Ill (SMI) Members

The MCO, subcontractors, and/or network providers:

1. Must adhere to MSM Chapter 400 – Mental Health Services, and state and federal policies.

2. Must ensure that members who are referred for evaluation for SED/SMI, or who have been determined SED/SMI, are obtaining the medically necessary evaluations by a qualified network provider within the scope of their practice, and that the member is receiving covered medically necessary medical and mental health services.

3. Must ensure that the parent/guardian of a minor member, or an adult who is referred for an assessment, is fully informed of the reason why the assessment is necessary. Obtaining authorization from the minor's parent/guardian or from an authorized representative of an adult member is required using the state prescribed forms.

4. Are the only entities that have the authority to make the SED/SMI determination for its member. SED/SMI determinations made by the appropriate practitioner within the 12-month period proceeding initial eligibility will be considered valid. A redetermination must be completed annually.

5. Must use state-prescribed forms to obtain consent for an SED/SMI evaluation, to document the determination, and to disenroll an SED member from managed care. Medicaid members with an SED diagnosis may elect to disenroll from managed care upon their SED determination.

   Members who receive either an SED or SMI determination must be redetermined at least annually. For SED members who have voluntarily elected to remain enrolled in managed care, the process for these redeterminations is the same as for

the initial determination. The State reserves the right to carve children with an SED determination out of the contract to implement a specialty managed care plan for those members in the future.

F. Out-Of-State (OOS) Providers

When it is necessary for members to obtain non-emergency services from an OOS provider, the MCO must negotiate a single case agreement to determine the rate prior to services being rendered. The MCO must require the OOS provider to accept the MCO's reimbursement as payment 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 members. The MCO must cover and pay for emergency services both in and out of state regardless of whether the provider has a contract.

G. Obstetrical/Gynecological Services

1. High-Risk Maternal Case Management

The MCO must make a good faith effort to screen Medicaid and NCU members identified as pregnant or postpartum for maternal high-risk factors. Network providers and case managers must refer a member that has been identified as having a high-risk maternal factor to the MCO's High-Risk Maternal Case Management Program and will remain enrolled through the duration of their 12-month postpartum coverage period.

The High-Risk Maternal Case Management Program will provide services such as patient education, nutritional services, personal care services, home health care, SUD services, and care coordination, in addition to maternity care according to the members preferences.

The case manager/care coordinator must assist the member in contacting appropriate agencies of non-covered/carved-out plan services, community health information, and medical care management to identify risk factors. The MCO must demonstrate ongoing efforts to assign case managers that have the experience and training specific to prenatal and postpartum care needs.

A "high risk" pregnancy is defined in MSM Chapter 600 – Physician Services, under Maternity Care. The MCO must develop a method using evidence-based guidance set forth by organizations such as the American Congress of Obstetricians and Gynecologists and follow the minimum method considerations outlined in the contract and follow the State's OBGYN policies listed in the State Plan and MSM Chapter 600 and Chapter 200 – Hospital Services.

2. Obstetrical Payments

Length of time that the pregnant woman is enrolled in the health plan is not a determining factor in payment to the obstetrician/nurse midwife. Payment to the delivering obstetrician/nurse midwife for a normal routine pregnancy shall be based upon the services and number of visits provided by the obstetrician/nurse midwife to the pregnant woman through the course of the 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/nurse midwife, regardless of network affiliation, when the member has been seen seven or more times for covered services by the delivering provider. If the provider has seen the member less than seven times, the obstetrician/nurse midwife will be paid according to the FFS reimbursement schedule.

A pregnant member who is enrolled with the MCO within the last trimester of pregnancy must be allowed to remain in the care of an out-of-network provider, if they choose. The MCO must have policies and procedures for this allowance.

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. New Enrollees within the last trimester of pregnancy

A pregnant member who is enrolled with the MCO within the last trimester of pregnancy must be allowed to remain in the care of an out-of-network provider, if they choose. The MCO must have policies and procedures for this allowance.

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

The MCO will receive a maternity kick payment to cover the maternity costs of any birth, stillborn, 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 at 27 weeks of gestation. Maternity kick payments will be generated upon submission of encounter data confirming the delivery. The MCO must provide documentation, with all of the mandatory criteria, within 21 calendar days of the request. Maternity Kick payment will only make one payment 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. Prenatal care is included in the capitation rate paid for the mother. Costs of care for the newborn are included in the capitation rate.

The State will not pay a SOBRA payment in a situation where there is no accompanying provider claim with all the required documentation for the delivery.

5. Family Planning Services

Family planning services are covered under MSM Chapter 600, Section 603.3. The MCO must not require members or their providers to obtain a referral, prior authorization, or post authorization for family planning services.

6. 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.

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

H. Essential Community Providers (ECP)

ECPs accept patients on a sliding scale fee, determined by the income of the patient; does not restrict access or services due to financial limitations; and can demonstrate to the State that the restriction of patient access to this provider would cause access problems for either Medicaid/NCU or low-income patients. The MCOs are required to negotiate in good faith with all of the ECPs located in the plan's geographic service area. The MCO may be required to contract with other agencies such as the juvenile justice system, Disproportionate Share Hospitals (DSHs), other state agencies, or various county-level entities.

I. Prior Authorizations

A Preauthorization or Prior Authorization is a process in which a member or provider submits a request to the MCO or the State for a provisional affirmation of coverage before a service, treatment plan, prescription drug, or durable medical equipment (DME) is provided to the member and before a claim is submitted for payment, sometimes called prior authorization, preauthorization, prior approval, or precertification.

The MCO must have written policies and procedures for requests for initial and continuing authorization of services. As part of these procedures, the MCO must adhere to State standards regarding the forms and/or required data elements for prior authorization requests. Medical necessity and utilization management decisions must be based on nationally recognized clinical criteria and standards of care. The MCO may utilize different authorization requirements than what is used by the State under FFS, as long as they are not more restrictive than FFS and comply with all requirements of the managed care contract, and the guidelines written in the MSM chapters regarding prior authorization for each type of service.

The MCO must monitor prior authorization requests. The State may require removal of prior authorization requirements for various services to align with procedures across MCOs or if determined necessary for the proper administration of the State and/or federal policy.

No prior authorization is required for emergency services; family planning services; FQHC and RHC services; CCBHC services; The first mental health or SUD assessment completed in a 12-month period; ICSS; or tobacco cessation treatments.

No referral is required for emergency services; family planning services; OB/GYN services; FQHC and RHC services; CCBHC services; mental health, and SUD services; ICSS; or tobacco cessation treatments.

3603.6 VALUE-ADDED SERVICES

MCOs are encouraged to offer additional preventive or cost-effective services to members as a Value-Added Service, if the services do not increase the cost to the State.

3603.7 DENTAL SERVICES

Dental services are not covered under medical benefits. 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, with the exception of Orthodontic Services that are covered under FFS. The MCO is responsible for ensuring referral and the coordination of dental care.

3603.8 PRIVATE DUTY NURSING (PDN) SERVICES

Nursing services for members who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of a hospital or NF. These services are provided through a Home Health Agency (HHA):

A. By a Registered Nurse (RN) or a Licensed Practical Nurse (LPN);

B. Under the directions of the member's physician; and

C. At the State's option, to a member in one or more of the following locations: In the member's home, any setting where normal life activities take place, a hospital, or an NF.

For additional information, reference the MSM Chapter 900 - Private Duty Nursing.

3603.9 PHARMACY SERVICES

Pharmacy services are included in the MCO benefit package and must follow 42 CFR 438.3. Any information relating to pharmacy services outlined in the current managed care contract must be disclosed within the designated timeframes, to the State, following the Reporting Requirements Exhibit and annual audit requirements.

Pharmacies that process prescription drug claims for members must be enrolled as a Medicaid/NCU provider and licensed in good standing by the State Board of Pharmacy. Medical necessity determination cannot be more restrictive than what is used in the Medicaid/NCU State Plans and MSMs.

Drug coverage policies must be available to the public via online and paper formats in one cohesive document that is ADA-compliant. This must include the list of drugs covered (both generic and name brand), as well as what tier each drug is on, as relevant and information on relevant drug approval criteria or guidelines, limits, prior authorization requirements, or other restrictions or requirements.

The MCO must promptly and appropriately cover all Medicaid/NCU covered outpatient drugs for which pharmaceutical manufacturers provide rebates, as required by CMS per Section 1927 of the SSA, with the exception of covered outpatient drugs subject to restriction as outlined in Section 1927(d)(2) of the SSA.

The MCO must adopt and comply with the State-defined Single Preferred Drug List (sPDL) and clinical policies. This includes the adoption of the State's fully clinical policy, including prior authorization, step edit, and utilization edit criteria, as well as the State's uniform PDL, including drugs covered by the pharmacy and the medical benefit for which the State providers restrictions or criteria. Drugs not covered under the State's drug coverage policies must be made available through an exception request process, requiring prescriber certification and justification of medical necessity. This exemption process does not apply to drug classes identified as excluded from coverage under Nevada State Plan, unless the drug review falls under EPSDT program provisions. The MCO must base prior authorization criteria and quantity limits on best practice or evidence-based practice standards.

A. Pharmacy Ownership or Affiliation/Preferred Specialty Pharmacy.

The MCO may utilize a pharmacy with which it has ownership or an affiliation or a preferred specialty pharmacy; However, this pharmacy must be readily accessible to all members and must not provide any restrictions or incentive requiring members to utilize that pharmacy.

B. Prescriber Brand Certification Policies.

The MCO must ensure that all prescribing providers abide by Prescriber Brand Certification policies, as outlined in MSM Chapter 1200 – Prescribed Drugs, when certifying that a specific brand of medication is medically necessary for a member.

C. Prescription and Pharmacy Transition Policy.

The MCO must have a policy for transitioning a member's prescriptions from another health plan/FFS. A member's current prescription cannot be terminated without consulting with the prescribing provider and informing the member. If the prescription is terminated, the MCO must document the reasons why the prescription is not medically necessary. A prescription cannot be transferred to an alternate pharmacy without obtaining direct consent from the member.

D. Pharmacy Lock-In Program.

The MCO must have a Lock-In program for members showing drug seeking behaviors, consistent with the State's Lock-In program and policy for FFS recipients. The MCO must restrict designated members to a specific pharmacy and/or a specific physician for controlled substances only. These members can use any pharmacy for their non-controlled drugs. The MCO must apply criteria for the Lock-In program as outlined in MSM Chapter 1200.

E. Pharmacy Encounter Data for Rebates.

The MCO must submit all pharmacy encounters and outpatient administered drug encounters to the State or its vendor. The MCO must ensure that covered outpatient drugs dispensed to eligible members are subject to the same rebate requirements as those applicable to the State under Section 1927 of the SSA. The State shall submit these encounters for rebates from manufacturers.

F. Preventing 340B Duplication.

The MCO must implement a mechanism to prevent duplicate discounts for drugs acquired through the 340B Drug Pricing Program using standard identifiers that align with the State's FFS 340B policy. Claims indicators must be established to exclude utilization data

for covered outpatient drugs acquired through the 340B Pricing Program to properly exclude from rebate invoicing pursuant to 42 CFR 438.3.

G. Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act Compliance:

The MCO must have a constructed or designed claims review, process, or program that includes:

1. Safety edits for subsequent fills for opioids and an automated claims review that indicates when a member is prescribed a subsequent fill;

2. Safety edits on the maximum daily Morphine Milligram Equivalents (MME) that can be prescribed to a member for the treatment of chronic pain, and a review process that indicates when an individual is prescribed in excess of that limitation;

3. Automation that identifies when a member is concurrently prescribed opioids and benzodiazepines or antipsychotics;

4. A program to monitor and manage the appropriate use of antipsychotic drugs by children under 18; and

5. A process to identify potential fraud or abuse of controlled substances by members, providers prescribing drugs to members, and pharmacies dispensing drugs to members.

This does not apply to members who are receiving hospice or palliative care; receiving treatment for cancer; or members who reside in a long-term care facility, a facility described in Section 1905(d) of the SSA, or another facility where frequently abused drugs are dispensed for residents through a contract with a single pharmacy.

H. Drug Utilization Review (DUR) Program

The MCO must implement and operate a DUR 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 SSA and 42 CFR 456 Subpart K. These activities must be reported to the State on an annual basis.

I. Pharmacy Benefit Manager Agreements

The MCO must ensure that the Pharmacy Benefit Manager (PBM) operates under a pass-through pricing model, meaning all payments and revenues related to PBM services (e.g.,

pharmacy fees, rebates, discounts) are passed directly to the MCO without any retention by the PBM. The PBM must fully disclose all revenue and financial benefits to the MCO, who must then report this to the State as required. The MCO must follow all provisions in the PBM agreement outlined in the current managed care contract.

The PBM is to be paid through an administrative fee model, which covers service costs and margin. The MCO must share the fee formula with the State and allow for State-requested changes. Additionally, the PBM Agreement must allow for a competitive market check every three years or annual renegotiation of terms.

3603.10 SERVICES FOR MEMBERS WITH SPECIAL HEALTH CARE NEEDS/CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN) AND MENTAL HEALTH SERVICES FOR ADULTS

The MCO benefit package must include certain services for members with special health care needs, including CYSHCN, 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 create and implement a treatment plan for members 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 required part of the request for services and the treatment plan must be:

A. Developed by the member's PCP or Case Manager if the member is receiving care management services, with member participation, and in consultation with any specialists caring for the member;

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 management standards.

The MCO must have a mechanism in place to allow these members access to a specialist, through a standing referral or an approved number of visits as deemed appropriate for the member'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.

3603.11 ORGAN TRANSPLANTS

These services are covered, with limitations, when medically necessary. Coverage limitations for these services are defined in the Medicaid/NCU State Plan and MSM Chapter 600. The MCO must follow all federal and state standards to ensure that similarly situated members are treated alike and that any restriction on organ transplant providers is consistent with providing access to high quality care for members.

3603.12 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 emphasize health promotion and disease prevention, incorporate community based health and wellness strategies, support efforts to build more resilient communities and 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 MCO's value based contracting strategies to achieve population health improvements.

At a minimum, it must provide interventions to address keeping members healthy, prevent chronic diseases, manage members with risk factors, coordination of care, managing members that are high-utilizers of services, and maintain or improve physical and psychosocial wellbeing of members. The MCO must complete a population health annual strategy report to the State in accordance with the Reporting Requirements Exhibit listed in the current managed care contract.

3603.13 IMMUNIZATIONS

The MCO must encourage its network providers to enroll and participate in the Vaccines for Children Program (VFC) which is administered by the Nevada DPBH. The immunization program will review and approve provider enrollment requests. The MCO must 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 members 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 must reimburse the VFC providers for the administration of vaccinations to members and ensure age-appropriate vaccinations are being provided. Reimbursement of vaccines and related fees that are not provided by the VFC program should be reimbursed by the MCOs.

3603.14 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT AND WELL BABY/CHILD SERVICES

The MCO is required to cover EPSDT services as described in 42 CFR 441.50 through 441.62 and MSM Chapter 1500 – Healthy Kids Program, to members under the age of 21 years and all Well Baby/Child Services. The screening must meet the EPSDT requirements found in the MSM Chapter 1500, Medicaid State Plan, and NCU State Plan.

The MCO is responsible for reimbursement of all medically necessary services under EPSDT. The MCO is responsible for coverage of the oral examination component, listed in MSM Chapter 1000, of the EPSDT physical exam and referral to a dental provider. The MCO is responsible for the coordination of care in order to ensure all medically necessary coverage is being provided under EPSDT.

The MCO is not required to provide any items or services which are determined to be unsafe or ineffective, or which are considered experimental. Treatments proven to be effective through evidence-based research and peer-reviewed studies will be considered non-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 members eligible for EPSDT services. These efforts may be reviewed and audited by the State or its designee.

The MCO must develop, and submit for approval to the State, written policies and procedures for an EPSDT Plan that includes:

A. conducting outreach and education, tracking, and follow-up to ensure compliance with the EPSDT periodicity schedules;

B. an emphasis on outreach and compliance monitoring taking into account the multilingual, multicultural nature of the served population, as well as other unique characteristics of this population;

C. procedures for follow-up of missed appointments, including missed referral appointments identified through EPSDT screens and exams and follow-up on any abnormal screening exams; and

D. procedures for referral, tracking, and follow-up for annual dental examinations and visits consistent with current policy statements issued by the American Academy of Pediatrics and the American Academy of Pediatric Dentists.

3603.15 IN LIEU OF SERVICES OR SETTINGS (ILOS)

A. Institutions for Mental Disease (IMDs)

The State has determined that providing members aged 21-64 access to services within an IMD for a limited timeframe is medically appropriate and a cost-effective substitute for services and/or settings outlined in the Medicaid State Plan.

Pursuant to 42 CFR 438.6, the MCO may provide Members aged 21-64 access to psychiatric or intensive crisis stabilization services (ICSS) in an IMD setting as an alternative to other inpatient settings, such as a hospital or subacute facility, that is licensed by the State of Nevada, as an ILOS. These alternative inpatient settings must be lower cost than traditional inpatient settings, and the length of the stay can be no longer than 15 cumulative days during the period of monthly capitation.

ICSS are short-term in nature, used to avoid inpatient hospitalization during a crisis, and are covered by a Substance Use, Prevention, Treatment and Recovery Services (SUPTRS) certified facility. Facilities must also be licensed by the Bureau of Health Care Quality Compliance (HCQC) within the NVHA. Services include community-based resources that can meet the need of an individual with an acute psychiatric crisis and provide a safe environment for care and recovery.

The MCO must coordinate with discharge planners to transition members from the short-term stay in the IMD to the appropriate post-hospital destination. Failure to transfer the member to the appropriate care setting within two calendar days after the member no longer meets an acute LOC, will result in the MCO reimbursing the acute care facility at the average skilled nursing facility (SNF) rate or the administrative day reimbursement rate, whichever is greater.

The MCO may only offer but not require members to utilize psychiatric or ICSS within an IMD setting, as ILOS are optional to members.

B. Housing Support or Services

Housing Supports and Services are defined as services and supports that assist a member in obtaining and remaining in a home that complies with all state and federal requirements per NRS 422.3964. This does not include the cost of room and board.

The MCO may cover Housing Support and Services as an ILOS if the member meets certain eligibility requirements and a qualified provider determines that Housing Supports and Services are medically appropriate for the member. The array of ILOS is optional to members per 42 CFR 438.3(e).

1. Housing Supports and Service Eligibility

A member will be eligible to receive Housing Supports and Services if the member is homeless or at risk of experiencing homelessness as defined under 24 CFR 91.5,

and the member is experiencing at least one or more of the following conditions or circumstances:

a. SMI or SED determination;

b. SUD diagnosis;

c. At risk of institutionalization or overdose or in need of residential services because of a SUD or a SEDor other behavioral health condition;

d. At risk of experiencing a behavioral health crisis or utilizing the emergency department;

e. Pregnant or had a recent live birth within the last 60 calendar days;

f. Discharged from a correctional or medical facility within the last 90 calendar days;

g. Transitioning, or will be transitioning within the next 30 calendar days, from an institutional or inpatient setting to the home or community setting; or

h. Victim of human trafficking or domestic violence.

The MCO must develop and utilize a consistent process for screening members for eligibility for these services that will be approved by the State. The eligibility screening tool must include, at minimum, a set of standardized questions to be developed jointly between the State and all MCOs. All qualified providers must conduct the eligibility screening process and provide all necessary documentation in the member's care plan/medical record to show the eligibility outlined in the contract. The MCO must coordinate Housing Supports and Services with county or other local entities and community organizations to assist eligible members in accessing any available separate financing for room and board and other social services and resources.

2. Housing Supports and Services shall replace State Plan coverage of the following services:

a. ER services, including behavioral health and crisis services provided in the hospital setting to the homeless population, by reducing or obviating the future need of this population to utilize these State Plan Covered Services;

b. Emergency medical transportation by reducing or obviating the future need of this population to utilize this State Plan Covered Service;

c. SNF services, residential treatment center services, inpatient hospital admissions and stays, and hospital psychiatric admissions and stays by addressing immediate needs and by reducing or obviating the future need of this population to utilize these State Plan Covered Services;

d. ICSS by reducing or obviating the future need of this population to utilize these State Plan Covered Services; and

e. Neonatal intensive care unit services for infants born to high-risk, homeless pregnant members by reducing or obviating the future need of this population to utilize these State Plan Covered Services.

The MCO must comply with all service limitations and any other requirements set forth by the State.

3. Housing Supports and Services shall consist of the following if determined to be medically appropriate and reasonably necessary:

a. Specialized case management for eligible members outlined in the contract.

b. Housing transition supports to assist an eligible member with securing housing outlined in the contract.

c. Housing-related deposits determined to assist an eligible member with identifying, securing, and financing one-time services and modifications necessary for establishing a household outlined in the contract. Housing-related deposits are only available when the member is unable to afford such housing-related expenses and are also receiving housing transition services.

d. Housing sustainment services to assist an eligible member with sustaining safe and stable housing once housing is secured by a member, including:

1. Conducting an assessment of needs and developing a Housing Sustainment Plan;

2. Providing early identification and intervention for behaviors that may jeopardize housing;

3. Providing education and training on the rights and responsibilities of the tenant and landlord;

4. Coordinating with the landlord and case manager, to address any issues that could impact housing stability;

5. Aid with developing and maintaining key relationships with landlord and property manager, with a goal of fostering successful tenancy;

6. Aiding in dispute resolution with the landlord and/or a neighbor to reduce risk of eviction or other adverse action;

7. Connecting the member with community resources to prevent eviction when housing is, or may potentially become, jeopardized;

8. Aiding with benefits advocacy, including but not limited to assistance with obtaining identification and documentation for Social Security Income eligibility and supporting the application process;

9. Coordinating with the member to review, update, and modify their budget plan and/or housing and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers;

10. Providing no more than two medically tailored meals a day for the member at home that meet the unique dietary needs of the member and medically supportive food and nutrition services and education, including medically-tailored groceries, healthy food vouchers, food pharmacies, cooking classes for no longer than 90 days as long as such services are part of a broader nutritional counseling and education program offered to members;

11. Conducting health and safety visits, including unit habitability inspections (not housing quality inspections), in coordination with the member; and

12. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy, employment support, and connection to community resources and services to support housing sustainability.

4. Providers of housing support and services must meet the following requirements:

a. For specialized case management: the qualified provider must conduct the assessment in a manner that is culturally and linguistically appropriate without bias.

b. For housing transition supports and housing sustainment services: qualified providers include a case manager or care coordinator employed by or contracted with the MCO; county and social services agencies; behavioral health providers; CCBHCs; community-based organizations that provide services to homeless populations; hospitals with programs for individuals experiencing homelessness; affordable housing providers; supportive housing providers; FQHCs; and RHCs. Housing sustainment services are only available when housing has been secured and until a case manager determines such services are no longer necessary

c. For housing-related deposits: the MCO may coordinate services through a case manager and pay for them directly to the landlord or necessary entity, or the MCO may contract with any of the qualified providers outlined in the contract to pay for the costs of one-time housing-related deposits for a member.

5. Healthcare Common Procedure Coding System (HCPCS) Codes for Housing Supports and Services

To identify the service being provided, the MCO shall use the following HCPCS Codes:

a. HCPCS Code T1023 plus a modifier "XU" to indicate screening and assessment planning for case management that results in a referral for this ILOS benefit.

b. HCPCS Codes H0043 with the modifier "XU", H2015 with the identifier "XU", and H2016 with the identifier "XU", as applicable, to indicate housing transition supports for this ILOS.

c. HCPCS Codes H0044 with the modifier "XU" to indicate housing-related deposits.

d. HCPCS Code T2051 with the modifier "XU" to indicate housing sustainment service at a per diem rate and T2041 with the modifier "XU" for 15-minute billing increments.

6. To the extent the MCO offers members the services described in the contract, the MCO must submit its policies and procedures for how it will ensure that these

services do not comprise a full nutritional regiment or include more than two meals a day to the State for approval.

7. The MCO must assess and vet any qualified providers of Housing Supports and Services with which it intends to contract, including qualified providers not eligible to enroll as a billing or service provider in the Nevada Medicaid/NCU program. This includes ensuring appropriate licenses, background checks, and other standards have been met with respect to ensuring safe, quality providers.

The MCO may propose to the State additional ILOS or settings to be covered under the contract. The State will evaluate to determine if such proposals are medically appropriate and cost-effective alternatives.

3603.16 ENROLLMENT AND DISENROLLMENT REQUIREMENTS AND LIMITATIONS

A. General Information and Requirements

The eligibility and enrollment functions are the responsibility of Nevada Medicaid and DSS; However, existing managed care regulations do not prohibit MCO's from conducting outreach and assisting members with completing and submitting renewal forms provided that the plan does not provide choice counseling defined in 42 CFR 438.2. MCOs may not complete any renewal form fields related to plan choice and may not sign the renewal form on behalf of the member. The MCO must accept each member who is enrolled in or assigned to the MCO by the State or fiscal agent and for whom a capitation payment has been made or will be made to the MCO.

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 and 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, national origin, sex, sexual orientation, gender identity, or disability, and will not use any policy or practice that has the effect of discrimination on any basis.

The State reserves the right to recover pro-rated or full month of the capitation payment whenever the MCO's responsibility to pay medical claims ends in mid-month or other reasons specified below, but is not limited to the member:

1. becomes incarcerated and their aid category changes their eligibility, unless the member is admitted as an inpatient to a hospital, NF, juvenile psychiatric facility, or intermediate care facility (ICF) while still enrolled in the MCO;

2. receives inpatient services within an IMD, psychiatric or SUD crisis residential services in a sub-acute facility with stays longer than 15 cumulative calendar days;

3. is placed in an out of home placement; or

4. enters an ICF/ID;

The MCO is responsible for services rendered during a period of retroactive enrollment in situations where eligibility errors 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. The State is responsible for making applicable capitation for the retroactive coverage.

B. Change in a Member's Status

In the event that the MCO becomes aware of a change in a member's status, the MCO must complete the following:

1. electronically report to DSS any change in a member's status that may impact eligibility or enrollment in the managed care program such as residence or death.

2. notify a member that any change in status, including family size and residence, must be immediately reported by the member to the DSS eligibility worker.

3. submit an attestation to the State that it has reported any change in the members' statuses to DSS.

C. Enrollment for Newly Eligible Medicaid or NCU Recipients

Newly approved Medicaid and NCU recipients who are not joining an existing case will have the opportunity to select their MCO at the time of application, or any time prior to the approval of their application. Absent a choice, the State will select an MCO for the recipient using the auto-assignment algorithm.

The MCO must allow for a pregnant member's continued use of their OB/GYN upon the member's enrollment with the MCO, if at all possible.

D. Enrollment of Newborns

The MCO is required to report births electronically in accordance with the Reporting Requirements Exhibit listed in the current managed care contract.

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.

2. NCU Newborns

   The head of household or mother must notify DSS 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 must 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, the newborn will be enrolled in the MCO as of the first day of the next administrative month. If the coverage extends beyond that 30-calendar day period, the child will not be eligible for NCU until after the insurance expires and the child's eligibility is determined under NCU eligibility rules.

E. Auto Assignment Process

For recipients who do not select an MCO or who are not automatically assigned to an MCO based on family or previous history, the State will assign the recipient to an MCO based on the auto-assignment algorithm detailed in the managed care contract.

F. Automatic Re-enrollment

Members disenrolled for two months or less solely due to the loss of Medicaid/NCU eligibility will be returned to their last known MCO. In the event that their loss of eligibility caused them to miss the Open Enrollment period, those who have been ineligible for more than two months or have lost their managed care enrollment for any period of time, will be treated the same as newly approved recipients.

G. Performance Based Auto Assignment

Once the State has sufficient quality data from all MCOs in a geographic service area reflecting service delivery, the State will use an auto-assignment algorithm based on MCO performance on selected quality measures with preference given to high performing health plans. The State will provide communication to the MCOs on an annual basis which will address the quality measures selected for use in the auto-assignment algorithm; any benchmarks selected to measure performance; the MCO's performance on the selected quality measures compared to the selected benchmarks or compared to other MCOs; and associated percentage of auto-assignment for the next contract year.

H. Disenrollment Requirements and Limitations

Disenrollment procedures are pursuant to 42 CFR 438.56. If the member was previously disenrolled from the MCO as the result of a grievance filed by the MCO and has not lost their eligibility for more than two months or maintained their eligibility, but moved out of the geographic service area, the member will not be re-enrolled with the MCO unless the member wins an appeal of the disenrollment. The member may be enrolled with another MCO. Members may be enrolled with the MCO to the extent they are treated as a newly approved Medicaid or NCU recipient.

Enrollment in a different MCO due to without cause disenrollment requests is effective at the first of the next administrative month. Enrollment in a different MCO due to for cause disenrollment requests will be effective no later than the 1st day of the 2nd administrative month following the month in which the member requests disenrollment or the MCO refers the disenrollment to the State. Disenrollment may not occur mid-month except where expressly required by federal or Nevada regulations.

1. Disenrollment or Change at the Request of the Member

Members eligible in the 90-day "right to change" period may request disenrollment from the MCO without cause at any time during this period. The member must submit their request in writing to the State's Fiscal Agent. After the first 90 days of enrollment, the member will be locked into an MCO until the next open enrollment period. There will be one open enrollment period once every 12 months. If the member wishes to disenroll at any time during the lock-in period, they must contact their current MCO and provide good cause for doing so. The MCO will determine if there is sufficient good cause to disenroll.

Good Cause is defined in 42 CFR 438.56 and 42 CFR 457.1201 and includes:

a. The member moves outside of the MCO's service area;

b. The MCO does not cover the services the member seeks because of moral or religious objections;

c. The member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk.

d. For members that use LTSS, if a provider's change in status from a network provider to an out-of-network provider with the MCO would cause the member to have to change their residential, institutional, or employment supports provider, and, as a result, the member would experience a disruption in their residence or employment.

e. Other reasons include but are not limited to poor quality of care, lack of access to services covered under the contract, lack of access to providers experienced in dealing with the member's health care needs, or a situation in which the State imposes intermediate sanctions on the MCO or notifies the MCO that it intends to terminate their contract.

2. Disenrollment at the Request of the MCO

The MCO may request disenrollment of a member if the continued enrollment of the member seriously impairs the MCO's ability to furnish services to either the particular member or other members or the member relocated their residences outside of the MCO's geographic services. In addition, the MCO must confirm the member has been referred to the MCO's Member 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 must provide all disenrollment requests to the State in writing for review and approval. The State will make a determination within 10 business days. If approval is granted, the member will be given notice by the MCO that disenrollment will occur effective the first day of the next administratively possible month after the member is given State Fair Hearing rights to appeal the decision.

The MCO may not request disenrollment of a member for any of the following reasons:

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

b. Pre-existing medical condition;

c. Utilization of medical services;

d. Diminished mental capacity;

e. Uncooperative or disruptive behavior resulting from the member's special needs (except when continued enrollment of such a member seriously impairs the MCO's ability to furnish services to either this particular member or other members);

f. Member's attempt to exercise grievance or appeal rights; or

g. Based on the member's national origin, creed, color, sex, religion, or age.

I. Enrollment, Disenrollment and Other Updates

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

J. Provider Enrollment Roster Notification

The MCO must establish and implement a mechanism to inform each PCP about any new MCO members 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 the State or the State's Fiscal Agent.

3603.17 CHANGE IN A MEMBER'S STATUS

The MCO must electronically report to DSS any change in a member's status that may affect eligibility or enrollment in the managed care program such as residence or death. An attestation needs to be submitted to the State that all changes in members' statuses were reported to DSS. The MCO must notify a member that any change in status, including family size and residence, must be immediately reported by the recipient to the DSS eligibility worker.

3603.18 TRANSITIONING/TRANSFERRING OF MEMBERS

A. Transitioning Recipients into MCOs

The MCO will be responsible for members as soon as they are enrolled. The MCO must have policies and procedures to ensure member's smooth transition from FFS or other health plan to the MCO, including but not limited to the following:

1. Members with medical conditions such as:
    a. Pregnancy (especially if high risk);
    b. Major organ or tissue transplantation services in process;
    c. Behavioral or mental health conditions;
    d. Terminal illness; and/or
    e. Intractable pain.
2. Members who, at the time of enrollment, are receiving:
    a. Chemotherapy and/or radiation therapy;
    b. Significant outpatient treatment or dialysis;
    c. Prescription drugs or DME;
    d. Behavioral health services;
    e. Mental Health or SUD treatment as ordered by a court under the jurisdiction of the State of Nevada;
    f. LTSS, including but not limited to personal care services and/or home health services; or
    g. Other services not included in the Medicaid/NCU State Plans but covered by Medicaid under EPSDT for children.
3. Members 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, to honor these prior authorizations
    d. Have post-surgical follow-up visits scheduled after their enrollment; and/or

e. Were released from a correctional facility under the jurisdiction of the State of Nevada within the prior six months.

B. Transferring Members Between MCOs

It may be necessary to transfer a member from one MCO to another or to FFS for a variety of reasons. When notified that a member 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(s). Prior to transferring a member, the MCO (or their subcontractor(s) when requested by the MCO) must send the receiving MCO or provider information regarding the member's medical condition within five calendar days of learning that a member is transferring, or sooner as medical needs dictate. This information shall include the name of the assigned PCP, as well as the following information, without limitation, as to whether the member is:

1. Hospitalized;

2. Pregnant;

3. Receiving dialysis;

4. Chronically ill and/or diagnosed with a priority condition (e.g., diabetic, hemophilic);

5. Receiving outpatient treatment and/or awaiting evaluation or treatment;

6. Receiving behavioral or mental health services;

7. Receiving Nevada Early Intervention Services (NEIS) in accordance with an Individualized Family Service Plan (IFSP);

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

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

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

11. Receiving SUD treatment;

12. Drugs;

13. Receiving DME or currently using rental equipment;

14. Receiving case management (including the case manager's name and phone number); or

15. Receiving LTSS, such as but not limited to, Personal Care Services and/or Home Health.

When a member changes MCOs or reverts to FFS while hospitalized, the transferring MCO shall notify the receiving MCO, the receiving provider(s) providing direct care (if the Member changes MCOs or transitions to FFS), and/or the State's Quality Improvement Organization (QIO-like vendor). The notification process must occur as soon as the transition is known to the MCO.

A member may need to be transitioned between Medicaid and the Health Insurance Exchange (HIX) coverage or other non-exchange coverage, due to changes in eligibility. 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.

The State reserves the right to carve out children with an SED determination during the contract period and to implement a specialty managed care plan for those members. For children identified as eligible for this specialty plan, the MCO must follow the requirements for transitioning a member to another plan.

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

For children that received Medicaid/NCU 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 under the requirements of EPSDT to the Provider(s) and level of services that were received while in FFS.

2. Any service Provider(s) 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.

3603.19 MEMBER INFORMATION REQUIREMENTS

The MCO must have written information about its services and access to services available upon request. Written information must also be available in the prevalent non-English languages, as determined by the State. "Prevalent" is determined as the primary language spoken by 1,000 or 5% (whichever is less) of the MCO's members. The MCO must have free verbal interpretation services available to every member and potential member in all non-English languages, not just prevalent languages and how to access this information at no cost.

Written material must use an easily understandable format and language written in no higher than a sixth-grade level. The MCO must also develop appropriate alternative methods for communicating with visually-impaired, hearing-impaired and accommodate physically disabled members in accordance with the revised regulations of the Americans with Disabilities Act (ADA).

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 for this reason to the State with its application for a Medicaid/NCU contract and whenever it adopts the policy during the term of the contract. The MCO must also notify members when it adopts a policy to discontinue coverage based on moral or religious objectives at least 30 calendar days prior to the effective date of the policy for any particular service. All of the following must meet all guidelines for written material as listed in this MSM and the contract.

A. Member Handbook

The MCO must provide all members with a Member Handbook using the State developed model handbook. The handbook 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 member."

The MCO must submit the Member Handbook to the State before it is published and/or distributed. The State 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 and provide annual updates for the handbook at least once per year.

The MCO must mail the handbook or instruct all members on how to access the handbook, within five business days of receiving notice of the member's enrollment and must notify them of their right to request and obtain this information at least once per year or upon request without cost. The MCO will also publish the Member Handbook on their 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 and

provide notice to members 30 days before the intended effective date when there are material changes that will affect access to services and information about the Managed Care Program.

At a minimum the information listed below must be included in the handbook so that it enables the members to effectively use the program:

1. An explanation of right to obtain available and accessible health care services; a description of all member rights; 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 members; 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. Confirmation of the member's PCP selection may be via an identification card and not printed directly in the member handbook.

3. Any restrictions on the member'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. Member 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 members understand the benefits to which they are entitled to, including ILOS.

7. Procedures for obtaining benefits, including authorization requirements.

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

9. Procedures for disenrollment without cause during the 90-calendar day period and procedures for disenrolling with cause, opportunities to select the remaining MCOs, and auto-assignment due to temporary loss of eligibility.

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 that providers and hospitals furnish emergency and post stabilization services under the contract; emergency transportation; and the fact that, subject to regulatory limitations, the member has a right to use any hospital or other setting for emergency services.

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 member's PCP, including explanation of authorization procedures and information that a referral is not required in choosing a family planning provider.

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.

14. Procedures for accessing emergency and non-emergency services when the member 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. Information for adult members on AD policies and include a description of applicable State law.

18. To the extent available, quality and performance indicators, including member experience.

19. An explanation of the EPSDT program as a distinct section that includes a list of all the services available to children, a statement that services are provided to the member with no costs, and a telephone number that the member can call to receive assistance in scheduling an appointment.

20. A distinct section for members who are pregnant or postpartum that explains services like high-risk maternal case management, and providers such as nurse midwives and doulas, that are available to members and provides a telephone number that the member can call to receive assistance in accessing these services and providers.

21. Information regarding prescription drug coverage, including a description of pharmacy policies and pharmacy programs covered by the MCO and the phone number for the State's Pharmacy Benefit Manager.

22. Notification of the member'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.

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

24. The transition of care policy and instructions on how to access continued services upon transition to FFS or another MCO.

B. Member Newsletter

The MCO must publish a newsletter for members at least twice per year. The newsletter will focus on topics of interest to members and must adhere to the requirements for written member materials. The MCO must publish these newsletters on the MCO's website.

C. Medical Records

The MCO must take steps to promote maintenance of medical records in legible, current, detailed, organized, and comprehensive manner that shall be maintained by the MCO's network providers. The records must be available for review by duly authorized representatives of the State and CMS upon request. The records must be current, detailed, organized in a comprehensive manner, and legible to someone other than the writer. A second review should evaluate any record judged illegible by one physician reviewer.

The MCO must have and enforce written policies and procedures to maintain the confidentiality of all medical records; provide accessibility and availability of medical records at the request of an authorized person and/or entity without disclosing confidential information to unauthorized persons; ensure adequate record keeping and record review processes.

All medical records must follow the standards as determined by the State outlined in the managed care contract. The member's medical record is the property of the provider who generates the record. The MCO must assist the member or the parent/legal guardian of the member in obtaining a copy of the member'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 member or parent/legal guardian of the member 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 a member changes PCPs 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.

D. Advanced Directives

The MCO must have written policies and procedures for ADs. An AD is defined as a written statement completed in advance of a serious illness or condition that allows the member to direct health care decisions when they are unable to do so. This allows the member to make decisions regarding the use or refusal of life-sustaining treatments and can consist of living wills and durable powers of attorney for health care decisions for individuals 18 years of age or older. At the time of enrollment, each member should be provided written information regarding ADs which includes the members' rights, education, and compliance with State laws.

3603.20 MEDICAL PROVIDER REQUIREMENTS

A. Primary Care Provider/Physician (PCP) or Primary Care Site

The MCO must allow each member the freedom to choose from among its network PCPs and change PCPs as requested. Procedures must be in place to ensure each member has an ongoing source of primary care appropriate to their needs.

Each member must elect or be assigned to a PCP within five business days of the effective date of enrollment. Members with disabilities must be given 30 calendar days to select a PCP.

Members with disabilities, chronic conditions, or complex conditions must be allowed to select a specialist as their PCP. Any specialist can be a PCP based on medically necessary condition(s). These members 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.

Members are allowed to remain with their existing PCP if the PCP is part of the MCO's network.

If a member has existing relationships with providers that are not part of the MCO's network upon enrollment, the MCO must allow and reimburse for continued use of the member's provider(s) until the member can be transferred to an appropriate network provider(s).

B. Assignment of a PCP or Primary Care Site

The MCO must ensure that members receive information about where they can receive care during the time period between enrollment and PCP selection/assignment. A written notification is required to be sent to the member informing them of their assigned PCP within five business days of assignment.

If a member does not choose a PCP, the MCO will assign members with PCPs by one or more of the following criteria:

1. A provider from whom they have previously received services, if the information is available;

2. A PCP or Primary Care Site who is geographically accessible to the member per 42CFR §438.68 and the Time and Distance requirements for PCPs outlined in the managed care contract;

3. All children within a single family to the same PCP;

4. A CYSHCN to a practitioner experienced in treating the member's condition, if the MCO knows of the condition; and/or

5. A PCP upon receipt of a claim for services rendered by a PCP to the member.

C. Changing a PCP or Primary Care Site

1. A member may change a PCP for any reason. The MCO shall notify members of procedures for changing PCPs.

2. In cases where a PCP has been terminated, the MCO must notify members in writing and allow them to select another PCP or make a re-assignment within 15 calendar days of the termination effective date and must ensure access to urgent care for members until re-assignment.

3. The MCO may initiate a PCP change for a member under the following circumstances:

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

   b. The member's residence has changed such that distance to the PCP is greater than the time and distance standards for PCPs. Such change will be made only with the consent of the member;

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

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

e. The member's claims or encounter history illustrates that the member is receiving Primary Care Services from a PCP other than the PCP assigned/selected;

f. The PCP has made a written request that the member be reassigned; or

g. The MCO has determined a PCP reassignment to be in the best interest of the member.

If the MCO or member initiates a PCP change, the MCO must provide the member with the opportunity to select another PCP within the MCO's network.

The MCO must track the number of requests to change PCPs and the reasons for such requests.

3603.21 PROVIDER DIRECTORY

The MCO must publish its provider directory for all geographic service areas in machine readable, online, and paper formats. The MCO must update the paper directory quarterly and the electronic directory on the website no later than 30 calendar days after the MCO receives updated provider information. The MCO must provide the State with the most current provider directory per the reporting requirements listed in the contract.

The Provider Directory must include all of the following:

A. A list of all current and active network providers by name, FQHCs, any subcontractors' provider directory, group affiliation, and specialties for all PCPs and specialists, hospitals, pharmacies, behavioral health, and LTSS providers, as appropriate;

B. Accurate demographic data for all network providers;

C. The specific age bands served by psychologists and psychiatrists that treat child and adolescent members. The age bands are 0-6, 7-12, 13-17, and 18-21;

D. The provider's website Uniform Resource Locator (URL), as appropriate;

E. If the provider is accepting new patients in the member's geographic service area;

F. The provider's board certification status;

G. All street addresses where the provider practices;

H. All telephone numbers associated with the practice sites;

I. Availability of evening or weekend hours;

J. Whether the provider offers covered services via telehealth;

K. The provider's cultural and linguistic capabilities, including languages (including American Sign Language (ASL)) spoken by the provider or a skilled medical interpreter at the provider's office;

L. Whether the provider has completed cultural competency training;

M. A picture of the provider, if available; and

N. Whether the provider's office/facility has accommodations for members for physical disabilities, including officers, exam room(s), and equipment.

3603.22 NETWORK MAINTENANCE AND AVAILABILITY OF SERVICES

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

1. Initial and ongoing credentialing;

2. Adding, deleting, and periodic provider contract renewal;

3. Monitoring of adherence to the network adequacy standards under the contract and remediation of any deficiencies;

4. Provider education; and,

5. Discipline/termination

B. The MCO must ensure and provide the following:

1. Network providers must offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid/NCU FFS.

2. A second opinion from a qualified network provider or arrange for a member to obtain a second opinion outside the network at no cost to the member.

3. Direct access for female members to a women's health specialist to provide women's routine and preventive health care services.

4. Access to health screenings, reproductive services, and vaccinations through county and state public health clinics services.

5. Notify the State's designated staff of any unexpected change that would impair the provider network in accordance with the Reporting Requirements Exhibit. This notification must include:

   a. Information about the nature of the change and how the change will affect the delivery of covered services;

   b. Plans for maintaining the quality of member care of the provider network; and

   c. Whether the change is likely to result in deficient delivery of covered services.

6. Notify the State of any change in its provider network that will substantially affect the ability of members to access services as soon as the change is known or not later than fifteen calendar days prior to the change.

7. MCOs must actively partner with the State, community providers, and stakeholders to identify and address issues and opportunities to improve health care access and availability of services for Medicaid/NCU members.

C. Suspension, termination, or other actions related to network providers

The MCO must have written policies and procedures for monitoring its network providers compliance and take corrective action if there is a failure to comply by the network providers. Appropriate action related to dual FFS and network providers must be taken and provide all documentation to the State related to any disciplinary action, sanction, refusal to contract based on credentialing review processes, or removal from the provider panel in a timely manner.

The MCO must immediately inform the State's Provider Enrollment Unit upon the MCO's awareness of any disciplinary action, sanction taken against a network provider, or any suspected provider fraud or abuse.

The MCO must check the Office of the Inspector General (OIG) website and the State's excluded provider list at least monthly to confirm its network providers have not been sanctioned. Upon notification or discovery that the OIG, State, any other state Medicaid/CHIP agency, or a certification/licensing entity has taken an action or imposed a sanction against a network provider, the MCO must review the provider's performance related to the managed care contract and take any action or impose any sanction, including disenrollment from the MCO's provider network.

1. The MCO may refuse to enter into, renew, or terminate an agreement with a provider if:

a. any person who has an ownership, has controlling interest, an agent, or managing employee of the provider, has been convicted of a crime offense related to that person's involvement in any program established under Medicare, Medicaid, or CHIP.

b. the provider did not fully and accurately make any required disclosure. Any action taken on a provider's application must be reported to the State's provider enrollment unit.

2. Provider termination

a. If a provider is terminated or disenrolled from the network, the MCO must inform the State's Provider Enrollment Unit in accordance and provide the basis, reasons, or causes for such action and any and all documentation, data, or records obtained, reviewed, or relied on to make the determination, including but not limited to provider/patient files, audit reports and findings, and Medical Necessity reviews.

b. If the denial of credentialing, termination, or disenrollment of a provider is due to suspected criminal actions or disciplinary actions related to fraud or abuse, the State is responsible for notifying the Medicaid Fraud Control Unit (MFCU) or OIG.

c. The MCO must give written notice of termination of a network provider, by the later of 30 calendar days prior to the effective date of the termination or 15 calendar days after receipt of issuance of the termination notice, to each member who received their primary care from or was seen on a regular basis by the terminated network provider.

3603.23 THIRD-PARTY LIABILITY (TPL) AND SUBROGATION

TPL refers to any individual, entity (e.g., insurance company) or program (e.g., Medicare) including group health plans, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974 (29 USC and 1167 (1)) service benefits plans 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 includes the Coordination of Benefits (COB), cost avoidance, and COB recovery. MCO's are required to follow the State's TPL process as described in this chapter. Nevada Medicaid and NCU are the payer of last resort. The MCO is responsible for developing and distributing communication forms to members to ensure members self-report TPL. In cases where TPL is known, the MCO must pursue TPL and ensure that it has been billed and processed prior to paying any portion of the claim.

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 must identify potential TPL, including Medicare, and deny the claim if it is for a service covered by other insurance based on the member's type of TPL coverage and type of service (e.g., medical service claim with medical service coverage, pharmacy service claim with pharmacy coverage). The MCO must allow for TPL overrides when the other insurance is exhausted or the service is not covered by the other liable party, making Medicaid/NCU the payer of last resort for the claim.

The MCO shall act as the State's authorized agent for the limited purpose of TPL for cost avoidance claims and collection, within the limitation of the Fair Debt Collection Practices Act, 15 USC §1692, of all TPL pursuant to 42 CFR §433 Subpart D and 42 CFR 447.20. The MCO's capitated payments include an offset in the rates for these collections. The MCO must vigorously pursue billing prior resources and TPL as these amounts are considered part of the risk-based capitation payment.

MCOs are required to secure signed acknowledgements from members or their authorized representative for any prior resources (Medicare, worker's compensation, private insurance, and similar resources). The MCO must also determine if casualty claims are filed and recover costs through subrogation on behalf of both Medicaid and NCU members. The MCO must utilize the EVS and TPL data provided by the State to assist in accomplishing this objective.

The State will monitor and evaluate the MCO's TPL and subrogation collection reports to validate collection activities and results. The MCO is expected to meet or exceed baseline target collections as determined by the State and its actuaries. If the MCO does not meet or exceed baseline TPL and subrogation collections, the State will conduct a review to determine if there is a legitimate reason. If there is no legitimate reason, the difference between baseline and actual collections will be deducted from the MCO's costs before the data is used to set future rates. The State will prospectively adjust capitation rates downward to account for expected TPL collections.

The MCO is required to obtain TPL information independently of the State for the purpose of avoiding claim payments or recovering payments made from liable third parties. TPL recovery will be incorporated into the capitated rate development by the State and its actuary. The MCO has 365 calendar 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. If the State assumes responsibility of a TPL recovery, the MCO is responsible for paying the costs incurred by the State to complete the recovery.

The MCO must follow all reporting requirements of TPL and subrogation as outlined in the managed care contract. All records of TPL eligibility data must be kept and maintained online following state and federal rules and regulations. All TPL business functions must follow the

requirements of MSM, CMS, State Medicaid Manual, and other state and federal rules and regulations. Exceptions to the TPL rule are IHS; CYSHCN; and State Victims of Crime.

3603.24 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 must 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 telehealth providers or pharmacies located outside of the U.S.

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.

3603.25 MANAGEMENT INFORMATION SYSTEM (MIS)

The MCO must operate the MIS capable of maintaining, providing, documenting, and retaining information sufficient to substantiate and report MCO's compliance with the contract requirements, and documenting administrative and clinical procedures while maintaining the privacy and confidentiality requirements pursuant to HIPAA.

A. All transactions subject to the HIPAA-compliant format include, but are not limited to:

1. Capitation payments;

2. Enrollments into and disenrollments from a health plan;

3. Eligibility inquiries and responses;

4. Referrals and prior authorizations;

5. Electronic Visit Verification (EVV);

6. Claims encounter data;

7. Claims status inquiries and responses; and

8. Payment and remittance advice.

The MCOs must comply with current International Classification of Diseases (ICD), Electronic Data Interchange (EDI) standards, Transformed Medicaid Statistical Information System (T-MSIS), National Electronic Data Interchange (NEDI) Transaction Set Implementation guide as defined by CMS regulation and policy.

No funding will be provided by the State for the MCO compliance with HIPAA, ICD, or EDI standards. The MCO must ensure compliance at its own expense with any new and/or modified interfaces that may be required by the State or CMS, including but not limited to those related to compliance with HIPAA regulations.

The MCO must provide the State with aggregate performance and outcome data, as well as its policies for transmission of data from network providers and submit its work plan or readiness survey assessing its ability to comply with HIPAA mandates in preparation for the standards and regulations. The MCO shall have internal procedures to ensure that data reported to the State is valid and to test validity and consistency on a regular basis.

The MCO must provide and work closely with the State, fiscal agent, and/or actuary for compatible data and establishing schedule for each interface listed in the managed care contract.

B. Eligibility Data

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

2. The MCO must update its eligibility database whenever members change their demographic information such as names, phone numbers, and/or addresses These changes will be sent to the State through a 408 Change in Demographics file to DSS.

C. Encounter and Claims Records

1. The MCO must maintain a health information system that collects, analyzes, integrates, and reports data and achieves the objectives of the ongoing Internal Quality Assurance Program (IQAP). The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollment for reasons other than the loss of program eligibility and must comply with the basic elements of a health information system listed in the managed care contract.

2. The encounter data reporting system should be designed to collect aggregated, unduplicated service counts provided across service categories, provider types (PT), and treatment facilities. This must use a standardized methodology capable of supporting CMS reporting categories for collecting service event data and costs associated with each category of service.

3. All encounter data must follow the State's taxonomy for PTs and specialties that must be appropriate to the services rendered for each associated encounter.

4. The MCO must 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 the State. The data shall be submitted in accordance with the requirements set forth in the managed care contract and the reporting requirements exhibit. The data shall include all services reimbursed by Medicaid.

5. The MCO must submit encounter data for the NCU program in the same way as for Medicaid, following 42 CFR 457.1285. NCU members must be clearly identified separately from Medicaid members, though data can be submitted together. Data must be submitted to the State or its vendor using EDI standards and federal regulations. No data should be submitted for services from providers excluded by Medicare, Medicaid, or CHIP. All encounter data must include adjustments and voids, and improper payments must be corrected within state-specified timeframes, regardless of collection status. All encounters must be submitted properly and accurately for reporting purposes.

6. The MCO must include the following data fields and any additional fields as specified by the State in pharmacy encounters:

   a. Members name and Medicaid/NCU ID;

   b. Date of birth;

   c. Providers name and NPI;

d. Prescription number;

e. National Drug Code (NDC);

f. Units dispensed;

g. Day's supply; and

h. The plan code for reporting.

D. EPSDT Tracking System

The MCO shall operate a system that tracks EPSDT activities for each enrolled Medicaid member by name and Medicaid identification number. The system must include all necessary data on the CMS-416 reporting form. This system must be enhanced, if needed, to meet any other reporting requirements instituted by CMS or the State.

E. EVV

The MCO must ensure that any provider of primary care site, home health, PDN services, and any other services identified by the State or CMS, uses an EVV system prior to paying claims. The cost related to EVV cannot be passed to providers or members. The MCO must provide assistance on utilization of the data collection system to providers and members receiving services and adhere to all EVV requirements set forth by federal and state laws, rules, regulations, the contract, and the MSMs.

3603.26 REPORTING REQUIREMENTS

The reporting schedule and specifications are specified in the Reporting Requirements Exhibit listed in the current managed care contract that must be used for submission of all required reports and forms.

The MCO is required to certify the data including, but not limited to, all documents specified by the State as required in the Reporting Exhibit and current managed care contract, such as enrollment information, encounter data, payment data, overpayment recovery data, and other information submitted to the State for the purposes of determining payments to the MCO. The MCO must ensure the data complies with the applicable certification requirements for data and documents specified by the State. 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, that the data is accurate, complete, and truthful, under the penalty of perjury, as requested by the State for participation in the Medicaid/NCU program and as stipulated in the contract, proposal, and related documents.

Unless clearly marked as "confidential" or "trade secret," information or documents provided by the MCO may be subject to public disclosure under NRS 239.010. The State is obligated to release such information unless it is protected by law or a common law balancing interests, such as compensation details, profit margins, consumer satisfaction, audits, litigation, or Healthcare Effectiveness Data and Information Set (HEDIS) data. The MCO may label documents as "confidential" or "trade secret," but must agree to indemnify and defend the State for honoring that designation. If a document is not labeled and is released, the MCO waives all claims for damages. When a public record's request is made for a labeled document, the State will notify the MCO and delay access for seven business days. During that time, the MCO must take action to protect the document; failure to do so results in a complete waiver of confidentiality.

The MCO must meet all reporting requirements and timeframes as required by the contract and all attachments and exhibits. Failure to meet all reporting requirements and timeframes may be considered to be in default or breach of said contract.

A. Encounter Data Report Files

The MCO is required to ensure that encounter data submissions meet specific accuracy thresholds, with at least 95% of encounters passing all edits within the first six months and 97% thereafter. Failure to demonstrate good faith efforts to meet these standards may result in progressive sanctions, including monetary penalties, unless the MCO is not solely responsible for the failure. Encounter data must be complete and accurate to support capitation rate development and submitting inaccurate or incomplete data may constitute a false claim under the False Claims Act (FCA) and other applicable laws. All encounters must be submitted electronically as HIPAA-compliant shadow claims and must include National Provider Identifiers (NPI) for all billing, servicing, and Ordering, Prescribing, and Referring (OPR) providers. The MCO must ensure that all providers rendering services to its members are registered with the State as Medicaid/NCU providers, including those eligible for but not required to have an NPI. Even paper claims must include NPIs and be converted into electronic shadow claims. Taxonomy codes must be submitted to the State's fiscal agent and used consistently across all encounters, including those rebilled to third-party insurers such as Medicare or private insurance. The MCO must also capture and submit all encounters from sub-capitated providers in full compliance with HIPAA standards. For atypical providers, the MCO must ensure they have a State-issued Atypical Provider Identifier before any payments are made and must be capable of transmitting these identifiers in encounter submissions. If the State or its vendor returns a disputed encounter file, the MCO must correct and resubmit the data or provide an explanation if corrections are not possible, in accordance with the Reporting Requirements Exhibit.

B. HEDIS Reporting

The State or its designee will evaluate the MCO's IQAP based on HEDIS measures, performance measures, and/or other measures defined in the State's Quality Strategy, as specified in the current managed care contract. The MCO must submit these reports in a timely manner pursuant to contract requirements in addition to the other reports required by this contract.

C. Sales and Transaction Reporting

The MCO must report transactions between the MCO and parties in interest to the State or other agencies and must be available to members upon reasonable request.

D. Quality Assurance Reporting

The MCOs must perform Performance Improvement Project (PIPs) pursuant to guidelines established jointly by the MCOs, the State, and the External Quality Review Organization (EQRO) as well as those identified in the current managed care contract. In addition, the MCO must provide outcome-based clinical reports and management reports in accordance with the Reporting Requirements Exhibit. Should the MCO fail to provide such reports in a timely manner, the State will require the MCO to submit a Plan of Correction (POC) to address contractual requirements regarding timely reporting submissions.

E. Member Experience Reporting

Each MCO must collect and submit to the State a child and adult Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, as well as CAHPS Survey for Children with Chronic Conditions (CCC), measuring members' experience prior to the third quarter of each contract year, unless the requirement is waived by the State due to an EQRO performed survey. This may be done in conjunction with the MCO's own experience or satisfaction survey. The State requires data stratified to indicate the experience rating of parents or guardians of NCU members. The MCO must report results from the CAHPS surveys and the supplemental items for the Child Questionnaires on access to specialist care and coordination of care from other health care providers. The State may request a specific sample, and/or survey tool. Survey results must be disclosed to the State or members upon the request of the State or member.

F. Financial Reporting

The MCO must meet the financial reporting requirements set forth in the managed care contract, including any revisions or additions to the requirements and in accordance with the Reporting Requirements Exhibit.

G. Program Integrity Unit (PIU)

1. Compliance Program

The MCO must have a documented compliance program that implements and maintains administrative and management arrangements or procedures, to detect and prevent fraud, waste, and abuse. The MCO's compliance program must include the elements necessary to monitor and enforce compliance with all applicable laws, policies and the managed care contract.

At minimum, compliance program documentation must include all of the following elements and any others as directed by the State:

a. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable federal and state standards under the managed care contract and all applicable federal and state requirements;

b. The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the CEO and the Board of Directors;

c. Establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level, charged with overseeing the MCO's compliance program;

d. Effective communication between the compliance officer, the MCO's employees, and the State;

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

f. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance programs as identified in the course of self-evaluation and audits, correction of such programs promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the managed care contract;

g. Mandatory ongoing training and education of the Compliance Officer, Program Integrity staff, other management and staff, and subcontractors on the prevention and detection of fraud, waste, abuse, and improper payments;

h. Delineation of the staff and division of responsibilities within the MCO's PIU;

i. Specific objectives and goals for Program Integrity operations in the coming year;

j. Attestations that the MCO has completed the FCA network provider requirement; and

k. A report evaluating performance against the specific objectives and goals from the previous year.

The MCO must include provisions for a method to verify that services were received by members. This could be the use of an Explanation of Benefits (EOB) or Verification of Services (VOS) letters that address the requirements in 42 CFR 455.20 and 42 CFR 433.116.

2. Embezzlement and Theft

As part of the compliance program, monitoring activities on an ongoing basis to prevent and detect embezzlement or theft by employees, network providers, and subcontractors is mandatory.

3. Fraud, Waste, and Abuse Identification and Referral

The MCO must maintain and monitor a hotline to receive allegations of fraud, waste, abuse, or improper payments that are prominently displayed in a standalone frame placed on the front page of the MCO's Medicaid/NCU website. A web page can be utilized to collect reports as long as it follows the guidelines in the contract.

The MCO and its subcontractors must include provisions in their compliance program documentation for the prompt referral of any potential fraud, waste, or abuse that is identified to the State's Surveillance and Utilization Review (SUR) unit.

A Credible Allegation of Fraud (CAF) is an allegation from any source when it has an indication of reliability.

The MCO must ensure that the PIU reviews and refers all allegations, tips, complaints, and referrals of any potential fraud, waste, or abuse in a timely manner (e.g., 10 business days). This could include sources from the MCO's fraud hotline or website; referrals from the State; referrals from the MCO's own organization,

including utilization of data systems to identify issues such as provider profiling or data analysis; EOB or VOS letters and complaints; or provider self-reported referrals.

The MCO must track, report, and refer all allegations, tips, complaints, and referrals alleging member misconduct, whether CAF or non-CAF to the State's SUR Unit. No referral to the MFCU is necessary.

When the MCO receives an allegation, tip, complaint, or referral related to potential provider fraud, the MCO must perform a preliminary investigation to determine whether a CAF exists. If it is determined that there is a CAF, the MCO must follow the CAF referral and payment suspension procedures.

All referrals to the State's SUR Unit, at a minimum, must include the following information and any other information specified by the State:

a. Provider's name;

b. Provider's Medicaid/NCU provider number or NPI;

c. Nevada Medicaid/NCU PT;

d. Member's name and Medicaid or NCU number;

e. Date and source of the original complaint or tip;

f. Description of alleged fraudulent activity, including specific laws or Medicaid/NCU policies violated, dates of fraudulent conduct, and approximate value of fraudulently obtained payments;

g. Any other agencies or entities (e.g., medical board, law enforcement) notified by the MCO and any actions those agencies or entities have taken; and

h. Findings from the MCO's preliminary investigation and proposed actions.

After submitting the fraud referral, the MCO must not take any further action on the specific allegation until the MFCU or SUR Unit responds.

If the MFCU or SUR Unit declines the fraud referral, the MCO must proceed with its own investigation to comply with the reporting requirements.

If the MFCU or SUR Unit accepts the fraud referral, they will instruct the MCO as to what further actions, if any, may be taken without impairing the investigation. The MCO must provide whoever is completing the investigation access to conduct private interviews of MCO personnel, subcontractors and their personnel, witnesses, and members. MCO and subcontractor personnel must cooperate fully by being available in person for interviews, consultations, grand jury proceedings, pre-trial conferences, and hearings at their own expense.

The State may approve or deny MCO requests for provider payment suspensions based on credible allegations of fraud. The MCO must follow the procedures and recovery of improper provider overpayment procedures outlined in the managed care contract.

H. Autism Spectrum Disorder (ASD) Reporting

This report may include information including the number of members diagnosed with ASD, the number of ASD-related services delivered by the MCO, and other information as requested by the State.

I. Applied Behavioral Analysis (ABA) Reporting

The MCO must submit an ABA report to the State. This report may include information including members' average wait times for ABA service appointments, the number of providers rendering ABA services and other information as requested by the State.

J. Other Reporting

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

3603.27 SANCTIONS, MONETARY PENALTIES, AND OTHER REMEDIES

In the event that the MCO, or any person with an ownership interest to the MCO, such as an affiliate, parent, or subcontractor, fails to comply or fails to perform with the managed care contract, the State may impose sanctions and any other administrative, contractual, or legal remedies available under federal or state law for a MCO's noncompliance.

No sanctions will constitute just cause for an interruption of providing covered services to members and the MCO is responsible for any fines or sanctions imposed upon the State by regulatory agencies as a result of noncompliance.

The State reserves the right to waive the application of sanctions and penalties at its discretion. Such waiver will not constitute an ongoing waiver of sanctions or penalties and is not to be construed as a waiver of the State's right to exercise the application of sanctions in any other instance.

A. Plans of Correction (POC)/Directed Plan of Correction (DPOC)

If the State determines that the MCO is not in compliance with or is underperforming against one or more requirements of the contract, the State will provide written notice regarding the details of the noncompliance with directives for fixing the deficiencies either by developing a POC or complying with a State DPOC. This notice also serves as a notice for sanctions in the event the State determines that sanctions are also necessary.

A POC must include, but may not be limited to:

1. specific problem(s) which require corrective action;

2. specific corrective actions to be taken for improvement;

3. goals and timeline of the corrective action;

4. identified changes in processes, structure, and internal/external education and processes for providing feedback to appropriate health professionals, providers, and staff;

5. type of follow-up monitoring, evaluation, and improvement; and

6. MCO's staff person(s) responsible for implementing and monitoring the POC and making the final determinations regarding quality problems.

The MCO must provide POCs to the State for review and approval. If a DPOC is imposed the MCO will have 15 calendar days to respond with evidence of correction or a timeline for correction. After evaluating the POC, the State will determine if it satisfactorily addresses the actions needed to correct the deficiencies.

If unsatisfactory, the State will indicate the section(s) requiring revision and request that the MCO submit an updated POC within 15 calendar days of receipt, unless otherwise specified. If the second POC is unsatisfactory, additional sanctions may be imposed sanctions.

Within 90 calendar days after an acceptable POC has been submitted or has been imposed, the State will initiate a follow-up review. If the MCO does not effectively implement or comply with the POC/DPOC within the timeframe specified, additional sanctions and other remedies may be imposed.

If State staff are required to spend 10 hours or more per week monitoring a POC/DPOC, the MCO must contract with a third party, either designated by the State or approved by the State, to oversee with the compliance.

The MCO must implement the POC/DPOC in compliance as specified in the managed care contract, including all attachments and exhibits. The State, it's EQRO, or an entity hired by the State, may provide quality assurance monitoring at the expense of the MCO.

B. Sanctions

The State may impose any or all non-monetary sanctions and monetary penalties based on determination of noncompliance as described in the managed care contract to the extent authorized by federal and state law. A sanction may be imposed if the MCO:

1. Fails to provide covered medically necessary items and services to a member, or impedes the ability of members to meet their health care needs and/or the ability of providers to adequately attend to those health care needs;

2. Imposes premiums or charges to the members that are in excess of what is permitted under the Medicaid/NCU program;

3. Discriminates against members based on their health status or need for health care services;

4. Misrepresentation or falsification of information;

5. Fails to comply with the requirements for physician incentive plans;

6. Distributes marketing materials that have not been approved by the State or that contain false or materially misleading information either directly or indirectly through any agent or independent; or

7. Violates any of the other requirements of Sections 1903(m) or 1932 of the SSA, or any implementing regulations.

All provisions of 42 CFR part 438, Subpart I and the managed care contract apply.

C. Appointment of Temporary Management

The State may impose the optional sanction of temporary management if it finds the MCO has continued egregious behavior, there is substantial risk to a member's health, or has repeatedly failed to meet requirements listed in the managed care contract.

D. Monetary Penalties and other Sanctions

In the event the State decides to assess monetary penalties, an invoice for payment of monetary penalties will be sent with the basis for the assessment; and the MCO will have 30 calendar days to either pay the invoice in full, or the State will withhold the amount from future capitation payments.

Payment of the invoice does not relieve the responsibility to comply in future reporting periods and/or instances.

The collection of monetary penalties by the State must be made without regard to any appeal rights the MCO may have pursuant; However, in the event an appeal results in a decision in favor of the MCO, any such funds withheld will be returned to the MCO as soon as practicable. Monetary penalties may be imposed in lieu of, or in addition to, actual damages at the discretion of the State.

The MCO will not be assessed monetary penalties when the failure to meet contract standards is determined to be a result of inaccuracies in the information supplied by the State, or actions or inaction on the part of the State. If the MCO suspects that the information supplied is in error, then the MCO must contact the State, in writing, within 10 business days of discovery.

When the State determines the MCO has a deficiency in a specific area that is not improving, certain actions will be taken until the issue is resolved. The MCO must provide a dedicated workspace during the time that State staff is on-site.

Any known or willful false statement, representation, or material omission of a material fact in any financial statement or disclosure filed will cause monetary penalty sanctions. Both the MCO and any culpable employee, officer, director, or agent may be subject to prosecution through the MFCU or adverse administrative action.

In the event a non-compliance results in a federal disallowance of federal funds, the MCO will be financially responsible to refund the amount of the federal disallowance and the corresponding State share to the State. If such disallowance is treated as a default or breach of contract, any such monetary penalties are not exclusive and are in addition to any other remedies available. All existing and future subcontracts require amendments to meet these requirements.

The State may recover actual damages incurred resulting from a non-performance of obligations and future capitation payments may be withheld for damages until paid in full. Other monetary penalties for failure to perform are listed in the managed care contract.

E. Suspension of Enrollment

The State may suspend enrollment into the MCO with two business days' notice for reasons such as:

1. The MCO's data systems are not in place or operating in such a manner to allow accurate and timely electronic transfer of information to or from the State. Enrollment will not be reinstated until the condition is corrected.

2. Marketing violations.

3. Failure to meet contractual requirements on monthly, quarterly, and annual reports.

4. Material deficiency in the MCO's provider network and/or quality of care and quality management issues.

5. Failure to meet contractual encounter data requirements, provide or deny payments for medically necessary covered services, and/or process claims in a contractually required and timely manner.

6. Inappropriately denying, or pending claims or payments, for medically necessary covered services provided to members.

F. Contract Termination

The State may terminate the MCO's contract, in whole or in part, and enroll the members into another MCO or provide covered services through others for reasons listed in the managed care contract.

Before termination, the State will provide the MCO a pre-termination hearing in accordance. A written notice will be provided explaining the intent to terminate, the reason for termination, and the time and place of the hearing.

After the hearing, the State will give the MCO written notice of the decision affirming or reversing the proposed termination and the effective date of termination.

For an affirming decision, the State will provide the members enrolled with the MCO a written notice of the termination and information on their options for receiving Medicaid/NCU services following the effective date of termination, which includes the ability for members to disenroll immediately without cause from the MCO.

Upon notice of contract termination, the MCO must continue to comply with all duties and obligations, including all responsibilities related to the provision of covered services for members, resolution of member and provider grievances and appeals, and payment of claims for covered services during the period of time when the MCO was under contract with the State.

1. No less than 90 calendar days prior to the termination date, the MCO must:

a. Submit a Termination Transition Plan to the State for review and approval, which describes the process for notifying and transferring all members to other appropriate managed care or FFS entities, as well as a network provider notification process;

b. Arrange for the secure maintenance of all records for audit and inspection by the State, CMS, and other authorized government officials;

c. Provide for the transfer of all data, including encounter data and medical records, to the State or other MCOs as requested by the State; and

d. Provide for the preparation and delivery of all reports, forms, and other documents to the State.

2. No less than 60 calendar days prior to the termination date, the MCO must:

a. Submit an updated Termination Transition Plan to the State that incorporates feedback from the State's review; and

b. Begin implementation of the updated Termination Transition Plan in such a manner as to ensure continuity of care for members.

3. No less than 45 calendar days prior to the termination date, the MCO must notify all:

a. Members in writing of the pending termination including the continuity of care requirements that will apply after they are transitioned and any other State-required language; and

b. Network providers in writing of the pending termination of this contract, including any State-required language.

As of the termination date, the MCO must promptly provide the State with information about all outstanding claims and arrange for the payment of such claims. Noncompliance with termination requirements may result in additional penalties.

3604 GRIEVANCES, APPEALS AND HEARINGS

The MCO must provide information about the grievance process, appeal process, and access to the State Fair Hearing system to members at the time of enrollment. This information must also be provided to providers and subcontractors at the time they enter into a contract with the MCO. The provisions listed in this section is to reflect the minimum requirements and are not intended to limit the scope of the MCO's process.

A. Member Grievances and Appeals

The MCOs must establish a system for members that includes a grievance and appeal process, and access to the State Fair Hearing System. The system, policy, and procedures must follow the State's requirements listed in the managed care contract. These policies and procedures must be described in writing and available online at any time to the State. Only one level of an internal appeal is allowed.

The MCO is required to establish and maintain an expedited review process for appeals when it is determined or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. Punitive action cannot take place against a provider who requests an expedited resolution or supports an appeal. If the expedited resolution of an appeal is denied, it must be transferred to the standard timeframe of no longer than 30 calendar days from the day the appeal is received with the exception of appeals that have a 14 additional calendar day extension. The member should be given prompt verbal notice of the denial and follow up within two calendar days with a written notice.

Grievance and appeal activities must be maintained and submitted to the State following the Report Requirements Exhibit.

A member, a member's authorized representative, or a provider acting on behalf of the member may file an appeal or grievance either verbally or in writing with the MCO within 60 calendar days from the date on the notice of adverse benefit determination. In the event a provider or authorized representative files the appeal they must first obtain the member's written permission. If a grievance or appeal is filed verbally, the MCO is required to document the contact for tracking purposes and to establish the earliest date of receipt. A written appeal is not required after making a verbal request.

If a member or representative exhausts the MCO's internal appeal process and upholds its Adverse Benefit Determination, a State Fair Hearing may be requested. The MCO must provide access to and information about the State Fair Hearing process in the event the appeal is not resolved in favor of the member. Grievances are not eligible for referral to the State Fair Hearing process.

B. Notice of Adverse Benefit Determination

The MCO must provide a timely written Notice of Adverse Benefit Determination to the member when the MCO takes adverse determination. The Notice of Adverse Benefit Determination must:

1. Be available in the State-established prevalent non-English languages, alternative formats with special needs, and easily understood language and comply;

2. Explain the action that was taken with the reasons for the determination, rights of the member, and access to copies of all documents relative to the determination at no charge;

3. Include the right to file an appeal, State Fair Hearing after the appeal has been exhausted and procedures on how to do so;

4. Explain circumstances for expedited resolution and how to request it;

5. Explain how to request continued benefits; and

6. Include who can request a hearing and specific law and/or regulations that support the decision being made.

C. Timing of the Notice of Adverse Benefit Determinations

The MCO is required to give notices at least 10 calendar days before the date of the Adverse Benefit Determination when it is a termination, suspension, or reduction of previously authorized covered services. This timeframe may be shortened to five calendar days if probable member fraud has occurred. If the action is a denial of payment, the notice must be given on the date of the determination. If a service authorization decision is not reached within the timeframes for standard or expediated services, a notice must be given on the date that the timeframes expire.

An MCO must give a notice no later than the date of the Adverse Benefit Determination if the MCO has factual information confirming the death of the member or the member has signed a statement that they no longer desire the services or requesting termination or reduction of services.

This is also true when the member:

1. is admitted to an institution that results in ineligibility for Medicaid/NCU services;

2. has an address that is unknown and the post office returns mail indicating no forwarding address;

3. has been accepted for Medicaid or CHIP services by another local, state, territory, or commonwealth;

4. has a physician prescribe a change in the level of medical care;

5. does not meet the preadmission screening requirements for admission to an NF; or

6. is being transferred from an institution, including but not limited to an NF, in an expedited fashion.

D. State Fair Hearings Process

The State Fair Hearing process is described in MSM Chapter 3100 - Hearings. A member, member's authorized representative, or the authorized representative of a deceased member'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 notice of resolution of the appeal. The MCO will participate in the State Fair Hearing process, at the MCO's expense, in each circumstance in which a member for whom the contractor has made an Adverse Benefit Determination requests a State Fair Hearing. The MCO is bound by the decision of the State Fair Hearing Officer and must comply with any decision resulting from the State Fair Hearing process. Provider enrollment, termination, or other contract disputes between the MCO and its providers and/or subcontractors will not be accepted. Grievances will also not be eligible for State Fair Hearings.

E. Expedited State Fair Hearing

The MCO must be available and prepared to participate in expedited State Fair Hearings. The State's timeframe for reaching an expedited decision is as expeditiously as the member's health condition requires, but no later than three working days for the State's receipt of a hearing request for a denial of services that meets the criteria for an expedited appeal but was not resolved or was resolved adversely using the MCO's expedited appeal timeframes. The Expedited State Fair Hearing process is outlined in MSM Chapter 3100.

F. Continuation of Benefits while the MCO's appeal process and the State Fair Hearing are Pending

1. The MCO must continue the member's benefits while the MCO's internal appeals process or the State Fair Hearing is pending if all of the following conditions exist:

a. The request for continuation of benefits is submitted on or before 10 calendar days after the mailed notice or the intended effective date of the adverse determination, whichever is later.

b. The member files the request for an appeal within 60 calendar days following the date on the Adverse Benefit Determination notice.

c. The appeal involves the termination, suspension, or reduction of a previously authorized service.

d. The services were ordered by an authorized provider.

e. The original periods covered by the original authorization have not expired.

f. The member requests an extension of benefits.

2. If, at the member's request, the MCO continues the benefits, they must be continued until one of the following occurs:

a. The member withdraws the appeal;

b. Ten calendar days pass after the MCO mails the Notice of Adverse Benefit Determination, providing the resolution of the appeal against the member, unless the member, within the 10-calendar day timeframe has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached; or

c. A State Fair Hearing Officer issues a hearing decision adverse to the member.

3. If the final resolution of the appeal is adverse to the member, the MCO may recover the cost of the services furnished to the member while the appeal was 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).

4. 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 member's health condition requires, but no later than 72 hours from the date the MCO receives notice reversing the determination. If the MCO or the State Fair Hearing Officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO must pay for those services.

G. Timeframes for Disposition of Grievances and Appeals

The MCO is requested to dispose of each grievance and resolve each appeal and provide notice as expeditiously as the member's health condition requires within the State's established timeframes specified as follows:

1. Standard disposition of grievances: The MCO is allowed no more than 45 calendar days from the date of receipt of the grievance.

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

3. Expedited resolution of appeals: The MCO must provide notice as expeditiously as the member's health condition requires, but no later than 72 hours from the receipt of the expedited appeal request.

4. Expedited resolution of appeals: If the MCO denies a request for expedited resolution of an appeal, it must transfer to the standard timeframe of no more than 30 calendar days from the date of receipt of the appeal (with a possible 14 calendar day extension).

The MCO must inform the member of the limited time available to present evidence and allegations of fact or law, in person or in writing, in the case of the expedited appeal. These timeframes for resolution of standard and expedited appeals and grievances may be extended up to 14 calendar days if the member requests such an extension or if the MCO demonstrates, to the satisfaction of the State, that there is a need for additional information and that the extension is in the member's interests.

If the State grants the request for an extension, the MCO must give the member written notice of the reason for the delay within two calendar days and inform the member of the right to file a grievance if the member disagrees with the decision. Prompt verbal 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 or grievance as expeditiously as possible, but no later than the date the extension expires.

In the event the MCO fails to adhere to the notice and timing requirements for appeals, the member is deemed to have exhausted the MCO's appeal process and may initiate a State Fair Hearing.

H. Handling of Grievances and Appeals

The MCO must acknowledge the receipt of each grievance and appeal, including verbal inquiries seeking to appeal, and provide the following to members and authorized representatives:

1. reasonable assistance in completing forms and other procedural steps, including arrangements for non-emergency transportation services to attend the Appeal hearing if applicable.

2. reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing and inform the member of the limited time available for this in the case of expedited resolution.

3. the opportunity, before and during the appeals process, to examine the case file, including medical records, and any other documents and records considered during the appeals process free of charge and sufficiently in advance of the resolution timeframe for appeals.

The MCO must ensure that the staff who make decisions on grievances and appeals are not involved in any previous level of review or decision-making or subordinates of any individual who was involved in a previous level of review or decision-making. Decisions should be based off all comments, documents, records, and other information submitted regardless of who submitted them.

MCO staff who make decisions should be healthcare professionals who have the appropriate clinical expertise in treating the member's condition or disease if the grievance or appeal involves an appeal of a denial based on medical necessity or clinical issues or a denial of an expedited resolution.

I. Notice of Resolution of a Grievance or Appeal

The MCO must notify the member of the disposition of the grievance or appeal in writing and must include the results of the resolution process and the date it was completed. The MCO must allow the member to request a state external review after receiving notice that the adverse benefit decision was upheld by the MCO. Reasonable efforts must be made to provide verbal notice of the resolution.

For appeals that are not wholly resolved in favor of the member, the notice must also include:

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

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

3. That the member may be held liable for the cost of those benefits if the State Fair Hearing's Officer upholds the MCO's Adverse Benefit Determination.

3604.1 PROVIDER DISPUTE AND DISPOSITION

The MCO must establish a process to resolve any provider grievances and appeals that are separate from the process of submitting on behalf of members. The written procedures must be submitted to the State for review and approval at the time the MCO policies and procedures are submitted and anytime thereafter when policies and procedures have been revised or updated. No policy or procedure can be implemented without approval from the State.

The MCO must maintain an electric record for each provider grievance or appeal to include the provider's name and NPI, a description of the issue, the date filed, dates and nature of actions taken, and final resolution and submit a report to the State documenting the provider grievances and appeals.

The State will receive all provider requests for State Fair Hearings, arrange for the State Fair Hearings, and provide the State Fair Hearings officer. Upon receipt of a request, the State will forward a copy to the MCO. The State ensures access to State Fair Hearing for any provider dissatisfied with an adverse determination.

A. The following provisions reflect minimum requirements for providers:

1. The MCO's final decision to be issued, in writing, no later than 90 calendar days after a grievance is filed and 30 calendar days after an appeal is filed;

2. The MCO must accept written or verbal grievances and appeals that are submitted directly by the provider as well as those that are submitted from other sources.

3. The MCO appeal process must address payment disputes and instances when the MCO chooses to deny, reduce, suspend, or terminate a provider's privileges with the MCO.

B. When a provider has exhausted the MCO's internal appeals process, the provider has a right to submit a written request to the State Fair Hearings office. Disputes eligible for the State Fair hearings process include:

1. Denial or limited authorization of a requested service;

2. Reduction, suspension, or termination of a previously authorized service;

3. Denial, in whole or part, of payment for a service;

4. Demand for recoupment; and

5. Failure of the MCO to meet specified.