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Department of Health and Human Services
Division of Health Care Financing and Policy

Nevada Medicaid

Managed Care Expansion, Medicaid Reimbursement & Network Adequacy

Legislative Committee on Health Care
April 20, 2016



Division Mission

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

EXHIBIT W - Health Care. Document consists of 12 pages.
Entire exhibit provided. Meeting Date: 04-20-16



Managed Care Expansion Project

Fee-for-Service

VS.

Managed Care

DHHS – Division of Health Care Financing and Policy

3



Background

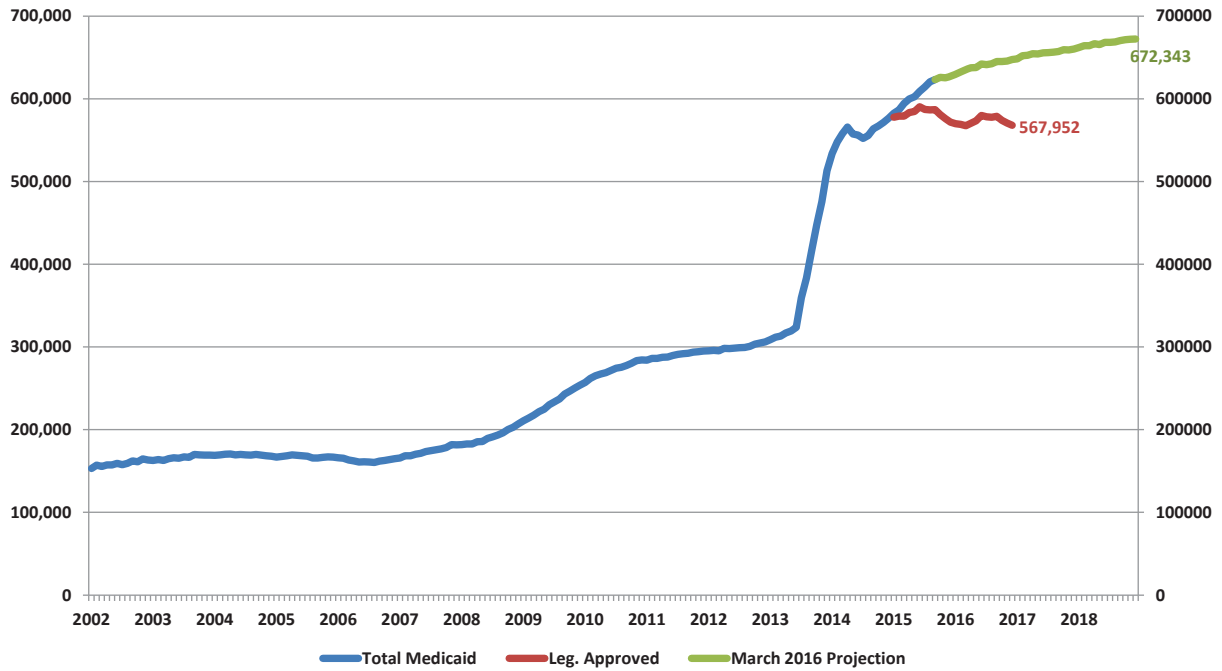
- Centers for Medicare and Medicaid Services(CMS) established the Triple Aim
 - Better care for individuals
 - Improved population health
 - Reduced costs by improving health outcomes
- Ensuring Medicaid program sustainability
- Passage of SB514

DHHS – Division of Health Care Financing and Policy

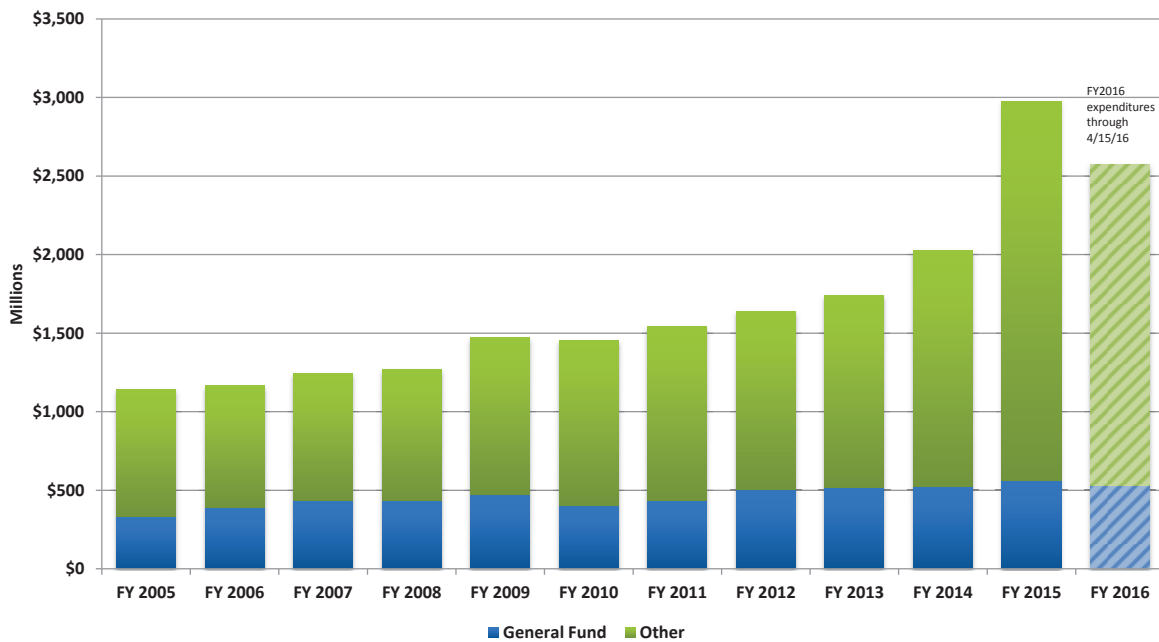
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Medicaid Caseload



Fiscal Year Expenditures





Purpose Statement

The Department of Health and Human Services is evaluating alternative service delivery models aimed at:

- Achieving better care for patients,
- Better health for our communities; and
- Lower costs through improved health outcomes.



Medicaid in Nevada

Fee-for-Service (FFS)

- Individuals can receive services from any provider enrolled with Nevada Medicaid
- No referrals from a primary care physician are required to see a specialist
- Individuals must coordinate and manage their own care

Managed Care (MC)

- A health care organization that:
 - Maintains a network of health care providers
 - Connect individuals with primary care & specialty providers
 - Helps people navigate the health care system
 - Provide care coordination
 - Provide patient education
 - Ensure the right service is provided at the right time



What Does Medicaid Managed Care Look Like in Nevada Today?

- All Medicaid recipients who live in urban Washoe County (Reno) or Clark County (greater Las Vegas area) who are not determined disabled by the Social Security Administration are mandated for managed care.
- Medicaid currently contracts with two Managed Care Organizations:
 - Health Plan of Nevada
 - Amerigroup



Services Currently in Managed Care

- Managed Care covers most of the services that are in the Medicaid-approved State Plan (not all-inclusive):
 - Physician/Hospital Services
 - Pharmacy
 - Behavioral Health Services
 - Personal Care Services
 - Home Health
 - Therapy Services
- Managed Care Organizations have the flexibility to offer additional services based on need and the plan selected



Services Not Currently Provided by Managed Care?

- Hospice
- Adult Day Health Care (ADHC)
- Non-Emergency Transportation (NET)
- Targeted Case Management (TCM)
- Home and Community-Based Waiver Services
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
- Residential Treatment Center (RTC) stays more than 30 days
- Nursing Facility Stays more than 45 days
- Orthodontia



What is the Future of Managed Care?

These options are currently under consideration:

- Increasing the number of Managed Care plans to offer greater choice and flexibility of services
- Expanding Managed Care to additional regions and/or statewide
- Including additional services that are not currently covered by managed care (*reducing or eliminating the current carve outs*)
- Expanding the population served by managed care to include aged, blind, or disabled individuals



What Has Been Done

- The DHHS, DHCFP and ADSD have held joint “listening sessions” across the state beginning in January 2016 through March 2016.
- The DHCFP has created a page on their website dedicated to this project. The link is: <http://dhcfp.nv.gov/Pgms/LTSS/MCE/MCEHome/>
- Focus Group sessions began in January 2016 and will continue throughout the evaluation process.
- The DHCFP issued an RFP for a consultant to assist in the research of the expansion options.



Next Steps

Current MCO Contracts

- RFP is due to be released in June 2016
 - Contract period begin date is July 1, 2017

MCO Expansion Project

- Hire the contractor to assist in evaluating the various options
- Continue receiving stakeholder input
- Issue a report with recommendations by the end of 2016 or early 2017



Medicaid Rates & Reimbursement



Medicaid Rates/Reimbursement

- Rates are calculated using different methodologies based on the CMS approved language in the Medicaid State Plan
- Most FFS rates are based on a percentage (plus or minus) of Medicare rates
- Medicare pays based on Diagnosis Related Groups (DRG) codes for Inpatient Hospital Services, however, Nevada is one of the few states that uses Revenue codes.
- Rates are reviewed on a rolling five year cycle, but frequently more often.



Medicaid Rates/Reimbursement

- Medicaid can only increase rates to the extent that funding is available
- Most rates are fixed at the year in which the rate went into effect, or at a point in time specified in the State Plan
- Significant rate changes are developed during budget planning and if funding is approved by legislature then State Plan Amendments (SPA) are required
- Some interim rate adjustments can be made if funding is available within the existing budget.



Medicaid Rates/Reimbursement

Proposed rate changes in process are:

- Special Care Rates for Behaviorally Complex Skilled Nursing Facility (SNF) recipients
- Multiple encounters for Federally Qualified Health Centers (FQHC) providers
- Pediatric enhancement for surgical codes (30000-39999)
- Emergency Medical Response for Fire Districts
- Neonatal Intensive Care Unit (NICU) tiered rates
- Community Paramedicine reimbursements
- New Residential Treatment Centers (RTC)



Provider Network & Network Adequacy



Network Adequacy

When the number of Nevadans with health care coverage increases and the statewide provider pool remains relatively the same, access to care becomes a statewide issue.

- The good news:
 - More people are getting needed care.
 - Reduced uninsured rate from 23% to 11%.
- The not so good news is we have a limited provider pool in certain geographic areas and specialties



Provider Network

20, 466 Providers Statewide

- 68 types of providers with many different specialties
 - Example: PT20 Physician has 75 different specialties from Anesthesiology, dermatology, family practice, general practice, internal medicine, pediatrics, pulmonary disease, rheumatology, urgent care, etc.
- Must enroll with Medicaid but the MCOs have separate enrollment criteria

Provider Type	Count	Provider Type	Count
010 Outpatient Surgery, Hosp Based	37	043 Laboratory,Pathology/Clinical	55
011 Hospital, Inpatient	126	044 Swing-Bed,Acute Hospital	5
012 Hospital, Outpatient	215	045 ESRD Facility	46
013 Psychiatric, Inpatient	19	046 Ambulatory Surgical Centers	61
014 Mental Health, Outpatient	5,973	047 IHS And Tribal Clinics	18
016 ICF-MR / Public	2	048 Senior Waiver(Frail Elderly)	88
017 Special Clinics	139	051 IHS Hospital/Inpat/Tribal	2
019 Nursing Facility	78	054 Targeted Case Management	42
020 Physician, M.D.,Osteopath	10,997	055 Trans Rehab Center,Outpatient	4
021 Podiatrist	92	056 Mental Hosp(Rehab/Sp), Inpat	16
022 Dentist	1,012	057 Adult Group Care Waiver	154
023 Hearing Aid Dispenser/Rel Ltd	6	058 Physically Disabled Waiver	156
024 Certified R.N. Practitioner	1,188	059 Facility Based Assisted Living	3
025 Optometrist	402	060 School Based	6
026 Psychologist	255	062 Health Maint Org (HMO)	5
027 Radiology/Noninvasive Diag Ctr	35	063 Residential Treatment Ctr	53
028 Pharmacy	611	064 Hospice	38
029 Home Health Agency	66	065 Hospice,Long Term Care	28
030 Personal Care Aid-Prov Agency	119	068 ICF-MR / Private	10
032 Ambulance,Air/Ground	78	072 Nurse Anesthetist	169
033 DME, Disposable, Prosthetics	479	074 Nurse Midwife	54
034 Therapy	1,100	075 Critical Access Hosp/Inpatient	12
035 Travel	2	076 Audiologist	82
036 Chiropractor	57	077 Physicians Assistant	863
037 Intravenous Therapy	6	081 Hospital Based ESRD provider	68
038 Home/Comm Based Waiver-Mr	108	082 Mental Hlth Rehab Svc/Non-Res	1,063
039 Adult Day Health Center	18	083 Pers Care Aid-Inter Serv Orgn	14
040 PCCM Services	2	085 Applied Behavior Analysis Prov	102
041 Optician,Optical Business	15	099 Treatment Home Room & Board	2
042 Outpatient Psych Hosp.,Private	3		
Grand Total = 26,459 Duplicated; 20,466 Unduplicated			



Actions taken to address Access to Care

Maximize Existing Network

- **Make Administrative Processes less Burdensome**
 - Prior Authorization alignment of policies between FFS and MCOs
 - Implement online provider portal for enrollment and change reporting (December 2016)
 - Implement online provider search capability for DME, vision, audiology and dental procedures that have limitations (January 2016)
- **Increase the Types of Services Certain Providers can Perform**
 - Implementation of Telehealth policy change (December 2016)
 - Increase to psychological interns (January 2016)
- **Increase Rates when Funding is Available**
 - Increased rates for physician, certified RN Practitioner and Physician Assistants (July 2015)
 - Increased Inpatient Psychiatric Rate (July 2014)
 - Increase the number of encounters for an Federally Qualified Health Center (FQHC) (Pending CMS approval)
- **Implement New Programs or Processes**
 - Adding Community Paramedicine as a reimbursable service (July 2016)
 - Health Care Guidance Program for high need FFS recipients
 - New NET transportation vendor will call and text recipients for reminders of appointments



Thank you!

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