

# Nevada Medicaid News

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Nevada Medicaid and Nevada Check Up  
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## New Medicaid Fiscal Agent For DHCFP

The Nevada Division of Health Care Financing and Policy (DHCFP) has selected a new fiscal agent, Hewlett Packard Enterprise Services (HPES).

This is the first communication to help providers understand the upcoming changes.

### What is new?

DHCFP has partnered with HPES in a five-year Government Healthcare Business Process Outsourcing contract to take over Medicaid fiscal agent processing from Magellan Medicaid Administration, Inc. HPES will enhance and manage the state's Medicaid Management Information System.

As part of the agreement, HPES will provide Medicaid, pharmacy claims and drug rebate processing, provider enrollment, prior authorization, utilization management, application maintenance and hosting, as well as other services. HPES will also imple-

ment a health information exchange and data warehouse solution.

### History

HPES, which was a founder of the healthcare IT services industry 45 years ago, will assist Nevada Medicaid in meeting demands of the new federal healthcare reform legislation, which includes 5010 and ICD-10.

### What can you expect?

Since the system is essentially a takeover of the existing system, claims processing and payments, appeals processes, and other Medicaid claims-related functions will remain the same.

HPES will be replacing the existing Magellan Medicaid Administration Nevada Medicaid website with the new HPES Provider Portal. Providers will use this new website to access forms, billing guidelines, training schedules, web announcements, newsletters, contact information, and

all other Medicaid-related documentation.

### Training

Training will be jointly provided throughout the transition between HPES and Magellan Medicaid Administration. This combined training will contribute to a seamless transition. Magellan Medicaid Administration will conduct the already-scheduled training, while HPES conducts a session on new features, address and phone number updates, and other key information providers will want to know about the implementation.

Providers can look forward to training on the new Provider Portal enrollment process prior to HPES taking over claims processing.

More information on training dates will be coming in upcoming newsletters.

Watch for future announcements containing information about additional training.

## HITECH And The Benefit To Providers

The Health Information Technology for Economic and Clinical Health (HITECH) Act seeks to improve American health care delivery and patient care through an unprecedented investment in health information technology (HIT). Since the HITECH Act was signed into law in February 2009, it has established a number of initiatives specifically designed to work together to provide the necessary assistance and technical support to providers, enable coordination and alignment within and among states, establish connectivity to the public health community in case of emergencies, and assure the workforce is properly trained and equipped to be meaningful users of electronic health records (EHR). Combined, these programs build the foundation for every American to benefit from an electronic health record, as part of a modernized, interconnected and vastly improved system of care delivery.

### Medicare and Medicaid EHR Incentive Programs:

The Medicare and Medicaid EHR Incentive Programs will provide incentive payments to eligible professionals and eligible hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. The Centers for Medicare and Medicaid Services (CMS) is the federal agency establishing these incentive programs. The CMS website at <http://www.cms.gov/EHRIncentivePrograms/> is the official federal source for facts about the incentive programs. Providers should visit the site often to learn what is considered meaningful use and for information about who is eligible for the programs, how to register, EHR training and events, and more.

Some states launched their Medicaid EHR Incentive Programs beginning Jan. 3, 2011, but most states will launch their programs later in 2011. The Division of Health Care Financing and Policy (DHCFP) is working with CMS during planning efforts for the development of the Nevada Medicaid EHR Incentive Program. To join the email distribution list or to get more information about Nevada's Health Information Technology (HIT) planning efforts, please send an email to [NevadaHIT@dhcfp.nv.gov](mailto:NevadaHIT@dhcfp.nv.gov) or visit <https://dhcfp.nv.gov/EHRIncentives.htm>.

### Provider assistance through the REC:

The Office of the National Coordinator HIT Extension Program established Regional Extension Centers (REC) to offer technical assistance, guidance and information on best practices to support and accelerate health care providers' efforts to become meaningful users of EHRs. HealthInsight, the designated REC for Nevada and Utah, is pleased to support providers engaging in the Medicare and Medicaid EHR Incentive Programs. HealthInsight can provide direct, substi-

tized assistance to providers' offices to help them meet the requirements.

Contact the REC team at (800) 483-0932 or [REC@HealthInsight.org](mailto:REC@HealthInsight.org), or for more information visit the Health Insight REC website at <http://www.healthinsight.org/Internal/REC.html>.

### HIT Workforce Training through CSN:

One component of the HIT Workforce Training Program is the Community College Consortia to Educate HIT Professionals, which seeks to rapidly create HIT education and training programs at community colleges or expand existing programs. The HIT workforce program is designed to get people trained quickly in the kind of computerized health information systems that are being installed by hospitals and medical offices. The electronic systems will replace inefficient paper records and allow health providers to quickly review and update a patient's medical history.

Community colleges funded under this initiative will establish intensive, non-degree training programs that can be completed in six months or less. The College of Southern Nevada (CSN) is a member college of a 14-college consortium across Arizona, California, Hawaii and Nevada selected to deliver HIT workforce training. CSN is the only college in Nevada participating in this program and space could become limited. Interested students should contact Cassie Gentry at [cassie.gentry@csn.edu](mailto:cassie.gentry@csn.edu) or for more information visit the CSN HIT Workforce Training website at <http://sites.csn.edu/health/overview-hit.html>.

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## Frequently Asked Questions (FAQs) Contain Useful Tips For Behavioral Health Providers Enrolling/Re-Enrolling In Nevada Medicaid

**B**ehavioral Health provider types 14 (Behavioral Health Outpatient Treatment) and 82 (Behavioral Health Rehabilitative Treatment) must re-enroll in Nevada Medicaid by Oct. 31, 2011. Providers who do not re-enroll will have their provider contract terminated effective Oct. 31, 2011. The result of the termination is that no payment will be made to the provider for dates of service after the effective date of the termination.

The online [Behavioral Health Enrollment and Re-Enrollment Frequently Asked Questions \(FAQs\)](#) document contains many valuable tips that will aid providers in their enrollment/re-enrollment. For example, one question provides tips to QMHA (specialty 301) and QBA (specialty 302) providers regarding obtaining and submitting Federal Bureau of Investigation (FBI) criminal background checks.

QMHAs and QBAs must submit the federal results of the background check, not the state results. Please review the full text of this FAQ taking special note of the text indicated here in red.

**Q:** The Enrollment Checklists for QMHA (specialty 301) and QBA (specialty 302) list a requirement for Federal Bureau of Investigation (FBI) criminal background checks. How do I obtain one and what do I do with it?

**A:** Following are tips regarding obtaining and submitting background checks:

- FBI criminal background checks may be obtained through the Nevada Department of Public Safety

(DPS) Records and Technology Division, 333 West Nye Lane, Suite 100, Carson City, NV 89706, (775) 684-6262, <http://dps.nv.gov>.

- Agencies may set up an account with the DPS. The agency is required to have the results of the background check. The QMHA/QBA should obtain a copy of the results letter from their agency to include with their enrollment documents. Please do not request the DPS to send the results letter directly to Magellan Medicaid Administration.
- Therapeutic care foster parent acceptance/clearance letters may be submitted in lieu of the background check.
- The active background check must be dated within the last 6 months for new enrollments (applies to a new provider joining an established or new agency) or dated within the last 5 years for re-enrollments (applies to QMHAs and QBAs who have been working for an enrolled agency and their services have been billed through the agency's enrollment until now).

Please review the full FAQs regularly as the document is updated periodically with new and clarified information.

**Note:** Submission of a re-enrollment application does not guarantee the provider's current enrollment will continue. If it is found that providers/groups do not meet the criteria for their provider type and/or specialty, their re-enrollment will be denied and their current enrollment will be terminated.

### A Message From DHCFP Regarding Prevention: *Men's Health*

**M**edicaid would like to invite providers to join in the effort to strive to heighten the awareness of prevention and encourage early detection and treatment of disease in the male population. Medicaid provides coverage for a full range of preventive lab/diagnostic

screening services such as **prostate-specific antigen (PSA)** screening and lipid panels, and electrocardiographs (EKGs), etc., associated with preventing diseases from developing or prevent serious complications of disease that significantly impact the health of men.

## Second Notification Of Impending Payment Error Rate Measurement (PERM) Review By Federal Contractors

The Centers for Medicare & Medicaid Services (CMS) measures the accuracy of Medicaid and state Children's Health Insurance Program (CHIP) payments made by each state for services rendered to recipients through the Payment Error Rate Measurement (PERM) program. CMS has contracted with A+ Government Solutions, Inc. to conduct the medical record and data processing reviews. The PERM review for Nevada will be conducted on a sample of claims paid during the period Oct. 1, 2010, through Sept. 30, 2011.

Medical or service documentation records are needed to support the medical record reviews and determine if the service provided was medically necessary and correctly paid in accordance with established policy. In order to obtain the appropriate medical record documentation,

A+ Government Solutions, Inc. will contact you, the provider, to verify your name and address and to determine how you want to receive the medical record request(s) (via facsimile or US mail). The medical record request letters will come on CMS letterhead. Once you have received the request for medical records, you must submit the documentation requested within 75 days. It is very important that you cooperate by sending in all requested documentation. If you fail to submit **appropriate and sufficient** documentation to support the claim billed to and paid by the DHCFP within the 75-day time frame, the payment will be considered an error and will be recovered. Past studies indicate the largest cause of errors occur in the medical record review area and are due to the provider sending either no documentation or insufficient documentation. Medical records request letters may

be sent out as early as September 2011.

Understandably, providers are concerned with maintaining the privacy of patient information; however, providers are required by Section 1902 (a)(27) of the Social Security Act to retain records necessary to disclose the extent of services provided to individuals receiving assistance and furnish CMS with information regarding any payments claimed by the provider for rendering services. The furnishing of information includes medical records. In addition, the collection and review of protected health information contained in individual-level medical or service documentation records for payment review purposes is permissible by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (45 CFR Part 160 and 164).

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## *Recovery Audit Contractor (RAC)*

Recently enacted health care reform legislation, formally known as the Patient Protection and Affordable Care Act (PPACA), calls for expansion of the Recovery Audit Contractor (RAC) Program to the Medicaid program.

Section 6411(a) of the PPACA requires states to contract with at least one RAC.

The contractors will be tasked with identification of underpayments and overpayments and the recovery of overpayments.

Medicaid RACs will be paid on a contingency fee basis. Individual states are permitted to determine the amount of the contingency fee paid to RACs with which it contracts. The PPACA also requires the states to have an adequate process for entities to appeal adverse determinations made by the Medicaid RACs. The RAC can review claims retroactively up to three years.

The Medicaid RAC program will not replace the state's other Program Integrity initiatives. In accordance with the statute, states must coordinate the RAC's efforts with those of existing

state entities and law enforcement authorities, as well as with federal authorities, in an effort to reduce the burden on Medicaid providers and to ensure that cases of fraud and abuse are processed through the appropriate channels.

States must comply with provisions in the final rule that will be issued by Centers for Medicare & Medicaid Services (CMS). At that time further information will be made available. Additionally, when an RAC is contracted with Nevada Medicaid, providers will be notified via a web announcement.



*News From Centers for Medicare & Medicaid Services (CMS):*

# The Pre-Existing Condition Insurance Plan - New Coverage Option For The Uninsured

If you have patients who've had a hard time finding health insurance because of a pre-existing condition or if they've been turned down for coverage, they're not out of options. They may now be eligible for a new program created by the Affordable Care Act – the Pre-Existing Condition Insurance Plan.

This transitional program is available for children and adults in Nevada who've been locked out of the health insurance market because of one or more pre-existing condition(s). In 2014, Americans – regardless of their health status – will have access to affordable health insurance when the nation transitions to a new marketplace.

Under the Pre-Existing Condition Insurance Plan, patients receive coverage for a wide range of medical benefits, including physician's services, hospital care and prescription drugs. All covered benefits are available – even to treat a pre-existing condition. Patients won't be charged a higher premium because of their medical condition and their eligibility isn't based on income.

Like standard health insurance plans, patients are required to pay a monthly premium, a deductible and some cost-sharing expenses. On July 1, 2011, premiums will drop by 37.5 percent in Nevada. "Standard" and "extended" policies are available. There's also a Health Savings Account option, under which patients can use pretax earnings to pay premiums.

Here are some examples of the new rates: A 53-year-old Nevadan will

pay \$260 per month for the standard option and \$350 per month for the extended coverage. A 40-year-old state resident will pay \$203 per month for standard coverage. A child up to 18 years old will pay \$113 per month for a standard policy.

The Pre-Existing Condition Insurance Plan is already getting results that are changing the lives of people across America who don't have health coverage and need medical care. James H., who lives in Texas, was diagnosed with brain cancer in 2010. Shortly after his diagnosis, James' insurance company rescinded his coverage, claiming that his cancer was a pre-existing condition. James knew his lack of coverage was a death sentence. Fortunately, James was able to join the Pre-Existing Condition Insurance Plan in Texas and is now receiving the medical treatment he needs.

Cathy A., who lives in Ohio and is a small business owner, has systemic lupus which has required very little treatment over the years, but she has consistently been denied health insurance because of her medical condition. Cathy noted that "without me working and paying the bills, my firm would close." After enrolling in the Pre-Existing Condition Insurance Plan, Cathy now has the peace of mind she deserves and she doesn't have to worry about the financial instability that goes with being uninsured.

To qualify for the Pre-Existing Condition Insurance Plan, a person must: be a citizen of the United States or be residing here legally, have been uninsured for at least 6 months before

applying, and have a pre-existing condition or have been denied insurance coverage because of their health condition. Please note that if you currently have insurance coverage that doesn't cover your medical condition or are enrolled in a state high risk pool, you are not eligible for the Pre-Existing Condition Insurance Plan.

*Like standard health insurance plans, patients are required to pay a monthly premium, a deductible and some cost-sharing expenses.*

Beginning July 2011, individuals applying for coverage can simply provide a letter from a doctor, physician assistant or nurse practitioner dated within the past 12 months stating that they have or, at any time in the past, had a medical condition, disability or illness. Applicants will no longer have to wait on an insurance company to send them a denial letter.

To find out more about the Pre-Existing Condition Insurance Plan, including eligibility, plan benefits and rates, and how to apply, visit [www.pcip.gov](http://www.pcip.gov). Click on "Find Your State" and select Nevada from a map of the United States or from a drop-down menu for details.

You can also dial the Call Center toll-free at **1-866-717-5826 (TTY 1-866-561-1604)**. The Call Center is open 5 a.m. to 8 p.m. Pacific Time.

# Reminder On TPL Or Eligibility Discrepancies – Who To Contact!

The Provider Support Unit at the Division of Health Care Financing and Policy (DHCFP) has created a new email account for Medicare-related Third Party Liability (TPL) issues.

Any issues or concerns you have regarding *Medicare Prime TPL*, email them to [TPL@dchfp.nv.gov](mailto:TPL@dchfp.nv.gov). Below are some additional contacts that may be helpful.

If you are having a problem with *Private/Commercial TPL*, including *Medicare Replacement/HMO plans*, contact HMS at [renotpl@hms.com](mailto:renotpl@hms.com) or call (775) 335-1040 in the Reno area or toll-free (800) 873-5875.

If you are having a problem with *eligibility that is not reflecting in EVS* but you have verified the recipient is eligible, contact Magellan Medicaid Administration at (877) 638-3472 and the staff will be able to direct the information accordingly for corrections.

## New Provider Sanction Policy

The Division of Health Care Financing and Policy (DHCFP) enacted new policy that imposes sanctions on providers who are terminated from Nevada Medicaid. When a provider is serving a sanction, they are not eligible to re-enroll in Nevada Medicaid until their sanction period is over.

Sanction time frames are tiered based on the termination cause. There are three tiers: Tier 1 is permanent sanction; Tier 2 is 7-year sanction; Tier 3 is 12-month sanction. In some instances, terminated providers are eligible for immediate re-application. More information may be found in the [Medicaid Services Manual \(MSM\)](#), Chapter 100, Section 106.

## Financial Institutions Located Outside The U.S. And Territories

With the enactment of the Patient Protection and Affordable Care Act (PPACA), providers who use financial institutions located outside the United States or its

territories will not be enrolled in Nevada Medicaid. In addition, providers will not receive reimbursement from Nevada Medicaid if services are provided outside the United States or its territories.

### Quarterly Update On Claims Paid

Nevada Medicaid and Nevada Check Up paid out to providers \$377,129,928 in claims during the three-month period of January, February and March 2011.

Nearly 100 percent of current claims continue to be adjudicated within 30 days.

The DHCFP and Magellan Medicaid Administration thank you for participating in Nevada Medicaid and Nevada Check Up.

### Contact Information

If you have a question concerning the manner in which a claim was adjudicated, please contact Magellan Medicaid Administration by calling (877) 638-3472.

If you have a question about Medicaid Service Policy or Rates, you can go to the Division of Health Care Financing and Policy (DHCFP) website at <http://dchfp.nv.gov>. Under the “DHCFP Index” box, move your cursor over “Contact Us” and select “[Main Phone Numbers](#).” Call the Administration Office of the area you want to contact.