**2017 MCNA Provider Agreement Review**

**Article I**

**“*Provider Manual*”** – made specifically part of the Agreement and contains defined terms, such as a “Clean Claim.” Also, the Provider Manual “may be changed from time to time by MCNA” (p.2). Amendments require thirty days prior notice. (p.12) Because the Provider Manual is part of the Agreement (Art. II (2)), Providers should also receive thirty days prior notice.

**Article III**

**Revise paragraph (1) – Covered Services as noted**

1. **Covered Services**. Provider shall provide to Covered Persons those Covered Services

described in the applicable Attachment(s) in accordance with the Provider Manual and according to the generally accepted standards of dental practice in the Provider’s community, the scope of Provider’s license and the terms and conditions of this. ~~Unless otherwise specified in an Attachment hereto,~~ Provider shall make necessary and appropriate arrangements to assure the availability of Covered Services to Covered Persons during Provider’s normal business hours~~. (i) on a twenty-four (24) hour per day, seven (7) day per week basis, (ii) urgent care services, including urgent specialty care, shall be provided within twenty four (24) hours of a Covered Person’s request, and (iii) therapeutic and diagnostic care shall be provided within fourteen (14) days of a Covered Person’s request. Provider will make arrangements to ensure coverage of Covered Persons after-hours or when Provider is otherwise absent.~~ Provider agrees that such arrangements will be with a Provider that is a Participating Dental Care Provider.

**Revise paragraph (4) – Determination of Covered Persons Eligibility as follows:**

4. **Determination of Covered Person Eligibility**. Provider shall verify, in accordance with the

Provider Manual, whether an individual seeking Covered Services is a Covered Person. MCNA shall provide real time information regarding whether an individual seeking services is a Covered Person. If ~~MCNA~~ a Provider determines that such individual ~~was~~ is not eligible for Covered Services at the time the services ~~were~~ are rendered, such services shall not be eligible for payment under this Agreement, and Provider may bill the individual or other responsible entity for such services.

(“at the time services **were** rendered” – makes it sound like the determination by MCNA happens after services, not before. Provider can bill patient if they are not a Covered Person, but if the determination happens after service, the chances of getting paid by the patient are reduced.)

**Revise paragraph (6) – Acceptance of New Patients as follows:**

6. **Acceptance of New Patients**. ~~To the extent that Provider is accepting new patients, Provider must also accept new patients who are Covered Persons.~~ Provider shall provide MCNA ~~forty-five (45) days prior~~ written notice of Provider’s decision to ~~no longer~~ accept new Covered Persons. In no event shall any established patient of Provider who becomes a Covered Person be considered a new patient.

7. **Referrals**. If Provider is a specialist, Provider shall deliver Covered Services to Covered

Persons upon referral from a MCNA primary dental care provider (“***PDP***”) or MCNA. Provider

shall arrange for any appropriate referrals of Covered Persons as needed in accordance with the requirements of the Provider Manual.

*Concern:  Is it reasonable to expect the Provider to confirm participation status of referrals?  With third party insurance it is always the responsibility of the insured to check participation status of a provider. Haven’t seen what the Provider Manual says.*

**Delete paragraph 8 in its entirety:**

~~8.~~ **~~Coordination of Care; Reporting to Primary Care Providers~~**~~. Provider shall, within a~~

~~reasonable time following consultation with, or testing of, a Covered Person (not to exceed one (1)~~

~~week), make a complete written report to the Covered Person’s PDP. However, with respect to~~

~~findings which indicate a need for immediate or urgent follow-up treatment or testing, or which~~

~~indicate a need for further or follow-up care outside the scope of the referral authorization or the~~

~~scope of Provider’s area of expertise, Provider shall make an immediate oral report to the Covered~~

~~Person’s PDP (if applicable), not to exceed twenty-four (24) hours from the time of Provider’s~~

~~consultation or receipt of the report of the testing, as applicable.~~

*Concern:  Covered Person's referred to our office for consultation are routinely scheduled for treatment after the consultation has been completed.  Our providers make a written report after treatment is complete.  There is no need to make a written report after the consultation.  Immediate oral reports are unrealistic in a busy practice.  Oral reports should be left to the provider's discretion regarding the immediacy of treatment/diagnosis.*

**(10) – Covered Person Communication**

10. **Covered Person Communication**. Provider shall obtain MCNA’s approval for Covered

Person communication as required by the Payor or State Contract and applicable State and federal law.

*If communications with the Patient about dental care do not require consent, then what communications are they concerned about?*

**Revise paragraph (12) – Disparagement Prohibition as follows:**

12. **Contractual Relationships.** **~~Disparagement Prohibition~~**. ~~Provider agrees not to disparage Payor or MCNA in any manner during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement.~~ Provider shall not interfere with MCNA’s contractual relationships including, but not limited to, those with other Participating Dental Care Providers. Nothing in this provision, however, shall be construed as limiting Provider’s ability to inform patients that this Agreement has been terminated or otherwise expired, or to promote Provider to the general public or to post information regarding other health plans consistent with Provider’s usual procedures, provided that no such promotion or advertisement is directed at any specific Covered Person or group of Covered Persons.

13. **Nondiscrimination**. Provider will provide services to Covered Persons without discrimination

on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence,

health status, type of payor, source of payment, physical or mental disability or veteran status, and

will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities

Act of 1991 (the “***ADA***”). Provider recognizes that as a governmental contractor, MCNA is subject

to various federal laws, executive orders and regulations regarding equal opportunity and

affirmative action, which also may be applicable to subcontractors.

*Concern:  Some providers have made a business decision to see only pediatric Covered Persons under the age of 19.  Is this considered discrimination?*

**Article IV**

**(3) – Federal False Claims**

Does this need to be included if no Providers receive payments over $5M?

**Article V**

**Revise paragraph (2) – Compensation as follows:**

2. **Compensation**. Provider shall be paid for services rendered to Members on a fee for service

basis in accordance with the fee schedule applicable to the MCNA plan(s) in which Provider is

participating provider as indicated in an Attachment to this Agreement (e.g. Medicaid, Medicare and

CHIP plans). MCNA shall pay claims in accordance with Neb.Rev.Stat. § 44-8004**.** If a Provider provides any Covered Service not specified in the State Contract or any non-covered Service, Provider shall not be entitled to any compensation for such services from MCNA. Provider

shall accept final payment made by MCNA, with the exception of applicable copayments, and/or

deductibles (Co-payments) as payment in full for all services provided by Provider except as

otherwise provided by this Agreement, and Provider shall not solicit or accept any surety or

guarantee of payment from state authorities or Covered Person(s).

(44-8004 Nebraska’s Clean Claim statute – pay within 30 days of a clean claim.)

*Concern:  Under the current Nebraska Medicaid dental system, patients are responsible for non-covered services if prior to treatment the patient is notified the service is non-covered and have the opportunity to decide to move forward with a non-covered service.  If the patient agrees and signs written documentation describing the non-covered service and the cost of such non covered service the Provider can collect from the recipient.  Does this Article change this? (I added “from MCNA” to clarify this)*

*Question: What would be a “Covered Service not specified in the State Contract?”*

**Revise paragraph (5) – Recoupment Rights as follows**

5. **Recoupment Rights**. Payor or MCNA shall have the right to ~~immediately~~ recoup any and all

amounts owed by Provider to Payor, MCNA or any Affiliate against amounts owed by Payor,

MCNA or Affiliate to Provider. ~~Provider agrees that all recoupment and any offset rights under this Agreement shall constitute rights of recoupment authorized under State or federal law and that such rights shall not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider.~~ Payor or MCNA shall review claims within two years from the date of the payment and send a determination letter concluding an overpayment within sixty days after receipt of all requested material from a provider. In any records request to a provider, furnish information sufficient for the provider to identify the patient, procedure, or location. Payor or MCNA shall develop and implement a procedure in which an overpayment may be resubmitted as a claims adjustment. MCNA shall provide a written notification and explanation of an adverse determination that includes the reason for the overpayment, the medical criteria on which the adverse determination was based, an explanation of the provider's appeal rights, and, if applicable, the appropriate procedure to submit a claims adjustment.

(Based upon Neb.Rev.Stat. § 68-974) \* CFR § 433.316 When discovery of [overpayment](https://www.law.cornell.edu/definitions/index.php?width=840&height=800&iframe=true&def_id=41cc936398446b7f582e6b0c32183de2&term_occur=1&term_src=Title:42:Chapter:IV:Subchapter:C:Part:433:Subpart:F:433.316) occurs and its significance.

*Effective March 23, 2010, section 6506 of the Patient Protection and Affordable Care Act, P.L. No. 111-148, provides an extension period for the collection of overpayments. Except in the case of overpayments due to fraud, States have up to 1 year from the date of discovery of a Medicaid overpayment to recover, or to attempt to recover, such overpayment before making an adjustment to refund the Federal share of the overpayment. For overpayments identified before the effective date, the previous rules on discovery of overpayment will be in effect.*

From Kentucky - **907 KAR 1:671**

**Section 2. Methods for Recoupment of Overpayments**. (1) If a determination is made by the department that a provider was overpaid, a demand letter shall be sent to the provider, at his last known mailing address. If a provider billed through an agent or entity, a copy of a demand letter may be mailed to a provider’s designated payment last known mailing address. The demand letter shall contain:

      (a) The amount of the overpayment;

      (b) The period of time involved;

      (c) The basis for determining the overpayment exists;

      (d) Language granting a provider sixty (60) days advance notice that the repayment is due in full; and

      (e) Appeal rights, if any.

      (2) Departmental adjustments of the reimbursements rates, and differences between estimated and actual costs a provider incurred in determining reimbursements, may create situations where a provider was overpaid. The letter of notification of adjustments and the monies due under this subsection shall include:

      (a) All required elements of subsection (1) of this section;

      (b) Documentation to support the department’s determination of adjustments; and

      (c) Appeal rights, if any.

      (3) The provider shall within:

      (a) Sixty (60) calendar days from the date of the demand letter, pay the amount of overpayment in full; or

      (b) Sixty (60) calendar days from the date of the demand letter, or during the administrative appeal process, submit a written request for a payment plan.

      (4) If the amount of overpayment resulted from rate revisions and subsequent recalculations within the Medicaid Management Information System, the department shall apply a rate adjustment against the next payment cycle for the provider prior to notifying the provider in writing of the amount of the overpayment.

      (5) A payment plan may be approved by the department, if a provider documents that payment in full would create an undue hardship. A written declaration of undue hardship shall include the following:

      (a) Copies of financial statements which indicate payment in full within sixty (60) calendar days would create an undue hardship; and

      (b) Copies of notarized letters from at least two (2) financial institutions indicating the provider's loan request was denied for the overpayment amount.

      (6) Except as provided for in subsection (7) of this section, payment plans shall not extend beyond a six (6) month period.

      (7) A payment plan approved, in writing, by the Commissioner of the Department for Medicaid Services, in accordance with subsection (5) of this section, may be approved in excess of six (6) months, if the monthly repayment exceeds twenty-five (25) percent of the provider's average monthly Medicaid payment based upon the payments made the previous twelve (12) months.

      (8) A payment plan approved in excess of six (6) months shall include provisions for payments of both principal and interest as provided in KRS Chapter 360.

      (9) If a provider fails to make a payment as specified in the payment plan or takes no action toward repayment, the department shall recoup the amount due from future payments. If a provider has insufficient funds available for recoupment through the payment system in the first payment cycle following the due date, or no longer participates in the Medicaid Program, payments shall continue to be recouped and the department may take all lawful actions to collect the debt.

      (10) Disputes.

      (a) If a provider disputes the amount of overpayment, a provider may initiate the administrative appeals process in accordance with Section 8 or 9 of this administrative regulation.

      (b) A timely-filed request of administrative appeal process shall stay the recoupment activities by the department pertaining to the issues on appeal until the administrative appeal process is final.

      (c) If the department, after reviewing all documentation submitted during the administrative appeal process, determines that no adjustments are required, the initial determination shall stand.

      (d) If the department determines that the amount of overpayment demand should be reduced, a refund due to the provider shall be refunded to him within thirty (30) calendar days from the date of the determination.

      (e) If it is determined that the amount requested should be increased, a provider shall be notified by a new demand letter pursuant to subsection (1) of this section.

      (11) Withholding Medicare payments to recover Medicaid overpayments.

      (a) The department may request that the Centers for Medicare and Medicaid Services (CMS) withhold future Medicare payments to a provider in order to recover Medicaid overpayments to that provider, pursuant to 42 U.S.C. 1395vv.

      (b) Amounts withheld and forwarded to the department by CMS which are ultimately determined by the department to be in excess of overpayments due to the Medicaid Program shall be returned to the provider.

      (12) Statutory recovery. The department shall not issue payments otherwise due to a provider, if the department has been notified by a state or federal government agency or by a court that a court order exists requiring the department to withhold payments. The payments shall be withheld in accordance with the provisions of the order.

      (13) Medicare overpayments. If ordered to recoup payment by CMS, the department shall recoup the federal share of Medicaid payments, which is the portion of the payment funded with federal funds, as a means to recover Medicare overpayments pursuant to 42 U.S.C. 1396m.

      (14) A contract for the sale or change of ownership of a provider participating in the Medicaid Program shall specify whether the buyer or seller is responsible for amounts owed to the department by the provider, regardless of whether the amounts have been identified at the time of the sale. In the absence of specification in the contract for the sale or change of ownership, the recipient of the payment, who otherwise would be the provider of record at the time the department made the erroneous payment, shall have the responsibility for liabilities arising from that payment, regardless of when identified.

**Article VI**

**(4) Consent to Release Dental Records**

Why is it the Provider’s responsibility to obtain the Covered Person’s consent for MCNA access to patient records?

**Revise paragraph (6) – Record Transfer as follows**

6. **Record Transfer**. Subject to applicable law, the State Contract and Payor Contract

requirements, Provider shall cooperate in the timely transfer of Covered Persons’ dental records to

any other health care provider or the State or Department. A Provider may charge a copy fee allowed by Neb.Rev.Stat. § 71-8403 ~~at~~  ~~charge and when required~~. Provider shall cooperate with MCNA to make available to the applicable State agency, or its designated representatives, any and all records, whether medical or financial, related to MCNA and the Provider’s activities undertaken pursuant to this Agreement.

**Revise paragraph (7) – On-Site Inspections as follows:**

7. **On-Site Inspections**. Provider agrees that dental office space or its facilities, as applicable,

shall be maintained in accordance with applicable federal and State regulatory requirements, and the

MCNA Provider Manual. Provider shall cooperate to schedule any onsite inspections with advance notice of not less than ten business days and make a good faith effort to establish a mutually agreed upon time and date for the onsite inspection ~~in announced and unannounced on-site inspections of dental office space~~ by MCNA, authorized government officials, and accreditation bodies. Provider shall compile any and all information in a timely manner required to evidence Provider’s compliance with this Agreement, as requested by such agency(ies), or as otherwise necessary for the expeditious completion of such on-site inspection.

(68-974(2)(g) requires 10 days notice regarding a recovery audit.)

**Article IX**

**Informal Dispute Resolution**

**Required to follow the process in the Provider Manual.**

**Article XI**

**(7) Amendments**

30 days notice of an Amendment. Provider can object to the Amendment, otherwise Amendment is accepted. *What happens if Provider objects??*

**(11) Notices**

Must be sent by certified mail or by recognized courier service. Is the USPS a recognized courier service? So MCNA will send notices of Amendments by Certified Mail?

**ATTACHMENT A**

**3.2 – Encounter Records**

Provider must comply will all electronic health encounter requirements. What if a Provider does not do electronic records?

**3.3 – Dental Records**

Retained for 7 years. Must provide the state/federal a hard copy within 14 days of the request. Once-in-a-lifetime event records retained indefinitely. *What is a once-in-a-lifetime event??*

**Revise paragraph 3.5 – Audits as follows:**

3.5 **Audits.** The State or federal government may conduct necessary inspections and audits to

assure quality, appropriateness or timeliness of services and reasonableness of costs. Provider

must provide any requested information within forty-five (45) ~~ten (10) business~~ days of request.

(Neb.Rev.Stat. § 68-974(8) requires 45 days)

**Revise paragraph 3.6 – Cultural Consideration and Competency as follows:**

3.6 **Cultural Consideration and Competency.** In accordance with Title IV of the Civil Rights

Act of 1964 (42 U.S.C. §2000d *et. seq*.) and its implementing regulation, 45 C.F.R. §80 (2001)

(as amended), Provider shall deliver Covered Services in a culturally competent manner to all

Covered Persons, including those with limited English proficiency and diverse cultural and

ethnic backgrounds. MCNA shall ~~and must~~ take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement.

(I didn’t see this on the MCNA Powerpoint at Annual Session, but apparently they said they would provide this. However, federal law only requires ***effective communication.)***

**3.12 – Access to Premises**

References 42 U.S.C. 1396(a)(30):

(30) (A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section [**1396b(i)(4)**](http://casemakerlegal.com/bDocView.aspx?catCalled=US%20Code%20(2016)&categoryAlias=STATUTES&state=Federal&statecd=US&codesec=1396b&sessionyr=2017&Title=42&datatype=S&noheader=0&nojumpmsg=0&nojumpmsg=0#1396b(i)(4)) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area; and

**Revise paragraph 3.14 – Provider Indemnity as follows:**

3.14 **~~Provider~~ Indemnity.** ~~Provider shall indemnify, defend and hold the State of Nebraska~~

~~harmless from all claims, losses, or suits relating to activities undertaken pursuant to this~~

~~Agreement.~~ Each party agrees to indemnify, defend, and hold harmless the other party from and against any loss, cost, or damage of any kind (including reasonable outside attorneys’ fees) to the extent arising out of its breach of this Agreement, and/or its negligence or willful misconduct. This indemnity shall not cover any claims in which there is a failure to give the indemnifying party prompt notice, but only if and to the extent that such failure materially prejudices the defense.

**Revise the first sentence of paragraph 3.18 as follows:**

3.18 **Disclosure.** The Provider agrees to screen all its employees, contractors, and contractor’s

employees annually ~~monthly~~ using the List of Excluded Individuals/Entities (LEIE) database to determine whether any of its employees, contractors, and contractor’s employees is excluded from

participation in Medicare, Medicaid, or other federal health care programs.

(Consistent with language later in 3.18 which requires annual attestation)

**4.4 – Costs of Non-covered Services**

Requires written authorization from Patient prior to performing non-covered services.

**Revise paragraph 4.8 – Time Limitation as follows:**

4.8 **Time Limitation**. Payor or MCNA or Provider may not bring any legal or equitable action with respect to any claim arising out of or relating to the Agreement or this Product Attachment more than two (2) years after the cause of action arose.