Citation	Condition or Requirement

1932 (a)(1)(A)

A. Section 1932 (a)(1)(A) of the Social Security Act.

The State of Nevada enrolls Medicaid recipients on a mandatory basis into managed care entities (i.e. managed care organization (MCOs) and primary care case managers (PCCMs) in the absence of section 1115 or section 1915 (b) waiver authority. This authority is granted under section 1932 (a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid recipients to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may not be used to mandate enrollment in Prepaid Inpatient Health Plan (PIHP) or to mandate the enrollment of Medicaid recipients who are Medicaid eligible, who are Native American Indians (unless they would be enrolled in certain plans—see IV.2 below), or who meet eligible certain categories of "special needs" beneficiaries (see IV.3-7.)

B. General Description of the Program and Public Process.

1932 (a)(1)(B)(i)
1932 (a)(1)(B)(ii)
42 CFR 438.50 (b)(1)

1. Describe the contracting entities by indicating if they are an MCO or PCCM.

An MCO must be in compliance with all applicable Nevada Revised Statutes, Nevada Administrative Code, the Code of Federal Regulations, the United States Code, and the Social Security Act which assure program and operational compliance as well as assuring services that are provided to Medicaid recipients enrolled in an MCO are done so with the same timeliness, amount, duration, and scope as those provided to fee-for-service Medicaid recipients.

The State of Nevada Division of Health Care Financing and Policy (DHCFP – aka Nevada Medicaid) oversees the administration of all Medicaid Managed Care Organizations (MCOs) in the state. Nevada Medicaid operates a fee-for-service and a managed care reimbursement and service delivery system with which to provide covered medically necessary services to its Medicaid eligible population. Contracted Managed Care Organizations (MCOs) are currently the sole such managed care entities providing Medicaid managed care in Nevada; at this time, Nevada Medicaid does not contract with PCCMs, PIHPs, or PAHPs.

Citation	Condition or Requirement
	Enrollment in an MCO is mandatory for TANF (Section 1931) and CHAP (poverty level pregnant women, infants, and children) recipients when there is more than one MCO option from which to choose in a geographic service area and optional in areas where only one plan exists. The eligibility and aid code determination functions for the Medicaid applicant and eligible population is the responsibility of the Division of Welfare and Supportive Services (DWSS).
CFR 438.50 (b)(2) **CFR438.50 (b)(3)**	**2. Discuss the payment method to be utilized (i.e. fee for service, capitation, case management fee, bonus/incentive and/or supplemental payments).** MCO contracts are comprehensive risk contracts and are paid a risk-based capitated rate for each eligible, enrolled Medicaid recipient 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 care exceed a threshold during a specified time period.
CFR 438.50 (b)(4)	**3. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented.** Pursuant to 42 CFR 438.50(b)(4), the State shall provide public notice to promote public involvement in the design and initial implementation of the program as well as during contract procurement. The public notice shall be a notice of publication published in a newspaper in Southern Nevada and in a newspaper in Northern Nevada. The notice of publication will include a statement of the need for amending the state plan and purpose of the proposed amendment, and the substance of the proposed regulation and issues involved and the manner in which interested persons may present their views thereon.

Citation	Condition or Requirement
1932 (a)(1)(A)	**4. Affirm if the state plan program will implement mandatory enrollment into managed care on a statewide basis. If not, identify the county/areas where mandatory enrollment will be implemented.** Mandatory enrollment occurs in the areas of Clark County and Washoe County.
	C. <u>State Assurances and Compliance with the Statute and Regulations.</u> The state assures all the applicable requirements that include but are not limited to the following statute and regulations are met:
1932 (a)(1)(A)(i)(I) 1903 (m) 438.50 (c)(1)	**1. Section 1903 (m) of the Act, for MCOs and MCO contracts.**
1932 (a)(1)(A)(i)(I) 1905 (t) 42 CFR 438.50 (c)(2) 1902 (a)(23(A)	**2. Section 1905 (t) of the Act for PCCMs and PCCM contracts.**
1932(a)(1)(A) 42 CFR 438.50(c)(3)	**3. Section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities.**
1932 (a)(1)(A) CFR 431.51	**4. 42 CFR 431.51 regarding freedom of choice for family planning 42 services and supplies as defined in Section 1905 (a)(4)(C).**
1932 (a)(1)(A) 42 CFR 438 42 CFR 438.50 (c)(4) 1903 (m)	**5. 42 CFR 438 for MCOs and PCCMs.**
1932 (a)(1)(A) 42 CFR 438.6 (c) 42 CFR 438.50 (c)(6)	**6. 42 CFR 438.6 (c) for payments under any risk contracts.**

Citation	Condition or Requirement
1932 (a)(1)(A) **42 CFR 447.362** **42 CFR 438.50 (c)(6)**	**7. 42 CFR 447.362 for payments under any non-risk contracts.**
45 CFR 74.40	**8. 45 CFR 74.40 for procurement of contracts.**

D. Eligible groups

1932 (a)(1)(A)(i)

1. List all eligible groups that will be enrolled on a mandatory basis.

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

a. Temporary Assistance for Needy Families (TANF);
b. Two parent TANF;
c. TANF – Related Medical Only;
d. TANF – Post Medical (pursuant to Section 1925 of the Social Security Act (the Act);
e. TANF – Transitional Medical (under Section 1925 of the Act);
f. TANF Related (Sneede vs. Kizer);
g. Child Health Assurance Program (CHAP); and
h. Aged Out Foster Care (young adults who have "aged out" of foster care).

2. Mandatory exempt groups

Use a check mark to indicate if the state will enroll any of the mandatory exempt groups on a voluntary basis.

1932 (2)(B)
42 CFR 438 (d)(1)

i. Recipients who are also eligible for Medicare

___The state will allow these individuals to voluntarily enroll in the managed care program.

Citation	Condition or Requirement
1932 (a)(2)(A)(ii); 42 CFR 438.50 (3)(v)	**vii. Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.** X The state will allow these individuals to voluntarily enroll in the managed care program.

E. Identification of Mandatory Exempt Populations.

Citation	Condition or Requirement
1932 (a)(2) 42 CFR 438.50 (d)	**1. How does the state define children who receive services funded under section 501 (a)(1)(D) of title V?** Children receiving services through a family-centered, community-based, coordinated care system receiving grant funds under section 501(a) (1) (D) of Title V are defined as those who receive services at Nevada Early Intervention Services located in Las Vegas, Reno, Carson City, Elko and Ely. The State will utilize database information to identify Medicaid recipients receiving these services. Additionally, children needing services from Nevada Early Intervention Services may be identified by a parent or guardian.
1932 (a)(2) 42 CFR 438.50 (d)	**2. Is the state's definition of these children in terms of program participation or special health care needs?** The State's definition of these children is based on program participation and/or parental or legal guardian identification.
1932 (a)(2) 42 CFR 438.50 (d)	**3. Does the scope of these title V services include services received through a family-centered, community-based, coordinated care system?** Yes.

Citation	Condition or Requirement

MCO, the parent or legal guardian is notified of their right to keep the child enrolled with the MCO or to request the child's disenrollment. If the parent or legal guardian decides to keep the child enrolled, the MCO is required to provide all services available under the Managed Care Contract. In addition, if the Individualized Family Service Plan (IFSP) or Individual Education Plan (IEP) has identified services which are not covered under Medicaid through the EPSDT benefit, or covered under the Managed Care Contract, the MCO is responsible for providing case management services on behalf of the child and family in order to ensure referral and linkage to other community resources in obtaining these identified services. If the parent or legal guardian elects to disenroll the child from the MCO, the child will be disenrolled from the MCO pursuant to 42 CFR 438.56 (e) (1) after which covered medically necessary services will be reimbursed through Medicaid fee-for-service.

1932 (a)(2)
42 CFR 438.50 (d)

6. **How does the state identify the following groups who are exempt from mandatory enrollment into managed care:**

   i. **Individuals who are also eligible for Medicare.**

   Dual Medicare-Medicaid eligibles are identified by aid code. System edits prevent enrollment of these Medicaid eligibles into Managed Care.

   ii. **Indians who are members of Federally recognized tribes, except when the MCO or PCCM is the Indian Health Service; or an Indian Health program or Urban Indian program is operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service.**

   American Indian identifying information, if provided by the recipient, is available from the eligibility system. Identification of American Indians can also occur directly from the recipient, parent, or guardian.

Citation	Condition or Requirement

42 CFR 438.50 — **F. List other populations (not previously mentioned) who are exempt from mandatory enrollment.**

Recipients with comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any insurance purchased from another organization or agency which cannot be billed by an MCO are exempt from mandatory enrollment.

42 CFR 438.50 — **G. List all other eligible groups that are permitted to enroll on a voluntary basis.**

The State assures that although the following Medicaid recipients are exempt from mandatory enrollment, they are allowed to voluntarily enroll in an MCO, if they so choose:

1. TANF and CHAP adults diagnosed as seriously mentally ill (SMI); and,
2. TANF and CHAP Children diagnosed as emotionally disturbed (SED).
3. TANF and CHAP Children diagnosed as Child(ren) with Special Health Care Needs (CSHCN).

H. Enrollment process.

1932 (a)(4)
42 CFR 438.50

1. **Definitions**

   i. **An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience or through contact with the recipient.**

   ii. **A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.**

Citation	Condition or Requirement

1932 (a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

i. the existing provider-recipient relationship;

After waiting 30 days to allow a recipient choice and prior to auto-assigning a recipient to an MCO, the State will review the recipients past enrollment records to determine whether the recipient has an MCO relationship. If such a relationship is confirmed, and the recipient has been ineligible for Medicaid for two (2) months or less, the recipient will be auto-assigned to that MCO. The MCO will then insure that the prior provider-recipient relationship is preserved. If there is no history of a previous MCO enrollment, the recipient will be assigned by family, following the head of household. If there is no history or family, the State utilizes a default algorithm process to assign the recipient to an MCO. Exceptions may be granted by the State.

If a family has been ineligible for over two months, they will be treated as newly eligible, that is: given a 30 day choice period; auto assigned in the absence of a choice; and they will have a 90 day right to change MCO period. All of this allows the recipient the opportunity to select an MCO that will preserve the existing provider recipient relationship. If an individual who has been absent for any length of time, including under or over two months, joins an existing case, either as a new or returning family member, they will be assigned to the same MCO as the rest of the family. Once recipients are established in their MCO and all choice periods have been exhausted, a lock in period will follow that is not to exceed 12 months. During an annual open enrollment period, the recipient may choose to change MCOs if they feel this will allow them better access to a provider they wish to establish, or renew, a relationship. Good cause is always allowed for changing MCOs, and may allow the splitting of families if it is in the best interest of the family.

ii. the relationship with providers that have traditionally served Medicaid recipients;

Citation	Condition or Requirement

After waiting 30 days to allow a recipient choice and prior to auto-assigning a recipient to an MCO, the State will review the recipients past enrollment records to determine whether the recipient has a prior MCO relationship. If such a relationship is confirmed, and the recipient has been ineligible for Medicaid for two (2) months or less, the recipient will be auto-assigned to that MCO. The MCO will then insure that the prior provider-recipient relationship is preserved. If the recipient is new to managed care or if there is no history of a previous MCO enrollment, the recipient will be assigned by family, following the head of household. If there is no history or family, the recipient is randomly assigned. Exceptions may be granted by the State.

iii. **the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702 (a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2).**

When maintaining provider-recipient relationships is not possible, the State will distribute recipients equitably among qualified MCOs based upon an algorithm developed by DHCFP. In order to serve the best interests of the State and program recipients, the algorithm will give weighted preference to any new MCO as well as MCOs with significantly lower enrollments, based on a formula developed by DHCFP.

1932 (a)(4)
42 CFR 438.50

3. **As part of the state's discussion on the default enrollment process, include the following items:**

i. **Indicate if the state will use a lock-in for managed care.**

The State of Nevada will use a lock-in for managed care.

ii. **Give the time frame for recipients to choose a health plan before being auto-assigned.**

Citation | Condition or Requirement

A recipient is allowed up to 30 days from the mailing of the case decision notice to choose a health plan before being auto-assigned.

iii. **Describe the state's process for notifying Medicaid recipients of their auto-assignment.**

The State prior approves the written enrollment packet which the contracted MCOs use to provide this notification to potential enrollees. Potential enrollees are notified of their choice options, including their right to disenroll with cause at any time, through the written enrollment packet they are provided at the time they are determined eligible for MCO enrollment. They are also informed of the State's process for default or auto assignment in the event they fail to choose an MCO as well as their right to change MCOs with or without cause during the first 90 days of their enrollment. If the recipient does not choose an MCO within the 30 day time frame afforded to them, they are informed of their auto-assignment through a letter they are sent after assignment, which also informs them of their right to change MCOs with or without cause during the first 90 days of their enrollment and by the information provided on their Medicaid Card commencing the month of coverage in which the assignment is effective.

iv. **Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment.**

An enrolled recipient may request disenrollment from the MCO with or without cause during the first 90 days of their enrollment. The request to disenroll from the MCO is made in writing. Medicaid recipients are notified of their right to disenroll from the MCO with or without cause during the first 90 days of their enrollment by the written information in the enrollment packet they are provided at the time they are determined eligible for MCO enrollment.

v. **Describe the default assignment algorithm used for auto-assignment.**

The auto assignment algorithm will assign members returning to a case, or re-establishing eligibility, in a

different manner from new cases where the entire family is receiving Medicaid for the first time.

Keeping the family together in the same plan, without disrupting the family's relationship with their current primary care provider or MCO is given priority.

Returning family members who join an open case will be assigned to the same MCO as the rest of the family and will not individually have a 90 day right to change period, nor will their addition to the family qualify any other members of the family for a right to change outside of the regular open enrollment period.

New additions to a case, whether newborn or additional family members who join the household after the MCO has been established are also assigned to the same MCO as the rest of the family and do not have 90 days to change plans; these new case members as well as the rest of the family remained locked in until the next open enrollment period. They will be assigned to the family's MCO whether or not they are an adult or child, and regardless of the time they have been absent from the case, even if it exceeds two months. They will not be given an option to change MCOs until the next open enrollment period.

If an entire case has been closed for over two (2) months, then the family will be treated similarly to a recipient who is eligible for the first time. That is, they will be given 30 days to make a choice of MCOs. Absent a choice they will be auto-assigned to their last known viable MCO. Enrollment in the MCO will begin at the beginning of the next administratively possible month. They will be notified of this assignment by mail, and in that same notification, they will be advised that they have ninety (90) days during which they may change MCOs. After the 90 days they will be locked in to the MCO until the next open enrollment period.

For a true first time recipient, that is one who has never received Medicaid or Nevada Checkup benefits, they will be initially provided with fee for service benefits and given a 30 day choice period to select the MCO they would like to enroll in. Their choice will go into effect the first day of the

next administratively possible month. Absent a choice by the recipient they will be randomly assigned to an MCO using the auto assignment algorithm shown below.

Regardless of which enrollment or auto assignment process is used, the head of household will be notified of all choices that need to be made, the timeframe for making these choices, and the consequence of not making a choice.

To reduce large disparities and adverse risk between MCOs, the default assignment algorithm used by the State for auto-assignment is as follows.

***Auto Assignment Algorithm**

Number of Plans in Geographic Service Area	Percentage of Recipients Assigned to Largest Plan	Percentage of Recipients Assigned to 2nd Largest Plan	Percentage of Recipients Assigned to 3rd Largest Plan	Percentage of Recipients Assigned to 4th Largest Plan
2 plans	34%	66%		
3 plans	17%	33%	50%	
4 plans	10%	10%	30%	50%

*** The function of the algorithm is to ultimately achieve no more than a 10% differential in enrollment between all MCO contractors. Once the differential is achieved, use of this algorithm will be discontinued and head of households will be auto assigned on rotating basis.**

vi. **Describe how the state will monitor any changes in the rate of default assignment.**

The State will monitor the auto-assignment rates on a monthly basis through a generated MMIS system report.

1932 (a)(4)
42 CFR 438.50

I. **State assurances on the enrollment process.**

1. **The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have**

Citation	Condition or Requirement

capacity to accept all who are seeking enrollment under the program.

2. **The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52 (b)(3).**

   _____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52 (a) for MCOs and PCCMs. (If applicable, place check mark to indicate state's affirmation.)

3. **The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932 (a)(3) (C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)**

   ___ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56 (g) if recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less. (If applicable, place check mark to indicate state's affirmation.)

1932 (a)(4)
42 CFR 438.50

J. Disenrollment

1. **Affirm if the state uses lock-in for managed care and identify how many months (up to 12 months) will the lock-in apply.**

   Nevada uses lock-in for managed care. There will be one open enrollment period annually. Beneficiaries will never be locked in for more than 12 months even if the Open Enrollment period changes.

2. **The state assures that recipient requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56 (c).**

   Subject to the limitations outlined in Section H.3.(v) of this SPA, an enrolled recipient may request disenrollment from the MCO with or without cause during the first 90 days of enrollment. There are no time restrictions for disenrollment with cause. Circumstances for disenrollment with cause are:

Citation	Condition or Requirement

- The recipient moves out of the MCO service area.
- The plan does not, because of moral or religious objections, cover the service the recipient seeks.
- The recipient 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 recipient's primary care provider or another provider determines that receiving the services separately would subject the recipient to unnecessary risk.
- Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the recipient's health care needs.

Beneficiaries will never be locked in for more than 12 months even if the Open Enrollment period changes.

3. What are the additional circumstances of "cause" for disenrollment? (If any.)

Determination by DHCFP on a case by case basis that one HMO is better able to provide for unusual needs of a specific family member, while at the same time the other HMO is better able to provide for unusual needs of a different family member.

- Determination by DHCFP

K. Information requirements for beneficiaries.

1932 (a)(5)
42 CFR 438.10
42CFR 438.50

_X_ The state assures that its state plan program is in compliance with 42 CFR 438.10 (i) for information requirements specific to MCOs 42 and PCCM programs operated under section (a)(1)(A)(i) state plan amendments.

L. Description of excluded services for each model (MCO & PCCM)

The following services are either excluded as an MCO covered benefit or have coverage limitations.

1. All services provided at Indian Health Service Facilities and Tribal Clinics:

Citation | Condition or Requirement

Native Americans may access and receive covered medically necessary services at Indian Health Service (IHS) facilities and Tribal Clinics. If a Native American voluntarily enrolls with an MCO and seeks covered services from IHS, the MCO should request and receive medical records regarding those covered services/treatments provided by IHS. If treatment is recommended by IHS and the enrollee seeks the recommended treatment through the MCO, the MCO must either provide the service or must document why the service is not medically necessary. The documentation may be reviewed by DHCFP or other reviewers. The MCO is required to coordinate all services with IHS. If a Native American recipient elects to disenroll from the MCO, the disenrollment will commence no later than the first day of the second administrative month and the services will then be reimbursed by FFS.

2. Non-emergency transportation

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

3. All Nursing Facility stays over forty-five (45) days

The MCO is required to cover the first 45 days of a nursing facility admission, pursuant to the Medicaid Services Manual (MSM). The MCO is also required to collect any patient liability (pursuant to 42 CFR 435.725) for each month a capitated payment is received, pursuant to the MSM. The MCO shall notify DHCFP by the fortieth (40th) day of any nursing facility stay admission expected to exceed forty-five (45) days. The enrollee will be disenrolled from the MCO and the stay will be covered by FFS commencing on the 46th day of the facility stay. DHCFP will retroactively adjust the capitation payment to cover only that portion of the month that the beneficiary is enrolled.

4. Swing bed stays in acute hospitals over forty-five (45) days

The MCO is required to cover the first forty-five (45) days of a swing bed admission pursuant to the MSM. The MCO is also required to collect any patient liability for each month a capitated payment is received, pursuant to the MSM. The MCO shall notify DHCFP by the fortieth (40th) day of any swing bed stay expected to exceed forty-five (45) days. The enrollee will be disenrolled from the MCO and the stay will be covered by FFS commencing on the forty-sixth (46th) day of the facility stay. DHCFP will retroactively adjust the

Citation	Condition or Requirement

capitation payment to cover only that portion of the month that the beneficiary is enrolled.

5. School Based Child Health Services (SBCHS)

DHCFP has an agreement with several school districts to provide selected medically necessary covered services through School Based Child Health Services (SBCHS) to eligible Title XIX Medicaid recipients.

Eligible Medicaid enrollees, who are three (3) years of age and older, can be referred to a school based child health service for an evaluation by their private physician, school physician, special education teacher, school nurse, school counselor, parent or guardian, or social worker. If the child is found eligible for these services, then an Individual Education Plan (IEP) is developed for the child. The IEP specifies services needed for the child to meet educational goals. A copy of the IEP will be sent to the child's PCP within the managed health care plan, and maintained in the enrollee's medical record.

The school districts provide, through school district employees or contract personnel, the majority of specified medically necessary covered services. Medicaid reimburses the school districts for these services in accordance with the school district contract. The Vendors will provide covered medically necessary services beyond those available through the school districts, or document why the services are not medically necessary. The documentation may be reviewed by DHCFP or its designees. Title XIX Medicaid eligible children are not limited to receiving health services through the school districts. Services may be obtained through the Vendor rather than the school district, if requested by the parent/legal guardian. The Vendor case manager shall coordinate with the school district in obtaining any services which are not covered by the plan or the school district.

6. Intermediate Care Facility for the Mentally Retarded (ICF/MR)

Residents of ICF/MR facilities are not eligible for enrollment with the MCO. If a recipient is admitted to an ICF/MR after MCO enrollment, the recipient will be disenrolled from the MCO and the admission, bed day rate, and ancillary services will be reimbursed through FFS. DHCFP will retroactively adjust the capitation payment to cover only that portion of the month that the beneficiary is enrolled.

Citation | Condition or Requirement

7. **Residential Treatment Center (RTC)**

   Medicaid enrollees will be disenrolled from the MCO in the month following the RTC admission. The RTC admission, bed day rate, and ancillary services will be reimbursed through FFS thereafter for Title XIX Medicaid Recipients.

8. **Hospice**

   Medicaid recipients who are receiving Hospice Services are not eligible for enrollment with the MCO. If a Medicaid recipient is made eligible for Hospice Services after MCO enrollment, the recipient will be disenrolled from the MCO and the Hospice Services will be reimbursed through FFS. DHCFP will retroactively adjust the capitation payment to cover only that portion of the month that the beneficiary is enrolled.

9. **Institutions for Mental Diseases (IMDs) for Title XIX eligible recipients ages twenty two (22) through sixty five (65) years of age**

   Federal regulations stipulate that Title XIX can only reimburse for services to IMD/psychiatric hospital patients who are 65 years of age or older or under the age of 21 years. Residents of IMD facilities who are 21 years of age through 64 years of age are not eligible for enrollment with the MCO. If a recipient is admitted to an IMD after MCO enrollment, the recipient will be disenrolled. DHCFP will retroactively adjust the capitation payment to cover only that portion of the month that the beneficiary is enrolled.

Citation	Condition or Requirement

10. Adult Day Health Care

Recipients who are receiving Adult Day Health Care (Provider Type 39) services are not eligible for enrollment with the MCO. If a recipient is made eligible for Adult Day Health Care after MCO enrollment, the recipient will be disenrolled and the Adult Day Health Care will be reimbursed through FFS. DHCFP will retroactively adjust the capitation payment to cover only that portion of the month that the beneficiary is enrolled.

11. Home and Community Based Waiver (HCBW) Services

Recipients who are receiving HCBW Services are not eligible for enrollment with the MCO. If a recipient is made eligible for HCBW Services after MCO enrollment, the recipient will be disenrolled and the HCBW Services will be reimbursed through FFS. DHCFP will retroactively adjust the capitation payment to cover only that portion of the month that the beneficiary is enrolled.

12. Pre-Admission Screening and Resident Review (PASRR) and Level of Care (LOC) Assessments

A PASRR and LOC are reimbursed by FFS. Conducting a PASRR and LOC will not prompt MCO disenrollment. However, if the recipient is admitted into a nursing facility as the result of a PASRR and LOC, the MCO is responsible for the first 45 days of admission for the recipient (see 3., above).

13. SED/SMI, with limitations

The MCO must ensure enrollees who are referred for evaluation for SED/SMI or who have been determined SED/SMI by the health plan are obtaining the medically necessary evaluations and that enrollees are transitioned, as necessary, to another provider in order to obtain their mental health services if such services are not available within the network. The MCO is required to notify DHCFP if a Title XIX Medicaid recipient elects to disenroll with the MCO following the determination of SED/SMI and forward the enrollee's medical records to the provider from whom the enrollee will receive the covered mental health services. However, in the event the Medicaid enrollee, who has received such a determination, chooses to remain enrolled with the MCO, the MCO will be responsible for providing all patient care.

Citation	Condition or Requirement

Such services include, but are not limited to: case management; lab work; prescription drugs; acute in-patient; and, other ancillary medical and mental health services required by the plan of treatment. Title XIX Medicaid eligible recipients have the option of disenrolling from the MCO, if determined to be SED or SMI. If an eligible recipient elects to disenroll from the MCO following a determination of SED or SMI, the disenrollment will commence no later than the first day of the second administrative month and the services will then be reimbursed by FFS.

An annual redetermination of SED/SMI status is required to maintain voluntary disenrollment.

14. Dental Services

Dental services are included in the MCO benefit package in all mandatory enrollment services areas. The MCO will be responsible for all covered medically necessary dental services. Under EPSDT, the MCO is required to cover any diagnostic, preventive, or corrective procedures that include the treatment of the teeth and associated structures of the oral cavity for disease, injury or impairment which may affect the oral or general health of Title XIX Medicaid eligible recipients under 21 years of age. Dental services covered by the MCO for adults ages 21 and older must include, at minimum, the same amount, duration, and scope of benefits allowed by the Nevada Medicaid State Plan, such as emergency, palliative, and prosthetic care. The MCO may elect to provide more expansive services for adults at their own discretion and risk.