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State/Territory Name: Nevada

State Plan Amendment (SPA) #: 13-031

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS-179
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

FEB 21 2014

Michael J. Willden, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, NV 89706

Dear Mr. Willden:

Enclosed is an approved copy of Nevada State Plan Amendment (SPA) 13-031. This SPA was submitted to my office on December 13, 2013 requesting to amend Attachment 3.1-F to reflect updated processes and eligibility groups for the managed care program and to incorporate the updated version of the Attachment 3.1-F template.

The approval is effective October 1, 2013. Attached are copies of the following pages to be incorporated into your State Plan:

- Attachment 3.1-F, Pages 1-26

If you have any questions, please contact Brian Zolynas by phone at (415) 744-3601 or by email at Brian.Zolynas@cms.hhs.gov .

Sincerely,

/s/
Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Laurie Squartsoff, Administrator, DHCFP
Marta Stagliano, Chief, Compliance, DHCFP

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **13-031**

2. STATE **NEVADA**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE **October 1, 2013**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1903(m)(2)(H) and 42 CFR 438.50(g)

7. FEDERAL BUDGET IMPACT:
a. FFY ~~2013~~ 2014 $0
b. FFY ~~2014~~ 2015 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-F, pgs. 1 -~~25~~ 26

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-F, pgs. 1 - 21
Section 3.5, Page 31j (TN 07-011) and ~~page 31k (TN 07-011)~~

10. SUBJECT OF AMENDMENT:
Nevada is amending the State Plan to reflect updated processes and eligibility groups as they relate to the DHCFP's Managed Care Programs.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/s/

13. TYPED NAME:
Michael J. Willden

14. TITLE:
Director, Department of Health and Human Services

15. DATE SUBMITTED: DEC 13 2013

16. RETURN TO:
Marta Stagliano, Chief of Program Integrity
DHCFP/Medicaid
1100 East William Street, Suite 101
Carson City, NV 89701

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 13, 2013

18. DATE APPROVED: FEB 21 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2013

20. SIGNATURE OF REGIONAL OFFICIAL: /s/

21. TYPED NAME: Gloria Nagle, Ph.D., MPA

22. TITLE: Associate Regional Administrator

23. REMARKS:

Pen and ink changes to Boxes 7, 8, 9, and 11.

FORM HCFA-179 (07-92)

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 beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or 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 beneficiaries 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 Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Native American Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii.)

The State also enrolls eligible Medicaid beneficiaries on a mandatory basis into a Primary Care Case Management (PCCM) program under the authority of a Section 1115 Research and Demonstration Waiver, titled the Nevada Comprehensive Care Waiver (NCCW).

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

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

1. The State will contract with an

____ i. MCO
____ ii. PCCM (including capitated PCCMs that qualify as PAHPs).
_X_ iii. Both

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) and Medicaid PCCM program(s) 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 primary managed care

Citation	Condition or Requirement

entities providing Medicaid managed care in Nevada; at this time, Nevada Medicaid does not contract with PIHPs or PAHPs.

Enrollment in an MCO is mandatory for Family Medical Category (FMC) [TANF (Section 1931), CHAP (poverty level pregnant women, infants, and children)] and the Adult Group (Childless Adults, ages 19-64 years, effective January 1, 2014) beneficiaries 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).

Enrollment in a PCCM under the NCCW is mandatory for Family Medical Category [FMC (TANF& CHAP)], MAABD, Parents & Caretakers, Pregnant Women, Infants and Children Under age 19, Former Foster care Children, Transitional Medical and Post Medical fee-for-service beneficiaries who meet program eligibility criteria and are not part of a PCCM excluded group, including those enrolled in an MCO. Those who qualify for the program will receive the benefit of a care manager who will facilitate improved health outcomes for the beneficiary. Medicaid eligibility and aid code determinations for Medicaid applicants are the responsibility of the Division of Welfare and Supportive Services (DWSS). Once enrolled in Medicaid Fee-For Service (FFS), the PCCM will determine who qualifies for the PCCM program based on the eligibility criteria.

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting MCO entity will be:

____i. fee for service;
_X_ii. capitation;
This applies to MCOs and PCCM.
____iii. a case management fee;
_X_iv. a bonus/incentive payment;
This applies to PCCM.
_X_v. a supplemental payment;
This applies to MCOs, or
_X_vi. other. (Please provide a description below).

Capitation:

MCO contracts are comprehensive risk contracts and are paid a risk-based capitated rate for each eligible, enrolled Medicaid

Citation	Condition or Requirement

beneficiary on a per-member, per-month (PMPM) basis. These capitated rates are certified to be actuarially sound.

Stop Loss:
Stop Loss occurs when costs of care exceed a threshold during a specified time period. Stop Loss is a re-insurance program where risk is shared between the DHCFP and the MCO for outlier episodic claims. For inpatient claims above a defined threshold, the State pays 75%, and the MCO Vendor has a co-pay of the remaining 25%.

Very Low Birth Weight Newborns (VLBW):
Payments for high-risk very low birth weight newborns are revenue neutral.VLBW payments are paid out of the zero-to-one year age band of capitation based on the risk–adjusted expectation of VLBW birth occurrences, per number of member-months' exposure. MCO plans submit clinical proof of VLBW (<1500 grams) occurrences and are paid according to date and time of delivery. Should eligible VLBW births exceed actuarial limits, MCO plans are fully at-risk for the remainder of the plan year.

PCCM:
PCCM contracts are paid at a PMPM basis for each eligible, enrolled Medicaid beneficiary. In addition, incentive payments could be made when the PCCM achieves specific cost savings goals and/or quality improvement measures.

1905(t)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

____ii. Incentives will be based upon specific activities and targets.

Citation	Condition or Requirement

____iii. Incentives will be based upon a fixed period of time.

____iv. Incentives will not be renewed automatically.

____v. Incentives will be made available to both public and private PCCMs.

____vi. Incentives will not be conditioned on intergovernmental transfer agreements.

_X_ vii. Not applicable to this 1932 state plan amendment.

42 CFR 438.50(b)(4)

4. 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. *(Example: public meeting, advisory groups.)*

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 Medical Care Advisory Committee (MCAC) advises the DHCFP regarding provisions of services for the health and medical care of Medicaid beneficiaries. Under the PCCM, an outreach plan is required and designed to educate stakeholders on its activities within the State.

1932(a)(1)(A)

5. The state plan MCO program will___/will not _X_ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory __X__/ voluntary_____ enrollment will be implemented in the following county/area(s):

   i. county/counties (mandatory) Urban Clark and Washoe counties

   For Native Americans, the Severe Emotional Disturbance (SED) group, the Serious Mental Illness (SMI) group and children who qualify as Children with Special Health Care Needs (CSHCN) in Urban Clark and Washoe counties, enrollment is voluntary and beneficiaries may "opt out" of the MCOs.

Citation	Condition or Requirement
	ii. county/counties (voluntary)__________________
	iii. area/areas (mandatory)____________________
	iv. area/areas (voluntary)____________________
	Mandatory enrollment occurs in the areas of Clark County and Washoe County for the MCOs for eligible beneficiaries. Mandatory enrollment in the PCCM is statewide for eligible beneficiaries.
	C. State Assurances and Compliance with the Statute and Regulations.
	If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1. __X__ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905 (t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. __X__The state assures that all the applicable requirements of section 1905 (t) of the Act for PCCMs and PCCM contracts will be met. Under the authority of the NCCW, the PCCM allows registered nurses to serve as primary care case managers for the PCCM program.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. __X__The state assures that all the applicable requirements of 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 will be met.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4. _X_The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905 (a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5. __X__The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.

Citation	Condition or Requirement

Under the authority of the NCCW, the following requirements of the State Plan are waived for the PCCM program:

1) Amount, duration and scope of services;
2) Comparability; and
3) Freedom of choice.

1932(a)(1)(A)
42 CFR 438.6(c)
42 CFR 438.50(c)(6)

6. __X_The state assures that all applicable requirements of CFR 438.6(c) for payments under any risk contracts will be met.

1932(a)(1)(A)
42 CFR 447.362
42 CFR 438.50(c)(6)

7. __X__The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.

45 CFR 74.40

8. _X_The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

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 beneficiaries found eligible for Medicaid program coverage under the following Medicaid eligibility categories when there are two or more MCOs in the geographic service area or when the beneficiaries meet the PCCM eligibility criteria under the NCCW:

Groups (a) – (m) (below) are eligible for MCO enrollment under 1932(a):

a. Family Medical Category (FMC)/Temporary Assistance for Needy Families (TANF);
b. Family Medical Category (FMC)/Two parent TANF;
c. Family Medical Category (FMC)/TANF–Related Medical Only;
d. Family Medical Category (FMC)/TANF–Post Medical (pursuant to Section 1925 of the Social Security Act (the Act);
e. Family Medical Category (FMC)/TANF–Transitional Medical (under Section 1925 of the Act);

Citation	Condition or Requirement

f. Family Medical Category (FMC)/TANF Related(Sneede vs. Kizer);
g. Family Medical Category (FMC)/Child Health Assurance Program (CHAP);
h. Aged Out Foster Care (young adults who have "aged out" of foster care);
i. Parents and Other Caretaker Relatives (Section 435.110);
j. Pregnant Women (Section 435.116);
k. Infants and Children Under Age 19 (Section 435.118);
l. Former Foster Care Children (Section 435.10); and
m. Adult Group (Childless Adults, ages 19 – 64 years) (Section 435.119).

In accordance with the 1115 Nevada Comprehensive Care Waiver (NCCW), the following groups (n) – (y) are PCCM eligibile and enrollment is mandatory.

n. Low Income Families with Children (SSA 1902 (a)(10)(A)(i)(I), SSA 1931, Eligibility rule CFR 435.110);
o. Pregnant Women and Children (CFR 435.116 and 435.118, SSA 1902);
p. Transitional Related Medicaid-Transitional Medical Assistance (TMA) (SSA 1902 (a)(10)(A)(i)(I), SSA 408(a)(11)(A), SSA 1925, SSA 1931 (c)(2);
q. Extended Post Medical (SSA 1902(a)(10)(A)(i)(I), SSA 408(a)(11)(B), SSA 1931(c)(1);
r. Adoption Support Medical (IV-E) (SSA 1902(a)(10)(A)(i)(I), 473(b)(3), IV-E Adoption Support Program, Public Law 96-272;
s. Supplemental Security Income (SSI) Recipients And Deemed SSI Recipients (SSA 1902(a)(10)(A)(i)(II)SSI recipients, SSA 1902(a)(10)(A)(i)(II)(aa) disabled children who lost SSI when the definition of disability for children changed in 1996, SSA 1902(a)(10)(A)(i)(II)(cc) individuals who are under 21 years of age eligible for Medicaid in the month that applied for SSI, SSA 1619(a), SSA 1905(q)/1902(a)(10)(A)(i)(II) (bb), SSA 1619(b);
t. Pickle Amendment (Section 503 of Public Law 94-566, 42 U.S.C., 1396a);
u. Aged & Blind Individuals-SSI Supplement-Independent Living (IL) (42 CFR 435.130, Section 402-Public Law 98-21);
v. Disabled Adult Children (1634(c), PL99-643)

Citation	Condition or Requirement
	w. Early Widows and Widowers (ages 60-64) (SSA 1634 (d), 42 CFR 435.138); x. Disabled Widows and Widowers (1634(b), 435.137); and y. Foster Care Medical-Aged Out (AO) (SSA 1902(a)(10)(A)(ii)(XVII).
	Per the NCCW, the following groups have optional enrollment in a PCCM:
	a. Ticket to Work and Work Incentives Improvement Act (TWWIIA) (SSA 1902 (a)(10)(A)(ii)(XV), Ticket to Work and Work Incentives Improvement Act 1999 (TWWIIA); b. Adoption Support Medical (NON IV-E) (SSA 1902(a)(10)9A)(ii)(VIII), 42 U.S.C. 671); and c. Aged & Blind Individuals-SSI Supplement-Adult Group Care Facility (AGCF) (42 CFR 453.232).
	2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.
	Use a check mark to affirm if there is voluntary enrollment in any of the following mandatory exempt groups.
1932(a)(2)(B) 42 CFR 438.50(d)(1)	i. ____Recipients who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*
1932(a)(2)(C) 42 CFR 438.50(d)(2)	ii. _X_ Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. Native Americans may opt out of managed care programs.

Citation	Condition or Requirement
	Children defined as Severely Emotionally Disturbed (SED) or as Children with Special Health Care Needs (CSHCN) and adults defined as Seriously Mentally Ill (SMI) have voluntary enrollment in managed care.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. ___Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. ____Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. ____Children under the age of 19 years who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. ____Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E. Adopted children with special needs under the age of 19 years receiving non-IV-E state adoption assistance who do not meet the eligibility criteria for federal participation in the IV-E adoption support program can voluntarily enroll in the PCCM (1902 (a)(10)(A)(ii)(VIII).
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. _X_ 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. This rule applies to the MCO programs, not the PCCM program(s). This group may opt out of the MCOs.
	E. Identification of Mandatory Exempt Groups
1932(a)(2) 42 CFR 438.50(d)	1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)* Children receiving services through a family-centered, community-based, coordinated care system receiving grant funds under section

Citation	Condition or Requirement
	501(a) (1) (D) of Title V are defined by the state in terms of either program participation and/or parental or legal guardian identification.
1932(a)(2) 42 CFR 438.50(d)	2. Place a check mark to affirm if the state's definition of title V children is determined by: _X_ i. program participation, ____ ii. special health care needs, or ____ iii.Both 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. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system. _X_ i. yes ____ ii. no
1932(a)(2) 42 CFR 438.50 (d)	4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)* i. Children under 19 years of age who are eligible for SSI under title XVI; All of these children are identified by aid code in the eligibility system. System edits prevent enrollment of these Medicaid eligibles into managed care. ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; All of these children are identified by aid code in the eligibility system. System edits prevent enrollment of these Medicaid eligibles into managed care. This group may be under a waiver plan which excludes them from mandatory enrollment. iii. Children under 19 years of age who are in foster care or other out-of-home placement;

Citation	Condition or Requirement

All of these children are identified by aid code in the eligibility system. System edits prevent enrollment of these Medicaid eligibles into managed care.

Children, aged 18 years to under 19 years old, with qualifying health conditions who are identified as being eligible for the Foster Care Medical-Aged Out (AO) group have optional enrollment in the PCCM program.

iv. Children under 19 years of age who are receiving foster care or adoption assistance.

All of these children are identified by aid code in the eligibility system. System edits prevent enrollment of these Medicaid eligibles into MCOs.

Children with qualifying health conditions, who are identified as being eligible for the Adoption Support Medical (IV-E) group, have mandatory enrollment in the PCCM program.

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

5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)*

Nevada has a database and self-identification mechanism for children with special health care needs. If a child is identified as a Child with Special Health Care Needs (CSHCN) following enrollment in an 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 Early and Periodic Screening, Diagnosis and Treatment (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

Citation	Condition or Requirement

MCO pursuant to 42 CFR 438.56(e)(1) after which covered medically necessary services will be reimbursed through Medicaid FFS.

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

6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)*

   i. Recipients 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 operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

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

42 CFR 438.50 F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment.

Beneficiaries 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.

The NCCW exempts a number of groups from enrollment in the PCCM.

42 CFR 438.50 G. List all other eligible groups who will be permitted to enroll on a voluntary basis

The following Medicaid beneficiaries are exempt from mandatory enrollment, but they are allowed to voluntarily enroll in an MCO, if they so

Citation	Condition or Requirement

choose:

1. Family Medical Category (FMC) [TANF and CHAP] adults diagnosed as Seriously Mentally Ill (SMI);
2. Family Medical Category (FMC) [TANF and CHAP] Children diagnosed as Seriously Emotionally Disturbed (SED);
3. Family Medical Category (FMC) [TANF and CHAP] Children diagnosed as Child(ren) with Special Health Care Needs (CSHCN); and
4. Adult Group (Childless Adults, ages 19-64 years who also qualify as Seriously Mentally Ill (SMI), effective January 1, 2014).

H. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

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.

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

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 (as defined in H.1.i).

New members will be allowed the opportunity to select an MCO with their Primary Care Provider (PCP) in network. Returning Medicaid beneficiaries will be assigned to their former MCO and PCP. The MCO will then ensure that the prior provider-beneficiary relationship is preserved if the provider is still in that MCO's network.

The State will provide new Medicaid beneficiaries with the websites and phone numbers of the State's contracted Medicaid MCOs. New Medicaid beneficiaries will be asked to complete

Citation	Condition or Requirement

their selection of an MCO at the time of Medicaid application. If none is chosen, the State will complete a default enrollment process, and they will be automatically assigned to an MCO based upon an algorithm developed by the State to distribute enrollees among the MCOs.

ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

Prior to auto-assigning a beneficiary to an MCO, the State will review the beneficiary's past enrollment records to determine whether the beneficiary has a prior MCO relationship. If such a relationship is confirmed, and the beneficiary has been ineligible for Medicaid managed care, the beneficiary will be auto-assigned to that MCO. The MCO will then ensure that the prior provider-beneficiary relationship is preserved if the provider is still in that MCO's network.

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). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

When assigning a beneficiary to a previous MCO is not possible, the State will distribute beneficiaries equitably among qualified MCOs based upon an algorithm developed by the DHCFP. The State may also adjust the auto-assignment algorithm in consideration of the MCO's clinical performance measure results or other measurements.

Under the NCCW, there is only one PCCM available to Medicaid beneficiaries. Beneficiaries enrolled in the PCCM will be given the choice of at least two care managers in the PCCM.

1932(a)(4)
42 CFR 438.50

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

i. The state of Nevada will _X_/will not____ use a lock-in for MCO enrollment.

Citation | Condition or Requirement

For the MCOs, the total lock-in period is 12 months inclusive of the initial 90 days up front to disenroll without cause. The beneficiaries will be notified of their option to change MCOs at least 60 days prior to the end of the lock-in period. Beneficiaries will be allowed to change MCOs during the annual open enrollment period.

PCCM beneficiaries are locked-in without an open enrollment period based upon the Freedom of Choice option waived under the authority of the NCCW. PCCM beneficiaries are allowed to change care managers at any time.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be at the time of Medicaid application.

MCO beneficiaries are asked to complete their selection of an MCO at the time of Medicaid application before being auto-assigned, unless they have a previous history with an MCO. Returning beneficiaries without family currently enrolled in an MCO will be assigned to their most recent MCO with an opportunity to choose a new MCO at the next Open Enrollment, at least once every 12 months. Returning beneficiaries with family currently enrolled in an MCO will automatically be enrolled in their family's MCO.

PCCM beneficiaries are automatically enrolled in the PCCM in the next administrative month once they meet program eligibility criteria for enrollment.

iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

Potential enrollees are notified of their choice options and asked to complete their selection of an MCO at the time of Medicaid application. They are notified of their right to disenroll with cause at any time through the written enrollment packet provided by the MCO and by a letter generated by the MMIS. They are also informed of the State's default enrollment process or auto assignment process. The State prior approves the written enrollment packet which the contracted MCOs use to provide this notification to potential enrollees, including the websites and phone numbers of the MCOs.

Citation | Condition or Requirement

For PCCM, the State will provide notice of enrollment to the beneficiary in advance of any initial contact by the PCCM.

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. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

All MCO enrollees who are entitled to disenroll without cause will receive a letter detailing that they have 90 days to change MCOs, even if they were automatically assigned to an MCO. Beneficiaries may disenroll without cause within the first 90 days of enrollment in the MCO and at least once every 12 months. Beneficiaries may disenroll with cause at any time.The request to disenroll from the MCO is made in writing to the MCO and occurs upon MCO approval. Details on how to submit a disenrollment request is explained to enrollees in the enrollment packet they are provided at the time they are determined eligible for MCO enrollment.

PCCM enrollees may disenroll with cause at any time. They will be provided disenrollment rights and procedures in writing from the PCCM.

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

Returning MCO enrollees will be assigned to their most recent MCO, regardless if they lost Medicaid eligibility or were in Medicaid FFS during this time, unless a family member has an open case. If the enrollee's return to MCO eligibility occurs during an open enrollment period, then the beneficiary will be allowed to choose their MCO at the time of MCO re-eligibility. If the beneficiary does not select an MCO, they will be auto assigned to an MCO. Following auto-assignment, they will have 90 days to change their MCO plan.

Returning beneficiaries who join an open case where another family member is currently enrolled in an MCO, 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

Citation	Condition or Requirement

for a right to change outside of the regular open enrollment period. Returning beneficiaries without a family member currently part of an open case will be auto assigned to their most recent MCO.

New additions to an open 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 MCOs; these new case members, as well as the rest of the family, remain locked-in until the next open enrollment period. The new addition 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. They will not be given an option to change MCOs until the next open enrollment period.

Enrollment in the MCO will begin at the beginning of the next administratively possible month. Returning beneficiaries, and those being added to an open case, will be notified of this assignment by mail and informed that they can disenroll at the next open enrollment period.

For a true first time beneficiary, that is one who has never been enrolled in an MCO, they will be given information on all MCOs and will be asked to complete their selection of an MCO at the time of Medicaid application. Their choice will go into effect the first day of the next administratively possible month. Absent a choice by the beneficiary, they will be assigned to an MCO using the auto assignment algorithm shown below. The beneficiary will be allowed 90 days to change plans and will then be locked in until the next open enrollment period, never to exceed 12 months.

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 State uses a default assignment algorithm for auto-assignment of first time beneficiaries. The algorithm will give weighted preference to any new MCO, as well as MCOs with significantly lower enrollments. This is based on a formula developed by the

Citation | Condition or Requirement

State. The State may also adjust the auto-assignment algorithm in consideration of the MCO's clinical performance measure results or other measurements. The algorithm is as follows:

*Auto Assignment Algorithm				
Number of Plans in Geographic Service Area	**Percentage of Beneficiaries Assigned to Largest Plan**	**Percentage of Beneficiaries Assigned to 2nd Largest Plan**	**Percentage of Beneficiaries Assigned to 3rd Largest Plan**	**Percentage of Beneficiaries 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. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

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

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

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

2. _X_ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model

Citation	Condition or Requirement

will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

Under the authority of the NCCW, freedom of choice for the PCCM(s) is restricted to a choice of at least two care managers in the PCCM.

3. ____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

   This exception to choice applies to the PCCM(s). Under the NCCW authority, beneficiaries are allowed to choose from at least two care managers. This does not apply to the MCOs, which are only located in urban areas.

   ___This provision is not applicable to this 1932 State Plan Amendment.

4. ___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.)

   _X_ This provision is not applicable to this 1932 State Plan Amendment.

5. _X_ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

   ___This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will _X_/will not___ use lock-in for managed care.

   Nevada uses lock-in for the MCOs. MCO beneficiaries will never be locked in for more than 12 months. There will be one open enrollment period at least annually.

   Nevada uses lock-in for the PCCM with no open enrollment periods since there is only one PCCM; however, they will have the option to

Citation	Condition or Requirement

choose between a minimum of two care managers at least once every 12 months.

2. The lock-in will apply for _12_ months (up to 12 months).

   There is an open enrollment period at least annually.

   PCCM enrollment is locked-in for all beneficiaries with no open enrollment periods since there is only one PCCM; however, they will have the option to choose between a minimum of two care managers at least once every 12 months.

3. Place a check mark to affirm state compliance.

   _X_The state assures that beneficiary 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 State Plan, an enrolled beneficiary may request disenrollment from the MCO with or without cause during the first 90 days of enrollment. Enrollment is mandatory in the PCCM program and there is only one PCCM from which to choose. There are no time restrictions for disenrollment with cause for the MCOs or the PCCM. Circumstances for disenrollment with cause are:

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

Citation	Condition or Requirement

access to providers experienced in dealing with the beneficiary's health care needs.

4. Describe any additional circumstances of "cause" for disenrollment (if any).

   For cause disenrollments can be determined by the DHCFP on a case by case basis where one MCO is better able to provide for unusual needs of a specific family member, while at the same time the other MCO is better able to provide for unusual needs of a different family member.

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

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

__X_ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1) A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

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

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 the DHCFP or other reviewers. The MCO is required to coordinate all services with IHS. If a Native American beneficiary elects to disenroll from the MCO, the disenrollment will commence no later than the first day of the next administrative month and the services will then be reimbursed by FFS.

Enrollment in the PCCM program is voluntary for Native American Medicaid FFS beneficiaries who meet the PCCM-qualifying health conditions.

Citation | Condition or Requirement

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 the 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 the 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. The 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 the 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. The DHCFP will retroactively adjust the capitation payment to cover only that portion of the month that the beneficiary is enrolled.

5. School Based Child Health Services (SBCHS)

The 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 beneficiaries.

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

Citation | Condition or Requirement

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 the 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 beneficiary is admitted to an ICF/MR after MCO enrollment, the beneficiary will be disenrolled from the MCO and the admission, bed day rate, and ancillary services will be reimbursed through FFS. The DHCFP will retroactively adjust the capitation payment to cover only that portion of the month that the beneficiary is enrolled.

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 Beneficiaries.

8. Hospice

Medicaid beneficiaries who are receiving hospice services are not eligible for enrollment with the MCO. If a Medicaid beneficiary is made eligible for hospice services after MCO enrollment, the beneficiary will be disenrolled from the MCO and the hospice services will be reimbursed through FFS. The DHCFP will retroactively adjust the

Citation	Condition or Requirement

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 beneficiaries ages twenty two (22) through sixty five (65) years of age

Federal regulations stipulate that FFP is not allowable for IMD services for patients who are between the ages of 22 through 64 years of age. The federal regulation allows for coverage of beneficiaries who are receiving inpatient psychiatric services, including IMD, to beneficiaries immediately prior to reaching age 21 years to continue services until (1) the service is no longer needed or (2) the date the beneficiary reaches the age of 22 years. A patient on conditional release or convalescent leave from an IMD is not considered to be a patient in an IMD per the federal regulation.

Beneficiaries admitted to an IMD after MCO enrollment may be disenrolled. The DHCFP will retroactively adjust the capitation payment to cover only that portion of the month that the beneficiary is enrolled.

10. Adult Day Health Care (ADHC)

Recipients who are receiving ADHC (Provider Type 39) services are not eligible for enrollment with the MCO. If a recipient is made eligible for ADHC after MCO enrollment, the recipient will be disenrolled and the ADHC will be reimbursed through FFS. The 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

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

Citation	Condition or Requirement

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 beneficiary 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 beneficiary (see 3., above).

13. Seriously Emotionally Disturbed/Severely Mentally Ill 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 the DHCFP if a Title XIX Medicaid beneficiary 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.

1932 (a)(1)(A)(ii) M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

The state will_____/will not _X_ intentionally limit the number of entities it contracts under a 1932 state plan option.

1. ____The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

2. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

3. ___The selective contracting provision in not applicable to this state plan.

Citation	Condition or Requirement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS-10120 (exp. 01/31/2008)