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State/Territory Name: Nevada

State Plan Amendment (SPA) #: 18-014

This file contains the following documents in the order listed:

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

San Francisco Regional Operations Group

March 6, 2019

Richard Whitley, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, NV 89706

Dear Mr. Whitley:

Enclosed is an approved copy of Nevada State Plan Amendment (SPA) 18-014. The SPA amends Attachment 4.22-C and the Alternative Benefit Plan (ABP) section to update NV's Health Insurance Premium Payment (HIPP) program. The SPA was submitted to CMS on December 6, 2018.

This SPA is approved effective November 30, 2018. Attached is a copy of the following pages to be incorporated into your state plan:

- Attachment 4.22-C, Pages 1, 2, and 3
- Attachment 3.1-L, ABP 9, Page 1

Please note there is a separate companion letter included with this SPA that serves to memorialize the agreement that the state will conduct outreach to the provider community to inform non-participating providers how to enroll in Medicaid for the purposes of receiving payment from the state for cost-sharing amounts that exceed the Medicaid permissible limits.

If you have any questions, please contact Peter Banks by phone at (415) 744-3782 or by email at Peter.Banks@cms.hhs.gov.

Sincerely,

Richard C. Allen
Director, Western Regional Operations Group
San Francisco Regional Office
Centers for Medicaid and CHIP Services

cc: Suzanne Bierman, State Medicaid Director

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

San Francisco Regional Operations Group

March 6, 2019

Richard Whitley, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, NV 89706

Dear Mr. Whitley:

This letter is being sent regarding the implementation of Nevada State Plan Amendment (SPA) 18-014, which was approved on March 6, 2019, and outlines the state's cost-effectiveness test of its Health Insurance Premium Payment (HIPP) program. As part of the review of the SPA, the Centers for Medicare & Medicaid Services (CMS) and the state discussed the requirements in section 1906(a)(3) of the Social Security Act to protect beneficiaries from incurring any out-of-pocket costs that exceed the cost sharing limits applicable in the Medicaid state plan. This letter serves to memorialize the agreement that the state will conduct outreach to the provider community to inform non-participating providers how to enroll in Medicaid for the purposes of receiving payment from the state for cost-sharing amounts that exceed the Medicaid permissible limits.

Individuals enrolled in premium assistance programs must be afforded the same benefits and cost sharing limits provided to all other Medicaid enrollees. Nevada indicated it will provide a wrap-around benefit for any Medicaid service not included in the employer-sponsored insurance plans. As for the cost sharing wrap-around, the state will implement a provider enrollment strategy by conducting outreach to the provider community to inform non-participating Medicaid providers how to enroll in Medicaid for the purpose of receiving payment from the state for cost-sharing amounts that exceed the Medicaid permissible limits for premium assistance enrollees. The state will identify providers who may be currently participating with commercial plans for which the state offers premium assistance but not contracted with Medicaid by matching Medicaid provider lists to existing known commercial provider lists. The state will also utilize its Medicaid Advisory Committee and other provider groups to engage with Medicaid non-participating providers, use the state's online provider pages (including on-line enrollment process) to share information with other providers and identify non-participating providers through claim submissions. The state may also choose to create a shortened provider application for providers who are already known to the state, and who have already undergone screening, because they accept Medicare and have a National Provider Identifier, similar to the way that states implement an abbreviated provider enrollment application for Medicare cross-over claims. For those providers who are still unwilling to enroll in Medicaid, the state will also enter into single case agreements with specific providers to

ensure that the provider can receive payment from the state for cost-sharing amounts that exceed the Medicaid permissible limits. By enrolling such providers, the state will be able to pay these providers directly for any cost sharing that exceed the cost sharing limits in the Medicaid state plan. The state will also inform beneficiaries how to contact the state's fiscal agent if the beneficiary intends to obtain care from a non-participating Medicaid provider.

During a call on February 21, 2019, the state agreed to work with CMS to identify metrics and collect data in order to evaluate the extent to which plan providers are enrolled in Medicaid, as well as the effectiveness of the state's strategies for enrolling additional plan providers. Some examples of data elements to consider are the number of: notifications to the state that an ESI provider is not enrolled in Medicaid; and (2) non-participating providers who choose to enroll after being contacted by the state. The state has also agreed to provide CMS additional data concerning the percentage of all providers in the state who are also Medicaid-enrolled providers and to note any differences in specialty and/or geographic area that adversely affect beneficiaries' access to Medicaid-enrolled providers. For example, there may be less mental health providers than primary care physicians or less providers in general in a rural area than an urban one.

CMS is available to provide ongoing technical assistance to the state on these issues as the state moves forward in implementing its premium assistance program. If you have any questions, please contact Peter Banks by phone at (415) 744-3782 or by email at Peter.Banks@cms.hhs.gov.

Sincerely,

[redacted]

Richard C. Allen
Director, Western Regional Operations Group
San Francisco Regional Office
Centers for Medicaid and CHIP Services

cc: Suzanne Bierman, State Medicaid Director

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: **18-014**

2. STATE: **NEVADA**

3. PROGRAM IDENTIFICATION: **TITLE XXI OF THE SOCIAL SECURITY ACT (CHIP)**

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

4. PROPOSED EFFECTIVE DATE
November 30, 2018

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:
Third Party Liability, Section 1906 of the Act
State Medicaid Manual (SMM) 3900

7. FEDERAL BUDGET IMPACT:
a. FFY 2019 ($2,303,790)
b. FFY 2020 ($2,764,548)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
PB
~~**Attachment 4.22-C Page 1**~~
Attachment 4.22-C Pgs. 1-3
ABP 9 Pg. 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
PB
~~**Attachment 4.22-C Page 1**~~
Attachment 4.22-C Pg. 1
ABP 9 Pgs. 1-2

10. SUBJECT OF AMENDMENT:

Third Party Liability-Health Insurance Premium Program (HIPP), "Condition and Requirements," is being updated to remove guideline criteria barriers to accessing services available through other group health plans in order to continue as a cost-effective program for enrollees and the State.

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.

[redacted]FFICIAL:

13. TYPED NAME:
Cody Phinney

14. TITLE:
Acting Administrator, Division of Healthcare Financing and Policy

15. DATE SUBMITTED:
12/6/18

16. RETURN TO:

Lynne Foster, Chief of Division Compliance
DHCFP/Medicaid
1100 East William Street, Suite 101
Carson City, NV 89701

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/6/18

18. DATE APPROVED:
March 6, 2019

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 11/30/18

20. SIGNATURE O[redacted]

21. TYPED NAME: Richard Allen

22. Director, Western Regional Operations Group

23. REMARKS:
Pen and Ink Request: 1. Box 8: Please change from "Attachment 4.22-C Pg. 1" to "Attachment 4.22-C Pgs. 1-3 / ABP 9 Pg. 1". 2. Box 9: Please change from "Attachment 4.22-C Pg. 1" to "Attachment 4.22-C Pg. 1 / ABP 9 Pgs. 1-2".

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nevada

Citation	Condition or Requirements

1906 of the Act State Method on Cost Effectiveness of Group Health Plans

1. The methodology used by Nevada for determining cost effectiveness of paying individual or group health insurance premiums for existing coverage shall be as follows:

   a. Applicant must be on Medicaid Fee-for-Service (FFS) for a minimum of six months.

   b. The state will take the following steps:

      a. Total 6 months billed group health plan divided by 6 = Average Premium Cost.

      b. Total 6 months Medicaid Medical Expenditures divided by 6 = Recognized Average Medicaid Expenditures.

      c. Recognized Average Medicaid Expenditures greater than Average Group Health Plan Premium plus Administrative Expenditures = Cost Effectiveness.

   c. The average Medicaid cost includes the benefits covered under the Medicaid eligibility group for which the individual would be determined eligible.

   d. Administrative costs include additional administrative cost to Medicaid for administering the premium assistance program as well as the following:

      Benefits wrap. If Medicaid services covered under the State Plan are not part of the services covered by a recipient's employer health care coverage, the recipient may obtain those services from participating Medicaid providers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nevada

Citation	Condition or Requirements

a. Cost-sharing wrap. The State will provide a cost-sharing wrap to any cost-sharing amounts that exceed the cost-sharing limits described in the State Plan.

b. Premiums for non-eligible family members. Non-eligible family members are covered only if it is necessary in order to enroll a Medicaid eligible family member in the group health plan.

e. The state may also cover a recipient who has an existing medical confirmed condition or illness that is determined to be cost-effective under the Health Insurance Premium Program (HIPP) expenditure methodology.

2. Individuals enrolled in the premium assistance program are afforded the same beneficiary protections provided to all other Medicaid enrollees. As discussed in the cost-effectiveness test above, the Nevada Medicaid program will provide a benefits wrap and cost-sharing wrap. To effectuate the cost sharing wrap:

a. The State has a provider enrollment process for non-participating providers to ensure that providers that service Medicaid beneficiaries can be enrolled and paid through the state Medicaid program for any and all cost sharing amounts that exceed the Medicaid permissible limits;

b. The State will encourage non-participating providers to enroll by conducting outreach to the provider community to educate non-participating Medicaid providers on how to enroll in Medicaid for the purposes of receiving payment from the State.

c. The State will inform beneficiaries regarding how to contact the state's fiscal agent if the beneficiary intends to obtain care from a non-participating provider.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nevada

Citation	Condition or Requirements

d. In cases where the State becomes aware of a non-participating Medicaid provider, the State may implement a "single case" agreement with that provider to allow cost-sharing wrap for a specific individual.

The cost sharing wrap is required by section 1906(a)(3) of the Social Security Act.

3. Redetermination Review

a. The DHCFP or contracted vendor shall complete a redetermination review at least yearly for all HIPP enrollees. The yearly review shall consist of:

i. Verifying Medicaid eligibility; and

ii. Completing a cost-effective analysis.

Failure to meet HIPP enrollment eligibility cost-effective criteria during annual redetermination review will result in disenrollment from the Nevada Medicaid HIPP Program.

Alternative Benefit Plan

State Name: Nevada | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: NV - 18 - 0014

Employer Sponsored Insurance and Payment of Premiums — ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package. **Yes**

Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:

The HIPP Program is available to any Fee-for-Service recipient that has access to Employer Sponsored Insurance Health Plan (ESI) that provides physician and major medical coverage. Nevada Medicaid may pay insurance premiums through ESI Plans for individuals and families when it is cost effective for the agency. In determining cost-effectiveness, the State uses a formula as set forth on Attachment 4.22-C in the State's approved Medicaid state plan. More details about the State's ESI program can be found at Attachment 4.22-C.

The state/territory otherwise provides for payment of premiums. **Yes**

Provide a description including the population covered, the amount of premium assistance by population, required contributions, cost-effectiveness test requirements, and benefits information.

The HIPP Program is available to any Fee-for-Service recipient that has access to Employer Sponsored Insurance Health Plan (ESI) that provides physician and major medical coverage. Nevada Medicaid may pay insurance premiums through ESI Plans for individuals and families when it is cost effective for the agency. In determining cost-effectiveness, the State uses a formula as set forth on Attachment 4.22-C in the State's approved Medicaid state plan. More details about the State's ESI program can be found at Attachment 4.22-C.

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

The state assures that ESI coverage is established in Section 3.2 (Coordination of Medicaid with Medicare and other insurance) and 4.22(h) (Third Party Liability methods for determining cost-effectiveness) of the state's approved Medicaid state plan. For a Medicaid beneficiary who receives coverage through ESI Plans, the state assures that the Medicaid beneficiary will receive a benefit package that includes a wrap of benefits around the ESI Plan that equals the benefit package to which the beneficiary is entitled under the state plan pages.

The additional health benefits, on top of the ESI, to which the beneficiary is entitled include those called out in ABP7 (FQHC/RHC services, family planning services, etc.)

V.20160722