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 ~~Employer-Based~~ Group Health Plans

Cost effectiveness is defined as the amount paid for premiums, coinsurance, deductibles and other cost sharing obligations under a group health plan. Additional administrative costs are likely to be less than the amount paid for an equivalent set of Medicaid services. 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. A minimum of ~~S~~six-months of medical expenditures or average six-months Medicaid payments ~~equal two times or~~are greater than the amount of the monthly insurance premium.

1. Average Medicaid costs will include Medicaid allowed services which are benefits covered under the group health plan policy, age of recipient and aid category. ~~Primary Medicaid benefits would include inpatient and outpatient services, hospital services, physician, dental, pharmacy, and ambulatory surgery services.~~

2. Administrative costs account for additional administrative cost to Medicaid for processing the group health information by determining the average increase in cost per recipient paid by the state on behalf of the recipient to Medicare or another state or federal program or service.

a. Other Medicaid services would be included if covered as an insurance benefit and indicated by recipient's medical condition. ~~Additional services could include home health services, nursing facility care, and durable medical equipment, or~~

b. 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.

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b. A Recipient who has an existing medically confirmed condition or illness and is determined to be cost-effective under the Health Insurance Premium Program (HIPP) expenditure methodology.~~has a catastrophic illness or condition (e.g., AIDS or AIDS-related condition, plegia, Downs Syndrome, Cerebral Palsy Cystic Fibrosis, Fetal Alcohol Syndrome, etc.)~~

c. Redetermination Review

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

a. Verifying Medicaid eligibility; and
b. 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.