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 described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place check mark to affirm such compliance.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System.

The State will contract with the entity(ies) below and reimburse them as noted under each entity type.

1. X MCO
   a. X Capitation

2. ☐PCCM (individual practitioners)
   a. ☐ Case management fee
   b. ☐ Bonus/incentive payments
   c. ☐ Other (please explain below)

3. X PCCM (entity based)
   a. X Case management fee
   b. X Bonus/incentive payments
   c. X Other (please explain below)

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

Citation | Condition or Requirement

Payment Methods

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

For states that elect to pay a PCCM a bonus/incentive payment as indicated in B.2.b. or B.3.b, place a check mark to affirm the state has met ***all*** of the following conditions (which are representative of the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

☐a. 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.

Not applicable to Nevada's PCCM as the incentive methodology was approved by CMS in the Nevada comprehensive Care Waiver (NCCW).

X b. Incentives will be based upon a fixed period of time.

X c. Incentives will not be renewed automatically.

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

X e. Incentives will not be conditioned on intergovernmental transfer agreements.

X f. Incentives will be based upon specific activities and targets.

Citation	Condition or Requirement
CFR 438.50(b)(4)	C. Public Process. Describe the public process including tribal consultation, if applicable, 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.
	D. 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 Beneficiaries 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)	5. X The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).
1932(a)(1)(A) 42 CFR 438	6. X The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met. 1903(m) Under the authority of the NCCW, the following requirements of the State Plan are waived for the PCCM program:

Citation | Condition or Requirement

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)

7. X The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.

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

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

45 CFR 92.36

9. X The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

1932(a)(1)(A)
1932(a)(2)

E. Populations and Geographic Area

1. **Included Populations.** Please check which eligibility populations are included, if they are enrolled on a mandatory (M) or voluntary (V) basis, and the geographic scope of enrollment. Under the geography column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions.

MCO					
Population	**M**	**Geographic Area**	V	**Geographic Area**	**Excluded**
Section 1931 Children & Related Populations – 1905(a)(i)	X	Urban Washoe and Urban Clark Counties			
Section 1931 Adults & Related Populations 1905(a)(ii)	X	Urban Washoe and Urban Clark Counties			
Low-Income Adult Group	X	Urban Washoe and Urban Clark Counties			
Former Foster Care Children under age 21	X	Urban Washoe and Urban Clark Counties			
Former Foster Care Children age 21-25	X	Urban Washoe and Urban Clark Counties			
Section 1925 Transitional Medicaid age 21 and older	X	Urban Washoe and Urban Clark Counties			
SSI and SSI related Blind Adults, age 18 or older* - 1905(a)(iv)					X
Poverty Level Pregnant Women – 1905(a)(viii)	X	Urban Washoe and Urban Clark Counties			
SSI and SSI related Blind Children, generally under age 18 – 1905(a)(iv)					X

Citation | Condition or Requirement

MCO					
Population	**M**	**Geographic Area**	V	**Geographic Area**	**Excluded**
SSI and SSI related Disabled children under age 18					X
SSI and SSI related Disabled adults age 18 and older – 1905(a)(v)					X
SSI and SSI Related Aged Populations age 65 or older- 1905(a)(iii)					X
SSI Related Groups Exempt from Mandatory Managed Care under 1932(a)(2)(B)					X
Recipients Eligible for Medicare					X
American Indian/Alaskan Natives			X	Urban Washoe and Urban Clark Counties	
Children under 19 who are eligible for SSI					X
Children under 19 who are eligible under Section 1902(e)(3)					X
Children under 19 in foster care or other in-home placement			X	Urban Washoe and Urban Clark Counties	
Children under 19 receiving services funded under section 501(a)(1)(D) of title V and in accordance with 42 CFR 438.50(d)(v)			X	Urban Washoe and Urban Clark Counties	
Other: Title XIX Medicaid children under 18 defined as the Severely Emotionally Disturbed (SED)			X	Urban Washoe and Urban Clark Counties	
Other Adults age 18 and over defined as Seriously Mentally Ill (SMI)**			X	Urban Washoe and Urban Clark Counties	

**Nevada Medicaid Newly Eligibles, defined as childless adults ages 19-64, and the expanded parent and caretakers ages 19-64, who are made eligible as part of the Patient Protection and Affordable Care Act (PPACA) expansion population and who are receiving the Alternative Benefit Plan, cannot opt out of managed care, where available, based on a determination of Serious Mental Illness (SMI).

Citation | Condition or Requirement

PCCM					
Population	**M**	**Geographic Area**	V	**Geographic Area**	**Excluded**
Section 1931 Children & Related Populations – 1905(a)(i)	X	Rural Nevada Non Urban Counties			
Section 1931 Adults & Related Populations 1905(a)(ii)					
Low-Income Adult Group	X	Rural Nevada Non Urban Counties			
Former Foster Care Children under age 21					X
Former Foster Care Children age 21-25	X	Rural Nevada Non Urban Counties			
Section 1925 Transitional Medicaid age 21 and older					X
SSI and SSI related Blind Adults, age 18 or older* - 1905(a)(iv)					
Poverty Level Pregnant Women – 1905(a)(viii)	X	Rural Nevada Non Urban Counties			
SSI and SSI related Blind Children, generally under age 18 – 1905(a)(iv)					
SSI and SSI related Disabled children under age 18					
SSI and SSI related Disabled adults age 18 and older – 1905(a)(v)					
SSI and SSI Related Aged Populations age 65 or older- 1905(a)(iii)					
SSI Related Groups Exempt from Mandatory Managed Care under 1932(a)(2)(B)					
Recipients Eligible for Medicare					
American Indian/Alaskan Natives			X	Statewide	
Children under 19 who are eligible for SSI	X	Rural Nevada Non Urban Counties			
Children under 19 who are eligible under Section 1902(e)(3)					
Children under 19 in foster care or other in-home placement					

Citation | Condition or Requirement

PCCM					
Population	**M**	**Geographic Area**	V	**Geographic Area**	**Excluded**
Children under 19 receiving services funded under section 501(a)(1)(D) of title V and in accordance with 42 CFR 438.50(d)(v)					

2. **Excluded Groups.** Within the populations identified above as Mandatory or Voluntary, there may be certain groups of individuals who are excluded from the managed care program. Please indicate if any of the following groups are excluded from participating in the program:

☐ Other Insurance--Medicaid beneficiaries who have other health insurance.

X Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

Nursing Facility:
The MCO is required to cover the first 45 days of a nursing facility admission. The MCO shall notify the DHCFP of any nursing facility stay admission expected to exceed forty-five (45) days. The beneficiary will be disenrolled from the MCO and the stay will be covered by FFS commencing on the 46th day of the facility stay.

ICF/ID:
Residents of ICF/ID facilities are not eligible for enrollment with the MCO. If a beneficiary is admitted to an ICF/ID 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.

☐ Enrolled in Another Managed Care Program - Medicaid beneficiaries who are enrolled in another Medicaid managed care program

☐ Eligibility Less Than 3 Months - Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

X Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

Beneficiaries who are receiving HCBS Waiver are not eligible for enrollment with the MCO. If a beneficiary is made eligible for the HCBS Waiver after MCO enrollment, the beneficiary will be disenrolled and the HCBS Waiver will be reimbursed through FFS.

☐ Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.

X Other (Please define):

Citation | Condition or Requirement

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. The MCO shall notify the DHCFP of any swing bed stay expected to exceed forty-five (45) days. The beneficiary 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.

Residential Treatment Center (RTC)
Medicaid beneficiaries 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.

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.

Seriously Emotionally Disturbed/Severely Mentally Ill SED/SMI, with limitations
The MCO is required to notify the DHCFP if a Title XIX Medicaid beneficiary elects to disenroll from the MCO following the determination of SED/SMI. However, in the event the Medicaid beneficiary, who has received such a determination, chooses to remain enrolled with the MCO, the MCO will be responsible for providing all patient care.

Nevada Medicaid Newly Eligibles, defined as childless adults ages 19-64, and the expanded parent and caretakers ages 19-64, who are made eligible as part of the PPACA expansion population and who are receiving the Alternative Benefit Plan, cannot opt out of managed care, where available, based on a determination of Serious Mental Illness (SMI).

1932(a)(4)

F. Enrollment Process.

1. Definitions.

   a. Auto Assignment- assignment of a beneficiary to a health plan when the beneficiary has not had an opportunity to select their health plan.

   b. Default Assignment- assignment of a beneficiary to a health plan when the beneficiary has had an opportunity to select their health plan.

2. Please describe how the state effectuates the enrollment process. Select an enrollment methodology from the following options and describe the elements listed beneath it:

   a. X The applicant is permitted to select a health plan at the time of application.

      i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

         At the time of application, the applicant is provided with each MCO plan's telephone number and website. The MCOs have complete lists of active providers on their websites. The applicants also have access to a

Citation | Condition or Requirement

comparison chart of the MCOs which highlights each plan's added benefits.

ii. What action the state takes if the applicant does not indicate a plan selection on the application.

A first time beneficiary, that is one who has never been enrolled in an MCO and who is not joining an established case, will be asked to complete their selection of an MCO at the time of Medicaid application. Their enrollment will go into effect immediately upon approval of their Medicaid eligibility.

Absent a choice by the applicant, the State will complete a default enrollment process, and they will be assigned to an MCO based upon an algorithm developed by the State to distribute enrollees among the MCOs.

The beneficiary has a 90 day period in which they are entitled to change MCOs. Beneficiaries may also change their MCO once every 12 months during open enrollment.

For a beneficiary, new to Medicaid or returning, who is joining an open case where another family member is currently enrolled in an MCO; they will automatically be assigned to the same MCO as the rest of the family and will not have a 90 day right to change period. Their enrollment will go into effect immediately upon approval of their Medicaid eligibility.

These new case members, as well as the rest of the family, remain locked-in until the next open enrollment period.

A returning Medicaid beneficiary who had a lapse in managed care enrollment for 2 months or less due to a loss in Medicaid eligibility will automatically be assigned to their former MCO. For those returning in the first month, their enrollment will go into effect the beginning of that month with no laps in enrollment. For those returning in the second month, their enrollment will go into effect immediately upon approval of their Medicaid eligibility. They will not have a 90 day right to change period and will be considered locked-in until the next open enrollment period.

A returning Medicaid beneficiary, who had a lapse in managed care enrollment for 2 months or less for reasons other than a loss in Medicaid eligibility OR for more than 2 months no matter the reason, will have enrollment rules applied as follows. Their enrollment will go into effect immediately upon approval of their Medicaid eligibility.

If the beneficiary is returning to an open case where another family member is currently enrolled in an MCO, they will automatically be assigned to the same MCO as the rest of the family and they will not have a 90 day right to change period and will be considered locked-in until the next open enrollment period.

Citation | Condition or Requirement

If there are no other family members on the case currently enrolled in an MCO, and the beneficiary made a new MCO choice on their application, they will be enrolled into their MCO of choice and may disenroll without cause within the first 90 days of enrollment.

If the beneficiary did not make a new choice on their application, they will be assigned to their former MCO and may disenroll without cause within the first 90 days of enrollment.

Regardless of which enrollment or default 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.

For the MCOs, the total maximum 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.

iii. If action includes making a default assignment, describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

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 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%**

Citation | Condition or Requirement

*** 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.**

iv. The state's process for notifying the beneficiary of the default assignment. (Example: *state generated correspondence*.)

Once an assignment has been made using the State's enrollment rules, the appropriate Welcome to Managed Care letter is mailed by the State's fiscal agent

b. ☐ The beneficiary has an active choice period following the eligibility determination.

i. How the beneficiary is notified of their initial choice period, including its duration.

ii. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

iii. Describe the algorithm used for default assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

iv. The state's process for notifying the beneficiary of the default assignment.

c. ☐ The beneficiary is auto-assigned to a health plan immediately upon being determined eligible.

i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

ii. The state's process for notifying the beneficiary of the auto-assignment. (*Example: state generated correspondence*.)

iii. Describe the algorithm used for auto-assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

1932(a)(4)
42 CFR 438.50

3. 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.

a. X The state assures it has an enrollment system that allows Beneficiaries 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.

Citation	Condition or Requirement

b. X The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid Beneficiaries 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).

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.

c. X The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties: All 15 rural Nevada counties.

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

d. 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 438.56

G. Disenrollment

1. The state will X/will not☐ limit disenrollment for managed care.

2. The disenrollment limitation will apply for twelve months (up to 12 months).

3. X The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe the state's process for notifying the Medicaid Beneficiaries of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

A beneficiary in their 90 day right to change period is notified by a Welcome to managed Care letter mailed by the State's fiscal agent. The letter provides the beneficiary with the instructions and timeframe for requesting a switch in their MCO plan.

5. 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.

Citation	Condition or Requirement
	H. Information Requirements for Beneficiaries
1932(a)(5)(c) 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(e) for information requirements specific to MCOs and PCCM programs operated under 1932(a)(1)(A)(i) state plan amendments.
1932(a)(5)(D)(b) 1903(m) 1905(t)(3)	I. List all benefits for which the MCO is responsible. The MCOs are responsible for providing their members all Medicaid State Plan benefits, except the following services: **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 HIS. The MCO is required to coordinate all services with IHS. **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. **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 the child is found eligible for these services, then an Individual Education Plan (IEP) is developed for the child, which is sent to the child's PCP within the managed health care plan. 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. **All Pre-admissions Screening and Resident Review (PASRR) and Level of Care (LOC)** Assessments are performed by the State's Fiscal Agent. Conducting a PASRR and LOC will not prompt MCO disenrollment, however, if the beneficiary is admitted to a nursing facility as the result of a PASRR and LOC, the MCO is responsible for the first 45 days of admission. **Adult Day Health Care** Adult Day Health Care (ADHC) services for eligible managed care beneficiaries are covered under fee-for-service. The Vendor is responsible for ensuring referral and coordination of care for ADHC services.

Citation	Condition or Requirement
	Targeted Case Management Targeted Case Management (TCM) has a specific meaning for Nevada Medicaid and Nevada Check Up. TCM, as defined by Chapter 2500 in the Medicaid Services Manual is carved out of the managed care contracts. Case management, with differs from TCM, is required from the contracted Vendors. **Orthodontic Services** The contracted MCOs are required to provide all covered medically necessary dental services with the exception of orthodontic services, which are covered under FFS.
1932(a)(5)(D)(b)(4) 42 CFR 438.228	J. X The state assures that each managed care organization has established an internal grievance procedure for enrollees.
1932(a)(5)(D)(b)(5) 42 CFR 438.206 42 CFR 438.207	K. Describe how the state has assured adequate capacity and services. The state has contract language that requires the MCOs to demonstrate that the capacity of their PCP network meets the FTE requirements for accepting eligible beneficiaries per service area. The MCOs are required to use geo-mapping and data-driven analyses to ensure compliance with access standards and take appropriate corrective action, if necessary, to comply with such access standards. The contract includes appointment access standards. If a recipient is having access to care issues, they can contact their MCO for assistance, which must ensure timely access to covered services. The MCOs partner actively with the DHCFP, community providers and stakeholders to identify and address issues and opportunities to improve health care access and availability for Medicaid and CHIP members.
1932(a)(5)(D)(c)(1)(A) 42 CFR 438.240	L. X The state assures that a quality assessment and improvement strategy has been developed and implemented.
1932(a)(5)(D)(c)(2)(A) 42 CFR 438.350	M. X The state assures that an external independent review conducted by a qualified independent entity will be performed yearly.
1932 (a)(1)(A)(ii)	N. 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. 1. The state will X/will not☐ intentionally limit the number of entities it contracts under a 1932 state plan option. 2. X The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services. 3. 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.)* Historically Nevada has limited its managed care program to two managed care organizations to ensure an adequate number of enrollees to support the

Citation	Condition or Requirement
	administrative and quality management requirements of the program. In the future, due to the large increase in enrollment in managed care resulting from Nevada implementing the expansion to the Medicaid population authorized by the Patient Protection and Affordable Care Act, Nevada may increase the number of managed care organizations it contracts with.
	4. ☐The selective contracting provision in not applicable to this state plan.

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, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

CMS-10120 (exp. 3/31/2014)